Attachment 2 - Application Checklist

The checklist presented in this Attachment 2 is provided to assist Applicants in ensuring that Applicant submits a complete Application. Please complete and return with Application. This Application Checklist is for the Applicant’s convenience and does not alter the Minimum Submission requirements in Section 3.2.

Application Submission Materials, Mandatory Except as Noted

N/A  Attachment 1 – Letter of Intent
☒  Attachment 2 – Application Checklist
☒  Attachment 3 – Applicant Information and Certification Sheet
☒  Executive Summary
☒  Full County Coverage Exception Requests (Section 3.2) *(Optional)*
☒  Reference Checks (Section 3.4.e.)
☒  Attachment 4 – Disclosure Exemption Certificate
☒  Attachment 4 – Exhibit 3 - List of Exempted Information.
☒  Attachment 5 – Responsibility Check Form
☒  Attachment 6 – General Questionnaire
N/A  Attachment 6 – Narratives
☒  Attachment 6 – Articles of Incorporation
☒  Attachment 6 – Chart or listing presenting the identities of and interrelationships between the parent, Affiliates and the Applicant.
☒  Attachment 6 – Subcontractor and Delegated Entities Report
☒  Attachment 7 – Provider Participation and Operations Questionnaire
☒  Attachment 7 – DSN Provider Report
☒  Attachment 8 – Value-Based Payments Questionnaire
☒  Attachment 8 – RFA VBP Data Template
☒  Attachment 9 – Health Information Technology Questionnaire
☒  Attachment 10 – Social Determinants of Health and Health Equity Questionnaire
☒  Attachment 11 – Behavioral Health Questionnaire
☒  Attachment 12 – Cost and Financial Questionnaire
☒  Attachment 12 – Pro Forma Workbook Templates (NAIC Form 13H)
☒  Attachment 12 – NAIC Biographical Certificate (NAIC Form 11)
☒  Attachment 12 – UCAA Supplemental Financial Analysis Workbook Template
☒  Attachment 12 – Three years of Audited Financial Reports
☒  Attachment 13 – Attestations
☒  Attachment 14 – Assurances
☒  Attachment 15 – Representations
☒  Attachment 16 – Member Transition Plan
☒  Redacted Copy of Application Documents for which confidentiality is asserted. All redacted items must be separately claimed in Attachment 4. *(Optional)*
Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: PacificSource Community Solutions
Address: 2965 NE Conners Ave
Bend, OR 97701

State of Incorporation: Oregon Entity Type: Domestic Non-Profit

Contact Name: Lindsey Hopper Phone: 541-706-5066
Email: lindsey.hopper@pacificsource.com

Oregon Business Registry Number: 1228429-90

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

1. Applicant understands and accepts the requirements of this RFA. By submitting an Application, Applicant acknowledges and agrees to be bound by (a) all the provisions of the RFA (as modified by any Addenda), specifically including RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims); and (b) the Contract terms and conditions in Appendix B, subject to negotiation and rate finalization as described in the RFA.

2. Applicant acknowledges receipt of any and all Addenda to this RFA.

3. Application is a firm offer for 180 days following the Closing.

4. If awarded a Contract, Applicant agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract.

5. I have knowledge regarding Applicant’s payment of taxes. I hereby certify that, to the best of my knowledge, Applicant is not in violation of any tax laws of the state or a political subdivision of the state, including, without limitation, ORS 305.620 and ORS chapters 316, 317 and 318.

6. I have knowledge regarding Applicant’s payment of debts. I hereby certify that, to the best of my knowledge, Applicant has no debts unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts.

7. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, gender, disability, sexual orientation, national origin. When awarding subcontracts, Applicant does not discriminate against any business certified under ORS 200.055 as a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business. If applicable, Applicant has, or will have prior to Contract execution, a written policy and practice, that meets the requirements described in ORS 279A.112 (formerly HB 3060), of preventing sexual harassment, sexual assault and discrimination against employees who are members of a protected class. OHA may not enter into a Contract with an Applicant that does not certify it has such a policy and practice. See https://www.oregon.gov/DAS/Procurement/Pages/hb3060.aspx for additional information and sample policy template.

8. Applicant and Applicant’s employees, agents, and subcontractors are not included on:
the "Specially Designated Nationals and Blocked Persons" list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at: https://www.treasury.gov/ofac/downloads/sdnlist.pdf, or

b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/

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

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

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

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

Signature: [Redacted]
Title: President/CEO Date: 04/15/2019

(Authorized to Bind Applicant)

State of Oregon)
) ss:
County of Lane)

Signed and sworn to before me on 4/15/19 (date) by Kenneth P. Provencher (Affiant’s name).

Notary Public for the State of Oregon
My Commission Expires: 6/14/22

OFFICIAL STAMP
LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022
Attachment 4 – Disclosure Exemption Certificate

Kenneth P. Provencher ("Representative"), representing PacificSource Community Solutions ("Applicant"), hereby affirms under penalty of False Claims liability that:

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

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

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

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

   1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:
      i. is not patented,
      ii. is known only to certain individuals within the Applicant’s organization and that is used in a business the Applicant conducts,
      iii. has actual or potential commercial value, and
      iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.
   
      Or
   
   2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:
      i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and
ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

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

5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exhibit Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.

6. I understand that disclosure of the information referenced in Exhibit A may depend on official or judicial determinations made in accordance with the Public Records Law.

Exhibit A to Attachment 4

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

PacificSource Community Solutions (PSCS) is an Oregon-based non-profit health plan currently serving coordinated care organization (CCO) members in Central Oregon and the Columbia Gorge. In our current operations as the CCO for Crook, Deschutes, Jefferson, and northern Klamath Counties, we partner with the Central Oregon Health Council (Health Council) to serve members through shared commitments to transparency in governance and financial operations, collective impact, and community reinvestment. PSCS formalizes these commitments through a Joint Management Agreement with the Health Council, which in turn operates the Community Advisory Council (CAC), the Clinical Advisory Panel, and the Finance Committee. Our model is further bolstered by inclusion of a broad and diverse set of stakeholders. Together, we are innovative, flexible, and responsive to the unique needs of our communities and the opportunities for health care transformation.

PSCS is part of the PacificSource family of companies, a non-profit company serving 325,000 commercial, Medicare, and Medicaid members across Oregon, Idaho, Montana, and Washington. PacificSource has an 86-year history as a trusted community partner providing access to care. PacificSource’s breadth, experience, capabilities, and resources allow PSCS to capitalize on a strong foundation of financial stability, scalable operations, a proven ability to implement value-based payments and cost control, and the expertise to build new models of health care delivery. In partnership with the Health Council, we bring expertise that provides the backbone supporting basic but crucial functions across claims processing and encountering, contracting, payment, compliance, utilization management, actuarial, analytics, and finance. PSCS has implemented successful value-based payment models and has already achieved many of the goals set forth in the Oregon Health Authority’s value-based payment roadmap. We are able to maintain sustainable cost growth through careful financial oversight and health services processes.

The unique Health Council structure enables community leaders across the CCO region to engage members through an effective CAC, facilitate a regional Community Health Assessment and Improvement Plan, spend Quality Pool funds and shared savings in alignment with community needs, and transform health care to address social needs and improve health equity. For example, through partnering with United Way of Deschutes County, a community movement is underway to identify high-risk populations, study the impact of trauma, resilience, and adverse childhood experiences, and fulfill the spectrum of needs for that population. PSCS has also substantially improved the availability of integrated and specialty behavioral health services through technical assistance, aligned payment models, and removing barriers.

We look forward to continuing to play a role in health system transformation in Central Oregon as a trusted partner of the Oregon Health Authority as we work with Oregon’s health care providers to serve Medicaid members in CCO 2.0.

Sincerely,

Kenneth P. Provencher
President and CEO, PacificSource

Lindsey Hopper
VP, Medicaid Programs, PacificSource
Reference

**Organization Name:** Bethlehem Inn

**Type of Organization:** Homeless Shelter

**Organization Primary Contact:** Gwenn Wysling, Executive Director

**Organization Address:** 3705 N Hwy 97, Bend, OR, 97701

**Phone Number:** 541.322.8768

**E-Mail Address:** gwenn@bethlehem.org

<table>
<thead>
<tr>
<th><strong>Project performed by the CCO for the Client within the last 5 years</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource Community Solutions (PSCS) funds Bethlehem Inn to provide physical and behavioral health care support services to CCO members housed in the shelter. PSCS supports Bethlehem Inn with regular payments using Health-Related Services funds to improve health outcomes for our shared population.</td>
</tr>
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<tr>
<th><strong>How the Project relates to Work under the RFA Sample Contract</strong></th>
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<tbody>
<tr>
<td><strong>Timely Payment:</strong> PSCS pays Bethlehem Inn timely upon receipt. PSCS has fulfilled this obligation throughout the term of the agreement.</td>
</tr>
</tbody>
</table>

**Analytics Support:** PSCS provides ongoing analytics support to Bethlehem Inn, as well as evaluation planning support and ad hoc reporting.

**Sustainability:** PSCS has funded several Bethlehem Inn initiatives to improve health outcomes for our shared population. For example, PSCS funds Bethlehem Inn to connect CCO members and residents with health care services.
**Reference**

**Organization Name:** Central Oregon Pediatric Associates  
**Type of Organization:** Pediatric Medical Clinic  
**Organization Primary Contact:** Wade Miller, Chief Executive Officer  
**Organization Address:** 2200 NE Professional Ct, Bend, OR 97701  
**Phone Number:** 541.389.6313  
**E-Mail Address:** wmiller@copakids.com

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<tr>
<th>Project performed by the CCO for the Client within the last 5 years</th>
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<tbody>
<tr>
<td>PacificSource Community Solutions (PSCS) contracts with Central Oregon Pediatric Associates (COPA) to pay for services delivered to CCO members by COPA’s providers in clinics across Central Oregon.</td>
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<tr>
<th>How the Project relates to Work under the RFA Sample Contract</th>
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<tr>
<td>Value-Based Payment: PSCS works collaboratively with COPA to support its success in a value-based payment (VBP) arrangement. PSCS supports COPA with analytics, timely risk reporting, and practice facilitation to promote shared success. PSCS has also made payments to COPA to support integration and expanded care coordination through Patient-Centered Primary Care Home value-based payments linked to COPA’s tier status. These funds support COPA’s primary care infrastructure and integrated services.</td>
</tr>
<tr>
<td>Claims Payment: PSCS pays COPA’s claims timely and processes an array of payment methodologies, including capitation, fee-for-service reimbursement, withholds, and shared savings. PSCS monitors its turnaround time and other key indicators of organizational performance to ensure that COPA’s needs are met on a timely basis.</td>
</tr>
<tr>
<td>Customer Service: PSCS offers customer service support and dedicated provider service support to ensure COPA’s needs are met. PSCS assigns a dedicated provider service representative to support COPA and dedicates quality improvement resources to support new strategies and care models.</td>
</tr>
<tr>
<td>Behavioral Health Integration: PSCS supports COPA’s progress towards integration and health system transformation by funding behavioral health integration services that meet the Integrated Behavioral Health Alliance standards. PSCS also offers technical assistance and on-site facilitation to support this work.</td>
</tr>
</tbody>
</table>
Reference

Organization Name: Crook County Public Health Department

Type of Organization: Public Health Department

Organization Primary Contact: Muriel DeLaVergne-Brown, Public Health Director

Organization Address: 375 NW Beaver St #100, Prineville, OR, 97754

Phone Number: 541.447.5165

E-Mail Address: mdelavergnebrown@h.co.crook.or.us

<table>
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<tr>
<th>Project performed by the CCO for the Client within the last 5 years</th>
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</thead>
<tbody>
<tr>
<td>PacificSource Community Solutions (PSCS) contracts with Crook County Public Health to provide physical and behavioral health services to CCO members in Crook County.</td>
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<tr>
<th>How the Project relates to Work under the RFA Sample Contract</th>
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<tbody>
<tr>
<td>Claims Payment: PSCS has worked to identify an array of services provided by Crook County and supports Crook County with fee-for-service payments in a timely manner.</td>
</tr>
</tbody>
</table>

Customer Service: PSCS provides customer service and dedicated provider service support to ensure Crook County’s needs are met. PSCS assigns a provider service representative to Crook County to offer individualized, timely support.

Additional Support: PSCS has funded several projects with Crook County to improve the health of our members. For example, PSCS funded Crook County to receive training in One Key Question and deploy this practice to improve the health and well-being of pregnant women, infants, and young children.
Reference

Organization Name: St. Charles Health System

Type of Organization: Hospital, Primary Care, and Specialty Care

Organization Primary Contact: Jennifer Welander, Chief Financial Officer

Organization Address: 2500 NE Neff Rd, Bend, OR, 97701

Phone Number: 541.382.4321

E-Mail Address: jrwelander@stcharleshealthcare.org

<table>
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<tr>
<th>Project performed by the CCO for the Client within the last 5 years</th>
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</thead>
<tbody>
<tr>
<td>PacificSource Community Solutions (PSCS) contracts with St. Charles Health System to pay for physical and behavioral health services (along with facility and ancillary services) provided by contracted and employed St. Charles providers for CCO members throughout Central Oregon.</td>
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<tr>
<th>How the Project relates to Work under the RFA Sample Contract</th>
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<tr>
<td>Value-Based Payment: PSCS works collaboratively with St. Charles Health System to support its success in a value-based payment (VBP) arrangement. PSCS provides analytics, timely risk reporting, and practice facilitation to promote shared success. PSCS has also made payments to St. Charles Health System to support integration and expanded care coordination through Patient-Centered Primary Care Home VBPs linked to the PCPCH tier of each St. Charles clinic. These funds support primary care infrastructure.</td>
</tr>
</tbody>
</table>

| Claims Payment: PSCS pays St. Charles’ claims timely and processes an array of payment methodologies, including capitation, fee-for-service reimbursement, withholds, and shared savings. PSCS monitors its turnaround time and other key indicators of organizational performance to ensure that St. Charles’ needs are met on a timely basis. |

| Customer Service: PSCS offers customer service support and dedicated provider service support to ensure St. Charles’ needs are met. PSCS assigns a provider service representative to St. Charles to offer individualized, timely support. |

| Behavioral Care Integration: PSCS supports St. Charles’ progress towards integration and health system transformation by funding behavioral health integration services that meet the Integrated Behavioral Health Alliance standards. PSCS also offers technical assistance and on-site facilitation to support this work. |
PSCS respectfully propose to serve less than a full county, consistent with the current boundary of the existing PSCS CCO that serves Central Oregon. Specifically, we propose that our service area cover residents who reside in these zip codes in northern Klamath County: 97731, 97733, 97737, and 97739.

(1) Serving these northern Klamath County residents will allow us to achieve the transformation goals of CCO 2.0 more effectively than county-wide coverage in the following areas:

Community engagement, governance, and accountability
In partnership with the Central Oregon Health Council (Health Council), our community governance structure provides for enhanced community engagement opportunities. Representatives from southern Deschutes County (i.e.: La Pine), which borders northern Klamath County, serve on the Health Council Board, Clinical Advisory Panel (CAP), Community Advisory Committee (CAC), and Community Health Improvement Plan (CHP) workgroups. The Health Council Board and the CAC meet at least annually in southern Deschutes County to engage with the community in public meetings. We have a strong relationship with the regional Federally Qualified Health Center (FQHC), La Pine Community Health Center. We contract with this FQHC system to serve southern Deschutes County and northern Klamath County. Their clinic sites are within 1-20 miles of all Klamath County zip codes we currently serve and propose to continue to serve in this Application. The FQHC runs a School-Based Health Center in one of the Klamath County zip codes we serve, which is the only site of care for residents in the town of Gilchrist, and the FQHC is very active in Health Council subcommittees as well as in the development of the CHA and CHP. Klamath County residents that live south of Crescent participate in CCO governance and community engagement to the south with Cascade Health Alliance due to the natural geographical divide. We are proposing to serve Central Oregon as a cohesive region, which includes the communities of northern Klamath County, and is consistent with our existing regional approach to community engagement, governance, and accountability. The Klamath County Commissioners support our application and desire to retain the current CCO service area boundaries in CCO 2.0, because residents in northern Klamath County benefit from receiving care in our service area, due to geographic proximity, and because of our commitment to provide the same quality of care to members in rural and frontier areas as those in urban areas.

Behavioral Health integration and access
The FQHC, discussed above, offers integrated behavioral health services and employs Behavioral Health Consultants in their clinics. Members have shared positive feedback about their services on member satisfaction surveys, regarding access to all services, including behavioral health. The clinics also provide walk-in services after regular business hours. Additionally, the FQHC offers the only health care services available in zip code 97737. In our 2016 Access Study, their consumer quantitative results were also positive: their assigned members rated access more favorably than members across the region as a whole. In addition, Deschutes County Health Services operates a clinic in southern Deschutes County and provides public health, behavioral health, and safety net services to members in northern Klamath County. Residents in northern Klamath County benefit from receiving care in our Service Area due to geographic proximity and ease of access. Similarly, residents south of the Klamath County zip
codes we are proposing to serve benefit from receiving care and ease of access in the southern part of the County, due to their geographic proximity. CCO members that reside in northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship, particularly during inclement weather.

**Social Determinants of Health and Health Equity**
Both the FQHC discussed above and Deschutes County Health Services serve individuals seeking care in northern Klamath County, regardless of insurance status or any other factor, to ensure equitable access. Both organizations participate actively in Health Council committees as well as in the development and implementation of the regional CHA and CHP. Both organizations screen for SDOH factors, such as transportation and food insecurity, within their patient population and connect members to such services. CCO members in northern Klamath County have interacted far more, if not completely, with providers and community-based organizations in the PSCS CCO versus Cascade Health Alliance. The model currently in place addresses SDOH-HE factors that are unique to northern Klamath County residents that, based on geography, naturally identify more with Deschutes County than southern Klamath County.

**Value-Based Payments and cost containment**
PSCS already contracts with the providers that serve the zip codes in northern Klamath County that we propose to serve. Both the FQHC discussed above and Deschutes County Health Services have been parties to value-based payment arrangements with the CCO for over five years. We have also provided funding to the FQHC to increase Patient Centered Primary Care Home (PCPCH) tiers and to integrate behavioral health services in their clinics. These agreements have proven effective for both parties in expanding access, containing cost, and improving quality. In addition, some providers have satellite offices located in the zip codes in northern Klamath County, but their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in the rest of Klamath County are based in Klamath Falls. Residents of northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship particularly during inclement weather. As discussed above, members residing in these four zip codes in northern Klamath are already being served by providers in southern Deschutes County and Bend. We will continue to explore the possibility of expanding value-based payments and further cost containment measures with these other providers; however, PSCS already has significant such payments and measures in place with the main providers in northern Klamath County.

**Financial viability**
Our request to retain the existing boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or risk. Instead, it is driven by our ability to best serve a community. We have existing contractual arrangements to serve members in northern Klamath County and make no decisions about them on a financial basis based on county lines. We do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of provider rate setting. We have made investments to expand access to residents of southern Deschutes County and northern Klamath County, based on emergency department utilization and the request of the FQHC, which serves members on a walk-in basis if they can accommodate the level of care without sending members to Bend. Any residents of southern Deschutes County or northern Klamath County who need a
higher level of care than can be provided in a primary care setting are referred by their provider to Bend and not to Klamath Falls.

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county; and Northern Klamath County residents in zip codes 97731, 97733, 97737, and 97739 tend to have patterns of care that take them to Deschutes County because it is significantly closer, geographically, than seeking services in Klamath County. We have been serving this community for over five years. This partial county service area will promote ease of access and expanded access for members, improve continuity of care for our members, increase meaningful provider interaction, and reinforce current patterns of travel that align with utilization of health care services, employment, and social services. As discussed above, PSCS already contracts with the providers that serve the four zip codes listed above. Some providers have satellite offices located in the zip codes in northern Klamath County, but their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in Klamath County are based in Klamath Falls. CCO members residing in northern Klamath County are already being served by providers in southern Deschutes County and Bend. With respect to referral patterns associated with provider affiliations, providers in southern Klamath County refer to the Sky Lakes Medical Center in Klamath Falls. In contrast, providers in northern Klamath County refer to providers available in La Pine and Bend. There are no services available in Klamath Falls that are not available in Bend. Because Bend is a larger community than Klamath Falls, more services are available in the Central Oregon region than the southern Klamath Falls region.

CCO members in northern Klamath County have interacted far more, if not completely, with providers and communities in the Central Oregon CCO than with the Klamath County CCO. The model currently in place has been effective in addressing and providing appropriate access with more meaningful provider interaction opportunities and less travel restrictions than heading south to Klamath County. Community members in northern Klamath County naturally, based on geography, identify and more easily connect to services in Deschutes County than southern Klamath County. Based on this same rationale, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.

(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas. Our request to retain the existing CCO boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or designed to minimize risk. Instead, it is driven by our ability to best serve a community that naturally fits within the Central Oregon definition and service region. We have existing contractual arrangements to serve members in northern Klamath County and make no decisions about them on a financial basis based on county lines. We do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of provider rate setting, and our proposal to the OHA does not create adverse selection. As discussed above, consistent with this assertion, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.
Attachment 5 - Responsibility Check Form

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

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?
   YES [x] NO [ ]

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant’s Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party?
   Number: 8
   How many contracts did not meet those standards? Number: 0
   If any, please explain.
   Response:

3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant’s firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:
   • obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,
   • violation of federal or state antitrust statutes relating to the submission of bids or proposals, or
   • embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?
   YES [ ] NO [x]
   If "YES," indicate the jurisdiction, date of indictment, charge or judgment, and names and summary of charges in the response field below.
   Response:

4. Within the last three years, has Applicant had:
   • any contracts terminated for default by any government agency, or
   • any lawsuits filed against it by creditors or involving contract disputes?
   YES [ ] NO [x]
   If "YES," please explain. (With regard to judgments, include jurisdiction and date of final judgment or dismissal.)
   Response:
5. Does Applicant have any outstanding or pending judgments against it?
   YES □ NO [X]

   Is Applicant experiencing financial distress or having difficulty securing financing?
   YES □ NO [X]

   Does Applicant have sufficient cash flow to fund day-to-day operations throughout the proposed Contract period?
   YES [X] NO □

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

6. Within the last three years, has Applicant filed a bankruptcy action, filed for reorganization, made a general assignment of assets for the benefit of creditors, or had an action for insolvency instituted against it?
   YES □ NO [X]

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

7. Does Applicant have all required licenses, insurance and/or registrations, if any, and is Applicant legally authorized to do business in the State of Oregon?
   YES [X] NO □

   If "NO," please explain.
   Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?
   YES [X] NO □ N/A □

   Submit a copy of the certificate with this form.
   Response: Certificate attached with this form.

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

Applicant Name: PacificSource Community Solutions
RFA: OHA-4690-19
Project Name: Coordinated Care Organizations 2.0

Signature: ___________________________ Title: President & CEO Date: 04/15/2019
(Authorized to Bind Applicant)
Certificate of Completion

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

Julie Grossnicklaus

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On 3/25/2019
State of Oregon
OFFICE OF THE SECRETARY OF STATE
Corporation Division

Certified Copy   678M980Q5

I, BEV CLARNO, Secretary of State of Oregon, and Custodian of the Seal of said State, do hereby certify:

That the attached

Document File

for

PACIFICSOURCE COMMUNITY SOLUTIONS

is a true copy of the original document(s).

In Testimony Whereof, I have hereunto set my hand and affixed hereto the Seal of the State of Oregon.

BEV CLARNO, SECRETARY OF STATE
4/2/2019

Come visit us on the internet at sos.oregon.gov/business
ARTICLES OF INCORPORATION

REGISTRY NUMBER
122842990

TYPE
DOMESTIC NONPROFIT CORPORATION

1. ENTITY NAME
CONNERS GROUP

2. MAILING ADDRESS
PO BOX 7068
SPRINGFIELD OR 97475 USA

3. NAME & ADDRESS OF REGISTERED AGENT
KRISTIN KERNUTT
110 INTERNATIONAL WAY
SPRINGFIELD OR 97477 USA

4. INCORPORATORS
KENNETH P PROVENCHER
PO BOX 7068
SPRINGFIELD OR 97475 USA

5. TYPE OF NONPROFIT CORPORATION
Public Benefit

6. MEMBERS?
Yes

7. DISTRIBUTION OF ASSETS
distributed to the sole member or to another public benefit non-profit corporation in accordance with Oregon law

8. OPTIONAL PROVISIONS
The corporation elects to indemnify its directors, officers, employees, agents for liability and related expenses under ORS 65.387 to 65.414.
By my signature, I declare as an authorized authority, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment, or both.

By typing my name in the electronic signature field, I am agreeing to conduct business electronically with the State of Oregon. I understand that transactions and/or signatures in records may not be denied legal effect solely because they are conducted, executed, or prepared in electronic form and that if a law requires a record or signature to be in writing, an electronic record or signature satisfies that requirement.

ELECTRONIC SIGNATURE

NAME
KRISTIN KERNUTT

TITLE
SECRETARY

DATE SIGNED
06-27-2016
ARTICLES OF MERGER

ARTICLE 1
MERGING CORPORATIONS

The merging corporations are Conners Group, an Oregon non-profit corporation formed under the Oregon Nonprofit Corporation Act (Registry Number 1228429-90), and PacificSource Community Solutions, Inc., an Oregon corporation formed under the Oregon Business Corporation Act (Registry Number 18280-95), which is the wholly-owned subsidiary of Conners Group.

ARTICLE 2
SURVIVING CORPORATION

The surviving corporation is PacificSource Community Solutions, an Oregon non-profit corporation (Registry Number 1228429-90), which is a name change.

ARTICLE 3
PLAN OF MERGER

The plan of merger is attached as Exhibit A.

ARTICLE 4
APPROVAL

4.1 Surviving Corporation. The plan of merger was duly authorized and approved by the board of directors and sole member of Conners Group. The approval by the sole member of Conners Group was as follows:

<table>
<thead>
<tr>
<th>Designation of Voting Group</th>
<th>Number of Members</th>
<th>Number of Votes Entitled to be Cast</th>
<th>Total Number of Votes Cast For</th>
<th>Total Number of Votes Cast Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

4.2 Nonsurviving Corporation. The plan of merger was duly authorized and approved by the board of directors and sole shareholder of PacificSource Community Solutions, Inc. The approval by the sole shareholder of PacificSource Community Solutions, Inc. was as follows:

<table>
<thead>
<tr>
<th>Designation of Voting Group</th>
<th>Number of Outstanding Shares</th>
<th>Number of Votes Entitled to be Cast</th>
<th>Total Number of Votes Cast For</th>
<th>Total Number of Votes Cast Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
</tr>
</tbody>
</table>

ARTICLE 5
EFFECTIVE DATE

These articles of merger will become effective on the later of (i) the date the articles of merger are filed by the Oregon Secretary of State, or (ii) December 31, 2016.

Dated: December 30, 2016

PacificSource Community Solutions
an Oregon non-profit corporation

By: Kristin E. Kernutt, Secretary

Person to contact about this filing: Kristin E. Kernutt
Daytime phone number: 541-225-1967

ARTICLES OF MERGER
This Agreement and Plan of Merger (this "Agreement"), dated as of December 31, 2016, is between Conners Group ("Conners"), an Oregon non-profit corporation, and PacificSource Community Solutions, Inc. ("PCS"), an Oregon corporation; the corporations are referred to jointly as the "Constituent Corporations."

RECITALS

A. The Constituent Corporations desire to effect a merger on the terms set forth in this Agreement, pursuant to the provisions of the Oregon Business Corporation Act and Oregon Nonprofit Corporation Act.

B. The Constituent Corporations intend the merger to be a reorganization within the meaning of IRC §368(a)(1)(A).

AGREEMENT

The Constituent Corporations mutually agree as follows:

SECTION 1. MERGER OF CONSTITUENT CORPORATIONS

1.1 Merger. At the Effective Date, PCS will be merged with and into Conners, the separate existence of PCS will cease, and Conners will survive as a non-profit corporation under the name PacificSource Community Solutions (the "Surviving Corporation"), organized under and governed by the laws of the state of Oregon. From that time, the Surviving Corporation, to the extent consistent with its articles of incorporation as altered by the merger, will possess all the rights, privileges, immunities, and franchises of each of the Constituent Corporations, all property belonging to PCS will be transferred to and vested in the Surviving Corporation without further act or deed, and the Surviving Corporation will be responsible for all liabilities of each of the Constituent Corporations, all in the manner and with the effect set forth in ORS 60.497 and ORS 65.494.

1.2 Further Assurances. From time to time after the Effective Date, the officers and directors of PCS who were last in office will execute and deliver such deeds and other instruments and will cause to be taken such further actions as will reasonably be necessary in order to vest or perfect in the Surviving Corporation title to and possession of all the property, interests, assets, rights, privileges, immunities, and franchises of PCS.

1.3 Effective Date. The merger of PCS and Conners will become effective on the later: (i) of the filing of articles of merger pursuant to ORS 60.494 and ORS 65.491, or (iii) December 31, 2016 (the "Effective Date").

1.4 Closing. Subject to the satisfaction of the conditions set forth in Section 4 of this Agreement, the closing of the contemplated transactions will occur at the principal offices of PacificSource Health Plans in Lane County, Oregon, on December 31, 2016, or at another time and place as the Constituent Corporations may mutually agree on. At that time, the parties will cause articles of merger to be filed.
SECTION 2. ARTICLES OF INCORPORATION, BYLAWS, DIRECTORS, AND OFFICERS

2.1 Articles of Incorporation. The Articles of Incorporation of Conners as in effect immediately before the Effective Date will be the Articles of Incorporation of the Surviving Corporation until amended in accordance with applicable law, except that the name of the entity will be PacificSource Community Solutions.

2.2 Bylaws. The bylaws of Conners as in effect immediately before the Effective Date will be the bylaws of the Surviving Corporation until amended or repealed.

2.3 Directors and Officers. The board of directors of the Surviving Corporation will consist of persons who are directors of Conners immediately before the Effective Date, and they will hold office in each case until their successors are elected and qualify. The officers of the Surviving Corporation will be persons who are the officers of Conners immediately before the Effective Date, and they will hold office in each case at the pleasure of the board of directors of the Surviving Corporation.

SECTION 3. OUTSTANDING PCS STOCK

3.1 Retirement of Stock. At the Effective Date, the outstanding shares of PCHP shall be cancelled without consideration.

3.2 Dissenting Shares. Each Dissenting Share will be treated in accordance with the provisions of ORS 60.551-60.594 relating to dissenters’ rights.

SECTION 4. CONDITIONS

4.1 Conditions to Obligation of PCS. The obligation of PCS to effect the merger is subject to the satisfaction or waiver of each of the following conditions:

4.1.1 This Agreement will have been duly approved by the board of directors of Conners in accordance with the Oregon Nonprofit Corporation Act.

4.1.2 This Agreement will have been approved by the holders of a majority of the outstanding shares of common stock of PCS entitled to vote on the matter in accordance with the Oregon Business Corporation Act.

4.1.3 All necessary state and federal approvals and licenses have been received or transferred, including limitation approval from the Oregon Health Authority.

4.2 Conditions to Obligation of Conners. The obligation of Conners to effect the merger is subject to the satisfaction or waiver of each of the following conditions:

4.2.1 This Agreement will have been duly approved by the board of directors of PCS in accordance with the Oregon Business Corporation Act.

4.2.2 This Agreement will have been approved by the holders of a majority of the outstanding shares of common stock of PCS entitled to vote on the matter in accordance with the Oregon Business Corporation Act.

4.2.3 No written notices of intention to demand payment of the fair value of the shares in accordance with provisions of ORS 60.564 will have been received prior to the taking of the vote of shareholders of PCS.
4.2.4 All necessary state and federal approvals and licenses have been received or transferred, including limitation approval from the Oregon Health Authority.

SECTION 5. TERMINATION

5.1 Failure of Shareholder Approval. This Agreement will automatically terminate in the event that it is brought to a vote and not adopted by the holders of a majority of the outstanding shares of common stock of PCS entitled to vote thereon at a meeting called for such purpose in accordance with the Oregon Business Corporation Act.

5.2 Other Termination. This Agreement may be terminated and the merger abandoned at any time before the Effective Date, whether before or after submission to or approval by the shareholders of either of the Constituent Corporations:

5.2.1 By mutual agreement of the boards of directors of PCS and Conners;

5.2.2 By the board of directors of PCS if any condition provided in Section 4.1 of this Agreement has not been satisfied or waived on or before the Effective Date;

5.2.3 By the board of directors of Conners if any condition provided in Section 4.2 of this Agreement has not been satisfied or waived on or before the Effective Date;

5.2.4 By the board of directors of either PCS or Conners (but only if the terminating party is not then in material breach of any agreement contained in this Agreement) if there has been a material breach of any of the agreements set forth in this Agreement on the part of the other party, which breach is not cured within 10 days after written notice to the party committing the breach, or which breach, by its nature, cannot be cured before the closing; or

5.2.5 By the board of directors of either PCS or Conners if the closing of the Merger has not occurred on or before December 31, 2016, unless the failure of the closing to occur by that date is due to the breach by the party seeking to terminate this Agreement of any agreement of that party set forth in this Agreement.

5.3 Effect of Termination. If this Agreement is terminated as provided in Section 5, this Agreement will become wholly void and of no effect, each party will bear its own expenses, and, except for the liability of a party whose material breach of any of the agreements set forth in this Agreement has occasioned the termination of this Agreement by the non-defaulting party, there will be no liability or obligation on the part of either party.

SECTION 6. MISCELLANEOUS PROVISIONS

6.1 Waivers. Each party, by written instrument, may extend the time for performing any of the obligations or other acts of the other party, waive performance of any of the obligations of the other party set forth in this Agreement, or waive any condition to its obligation to effect the merger other than the conditions contained in Sections 4.1.1, 4.1.2, 4.2.1, and 4.2.2 of this Agreement.

6.2 Survival. None of the agreements in this Agreement, including any rights arising out of any breach of such agreements, will survive the Effective Date, except for those agreements that by their express terms apply in whole or in part after the Effective Date.
6.3 Amendment. This Agreement may be amended at any time before the Effective Date, whether before or after the meeting of the shareholders of PCS, with approval of the respective boards of directors of the Constituent Corporations.

6.4 Expenses. Each party will pay the expenses incurred by it in connection with the transactions contemplated hereby.

6.5 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state of Oregon, without regard to conflict-of-laws principles.

The parties enter into this agreement as of the date first written above.

Conners Group

By: [Signature]
Kenneth P. Provencher
President/CEO

PacificSource Community Solutions, Inc.

By: [Signature]
Kenneth P. Provencher
President/CEO
Kenneth P. Provencher, MBA  
110 International Way  
Springfield, OR 97477  
ken.provencher@pacificsource.com

Experience

PacificSource Health Plans  
1995–Present  
Springfield, OR

President and Chief Executive Officer (2001–Present)  
Chief Executive for 315,000 member health plan with annual revenues of $1.5 billion and 1,000 employees serving Oregon, Idaho and Montana. Also serve as President of PacificSource Foundation for Health Improvement and as CEO for PacificSource Health Plans (commercial health plan), PacificSource Community Health Plans (Medicare Advantage health plan), PacificSource Community Solutions (Medicaid health plans/CCO), PacificSource Administrators (TPA), and IPN (a provider network).

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

Vice President of Operations (1996–2000)  
Responsible for administration, direction and coordination of all aspects of operations including claims, customer service, provider network management and billing/membership departments.

Provider Contracting Director (1995–1996)  
Responsible for provider network development, contracting and management to support both HMO and PPO products.

Oregon State University  
Corvallis, OR  
1997–2006

Adjunct Instructor  
Taught “Reimbursement Mechanisms” and “Contracting and Negotiations” courses in graduate and undergraduate Health Administration program.

Previous Positions  
Vice President (1990–1994)  
Director, Managed Care (1988–1990)

United Health Services, Binghamton, NY (1986–1988)  
Administrative Director for the UHS Network

Blue Cross and Blue Shield of N. Carolina, Durham, NC (1985–1986)  
Director of Finance and Operations

Kaiser Permanente, Portland, OR (Summer 1984)  
Summer Intern
Centre Community Hospital, State College, PA (1980–1983)
Psychiatric Assistant

Research Assistant

Education

Wharton School, University of Pennsylvania, Philadelphia, PA
MBA, Health Care Management, (1985)

College of William and Mary, Williamsburg, VA
Graduate Study, Psychology, (1977 – 1979)

Providence College, Providence, RI
BA, Psychology, magna cum laude, (1977)

Professional, Civic and Volunteer Activities

- Board Member and Past Co-Chair, Oregon Health Leadership Council
- Board Member, Alliance of Community Health Plans
- Trustee, Oregon State University Foundation
- Member, 2018 Governor’s Work Group on Medicaid Financing
- Member, Oregon Marketplace Advisory Committee
- Mentor, AHIP Executive Leadership Program
- Member and Chair, Oregon State University College of Public Health Community Advisory Committee
- Former Board Member, Chair and Vice Chair, Oregon Medical Insurance Pool/State Reinsurance Board
- Former Board Member and Chair, United Way of Lane County
- Former Executive Committee Member and Past Chair, United Way of Lane County 100% Access Coalition
- Former Member, Oregon Health System Transformation Team
- Former Board Member, Health Matters
- Former Board Member and Chair, The Foundation for Medical Excellence
- Former Member and Chair, Oregon Health Care Safety Net Advisory Council
- Former Member, Oregon Health Information and Privacy Collaboration Steering Committee
- Former Member, Archimedes Design Team
- Former Member, Oregon Health Policy Commission Delivery System Advisory Board
- Former Member, Oregon Health Fund Board Delivery Systems Committee
- Former Coach and Program Coordinator, Crescent Valley Middle School Boys Basketball Program
- Former Board Member, President and Coach, Corvallis Little League
Peter F. Davidson, CPA

110 International Way
Springfield, OR 97477
peter.davidson@pacificsource.com

Experience

PacificSource Health Plans

2008–Present

Executive Vice President and Chief Financial Officer
CFO for 315,000 member health plan with annual revenues of $1.5 billion and 1,000 employees serving Oregon, Idaho and Montana commercial, Medicare and Medicaid members. PacificSource Health Plans, and its subsidiaries, deliver healthcare solutions to businesses and individuals in Oregon, Idaho, Washington and Montana. PacificSource is an 85 year-old company that values partnership, service excellence, and community solutions for improving the healthcare delivery system. Responsibilities include oversight of the organization’s financial, investment, actuarial, legal and underwriting departments. Key duties involve long range planning and strategic growth.

Oregon Medical Group

1998–2008

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

Joseph J. Bean Associates

1995–1998

Partner
Vice President and partner in a management and development firm specializing in the operation of healthcare companies.

Certified Public Accounting
1987–1994

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

Professional License / Affiliations

Certified Public Accountant- CPA
Certified by the State of California Board of Accountancy, August 1986, Current license to practice held in Oregon #13213
Current Affiliations
- AICPA – Member
- PacificSource Foundation for Health Improvement

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

Education

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

Brunswick, ME
Erick Doolen

110 International Way
Springfield, OR 97477
erick.doolen@pacificsource.com

Experience

PacificSource Health Plans  Springfield, OR
2005–Present

Executive VP, Chief Operating Officer and Chief Information Officer (2015–Present)
Responsible for Information Technology, Human Resources, Facilities, and key operations areas, including claims, customer service, enrollment and billing for PacificSource’s Commercial, Medicare Advantage, and Medicaid lines of business. Responsibilities include managing over 500 employees with a budget over $60M.

- Responsible for in-sourcing of claims processing, encounter processing, and customer service for PacificSource’s Medicaid line of business. This increased the service level for both of the Coordinated Care Organizations (CCO).
- Developed overall facilities plan to support period of rapid growth and expanded or added capacity to six regional offices. Additionally, developed support for acquisition of new facility for consolidation of headquarters that resulted in acquiring $26M / 400,000 sf building.
- Ongoing efforts to build continuous improvement program that has significantly improved operations across the company, including reducing seasonal variations and empowering employees to take on more improvement projects.

Senior Vice President of Operations and Chief Information Officer (2010–2015)
Responsible for information technology, claims, customer service, membership, and billing across PacificSource’s Commercial, Medicare, and Medicaid lines of business.

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

Chief Information Officer (2005–2010)
Responsible for strategic technology investments and delivery of information technology to the company. Led five IT teams with over fifty IT professionals for the implementation of new capabilities, and the ongoing operations of the existing portfolio of IT applications and services. As the Security Officer, responsible for all aspects of IT security including ensuring appropriate investment in security capability and fulfilling HIPAA security duties.
**PacificSource Supported Volunteering**

**Oregon Health Leadership Council’s (OHLC) Administrative Simplification Executive Committee Co-Chair** (2010–Present)

In support of the overall OHLC goal of controlling healthcare costs, the Administrative Simplification efforts have developed standards for electronic transactions, implemented a single sign-on solution for health plan portals, and identified provider portal best practices.

**Health Information Technology Oversight (HITOC) Council member** (2012–Present), Chair (2015–Present)

Appointed by the Oregon Governor to serve on HITOC. This council is responsible for setting goals and developing a strategic health information technology plan, and monitoring progress in achieving those goals.

**Common Credentialing Advisory Group (CCAG) Co-Chair** (2013–2018)

Served as Co-Chair from the inception of the CCAG through when program was put on hold by the Oregon Health Authority (OHA). This stakeholder advisory group was created as a part of SB 604 to provide input to OHA on the implementation of a common provider credentialing solution.

**Oregon Administrative Simplification Work Group Member** (2010)

This stakeholder work group was created by the Office of Oregon Health Policy and Research as a result of HB 2009, to develop recommendations for standardizing administrative transactions between health plans and healthcare providers.

**Hewlett-Packard Company**

*Corvallis, OR*


**Imaging and Printing Group Americas IT Director** (2005)

Responsible for information systems for the customer facing processes in the Americas.


Responsible for factory control and information systems across five inkjet supplies manufacturing factories including 290 engineers in the United States, Asia, and Europe.


Responsible for control systems on custom manufacturing equipment used to produce new inkjet cartridge components. Managed team of process, software and tooling engineers responsible for a manufacturing tool set and control systems used to manufacture inkjet cartridge components.

**Education**

**Washington University**, St. Louis, MO

Bachelor of Science in Electrical Engineering and Bachelor of Science in Computer Science, 1987
J. Edward McEachern, MD  
110 International Way  
Springfield, OR 97477  
edward.mceachern@pacificsource.com

Experience

PacificSource Health Plans  
Boise, Idaho  
2015–Present

Chief Medical Officer, Executive Vice President, Senior Leadership Team (2018 – Present)  
Executive Management Group, Health Services (2015–Present)

Responsible for all aspects of utilization and care management, quality and risk, grievance and appeals. Maintain relationships with providers in Washington, Oregon, Montana, and Idaho.

Saint Alphonsus Health System, Trinity Health System, Executive Director, Operations  
2012–2015

Operational Director of all employed physicians, owned health plans and in-patient physicians.

Idaho Emergency Physicians  
Meridian, Idaho  
2011–2012

Chief Executive Officer

- Doubled group size and revenues in two years (hired twenty-three new ED physicians)
- Achieved “Best Places to Work, Modern Healthcare, 2012”
- Established PA and NP adjunct models
- Started Emergency TeleMedicine, TeleStroke, and TeleBurn programs
- Established PA Emergency Medicine Fellowship
- Established two joint ventures with two separate hospitals in two years

Daedalus Ltd.  
Nationwide  
1999–2012

President

Responsible for all healthcare developments for this venture capital firm

University of Utah Department of Orthopaedics  
Salt Lake City, Utah  
1999–2005

Chief Executive Officer

- Built 200,000 GSF hospital from inception to operations
- Brought hospital on-line
- Grew orthopaedic group from 26 to 54 physicians
- Achieved $32M change from loss to profitability in two years
Blue Cross & Blue Shield of Ohio  
1995–1998

Chief Medical Officer

- Responsible for all aspects of care management driving Medical Loss Ratio from 92% to 82% in eight quarters
- Plan profits increase $1.2M a month per product over the eight quarters, overall $300M in profits
- Developed the first Medicaid Risk HMO in the US, profitably
- Managed over 6.4 million PPO lives, 1.6 million HMO covered lives and 500,000 Medicaid HMO lives with 64,000 physicians in-network
- Pivotal in the merger of HCA and Blue Cross and Blue Shield of Ohio into Medical Mutual of Ohio
- Developed in-house case and care management, network design, and care outcomes “dashboards” for Platinum panel physicians

Academic Appointments and Achievements

- Faculty member (past) at Emory and Vanderbilt University
- Associate Professor (current) of Orthopaedics at the University of Utah School of Medicine
- Assistant Professor (current) at the University of Utah, David Eccles School of Business
- Epidemiology/Biostatistics at Case Western Reserve University School of Medicine
- Have given over 500 invited lectures
- 131 funded studies currently with over $3.1M in competitive grant funding
- Six patents, seven books, eleven chapters in books and over 40 peer reviewed articles published
- Over 250 invited keynote presentations given

Education

University of California at San Francisco, School of Medicine, San Francisco, CA  

Case Western Reserve University, School of Medicine, Cleveland, OH  
Medical Degree, Internal Medicine Residency, (1992–1996)

University of St. Andrews, St Andrews, Fife, Scotland  
Honors Statistics and Biology (MS, Co-Terminal Degree with Emory University), (1982–1983)

Emory University, Atlanta, GA  
BS with Honors, Biology; Minor in Philosophy & German Atlanta, (1978–1983)
Attachment 6 – Contact List

Attachment 6, Section A.1.m: Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant’s contact name, telephone number, and email address for each of the following:

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

<table>
<thead>
<tr>
<th>Application</th>
<th>Contact Name</th>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachments</th>
<th>Contact Name</th>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment 1 – Letter of Intent</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 2 – Application Checklist</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 3 – Applicant Information and Certification Sheet</td>
<td>Kenneth P. Provencher, President and CEO</td>
<td>541-684-5286</td>
<td><a href="mailto:ken.provencher@pacificsource.com">ken.provencher@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 4 – Disclosure Exemption Certificate</td>
<td>Kenneth P. Provencher, President and CEO</td>
<td>541-684-5286</td>
<td><a href="mailto:ken.provencher@pacificsource.com">ken.provencher@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 5 – Responsibility Check Form</td>
<td>Kenneth P. Provencher, President and CEO</td>
<td>541-684-5286</td>
<td><a href="mailto:ken.provencher@pacificsource.com">ken.provencher@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 6 – General Questions</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
</tr>
<tr>
<td>Attachment 7 – Provider Participation and Operations Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<tr>
<td>Attachment 8 – Value-Based Payments Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>Attachment 9 – Health Information Technology Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<tr>
<td>Attachment 10 – Social Determinants of Health</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>and Health Equity Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<tr>
<td>Attachment 11 – Behavioral Health Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>Attachment 12 – Cost and Financial Questionnaire</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>Attachment 12 – Cost and Financial Questionnaire</td>
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<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>Attachment 13 – Attestations</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td>Attachment 14 – Assurances</td>
<td>Kenneth P. Provencher, President and CEO</td>
<td>541-684-5286</td>
<td><a href="mailto:ken.provencher@pacificsource.com">ken.provencher@pacificsource.com</a></td>
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<td>Attachment 15 – Representations</td>
<td>Kenneth P. Provencher, President and CEO</td>
<td>541-684-5286</td>
<td><a href="mailto:ken.provencher@pacificsource.com">ken.provencher@pacificsource.com</a></td>
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<td>Attachment 16 – Member Transition Plan</td>
<td>Lindsey Hopper, VP Medicaid</td>
<td>541-706-5066</td>
<td><a href="mailto:lindsey.hopper@pacificsource.com">lindsey.hopper@pacificsource.com</a></td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Exhibit A - Definitions</td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Exhibit B – Statement of Work: Governance and Organizational Relationships</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
<td>541-706-5181</td>
<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Exhibit B – Statement of Work: Covered/Non-Covered Services</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td>Exhibit B – Statement of Work: Patient Rights and Responsibilities, Engagement and Choice</td>
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<td>Exhibit B – Statement of Work: Providers and Delivery System</td>
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<td>Performance, Outcomes, and Accountability</td>
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<td>Exhibit D – Standard Terms and Conditions</td>
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<td>Exhibit E – Required Federal Terms and Conditions</td>
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<td>Exhibit F – Insurance Requirements</td>
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<td>Exhibit G – Reporting of Delivery System Network Providers, Cooperative Agreements, and Hospital Adequacy</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td>Exhibit H – Value Based Payment</td>
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<td>Exhibit J – Health Information Technology</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td>Exhibit L – Solvency Plan and Financial Reporting and Cost</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td>Exhibit M – Behavioral Health</td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Exhibit N – Social Determinates of Health and Health Equity</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Operations and Administration</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<td>Jessica Sayers, Medicaid Contract Manager</td>
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<td>Systems Management</td>
<td>Jessica Sayers, Medicaid Contract Manager</td>
<td>541-706-5181</td>
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<td>General</td>
<td>Jane Hannabach, VP Government Operations</td>
<td>541-330-2530</td>
<td><a href="mailto:jane.hannabach@pacificsource.com">jane.hannabach@pacificsource.com</a></td>
</tr>
</tbody>
</table>
Erick Doolen
110 International Way
Springfield, OR 97477
erick.doolen@pacificsource.com

Experience

PacificSource Health Plans Springfield, OR
2005–Present

Executive VP, Chief Operating Officer, and Chief Information Officer (2015–Present)
Responsible for Information Technology, Human Resources, Facilities, and key operations areas including claims, customer service, enrollment and billing for Commercial, Medicare Advantage, and Medicaid lines of business. Responsibilities include managing over 500 employees with a budget over $60M.

- Responsible for in-sourcing of claims processing, encounter processing, and customer service for Medicaid line of business. This increased the service level for both of the Coordinated Care Organizations (CCO).
- Developed overall facilities plan to support period of rapid growth and expanded or added capacity to six regional offices. Additionally developed support for acquisition of new facility for consolidation of headquarters that resulted in acquiring $26M / 400,000 sf building.

Continued to build continuous improvement program that has significant improved operations across the company including reducing seasonal variations and empowering employees to take on more improvement projects.

Senior Vice President of Operations and Chief Information Officer (2010–2015)
Responsible for information technology, claims, customer service, membership, and billing across Commercial, Medicare, and Medicaid lines of business. Responsible for the integration of Operations and IT when PacificSource acquired a company in Central Oregon with new lines of business, including Medicare and Medicaid. Integration included the conversion of the Medicare business onto PacificSource systems with Operations in the Bend office. Additionally, IT was integrated across the company with a functional structure to support all lines of business.

Chief Information Officer (2005–2010)
Responsible for strategic technology investments and delivery of information technology to the company. Led five IT teams with over fifty IT professionals for the implementation of new capabilities and the ongoing operations of the existing portfolio of IT applications and services. As the Security Officer responsible for all aspects of IT security including ensuring appropriate investment in security capability and fulfilling HIPAA security duties.
PacificSource Supported Volunteering

Oregon Health Leadership Council’s Administrative Simplification Executive Committee Co-Chair (2010–Present)
In support of the overall OHLC goal of controlling healthcare costs, the Administrative Simplification efforts have developed standards for electronic transactions, implemented a single sign-on solution for health plan portals, and identified provider portal best practices.

Health Information Technology Oversight (HITOC) Council member (2012–Present), Chair (2015–Present)
Appointed by the Oregon Governor to serve on HITOC. This council is responsible for setting goals and developing a strategic health information technology plan and monitoring progress in achieving those goals.

Served as Co-Chair from the inception of the CCAG through when program was put on hold by the Oregon Health Authority (OHA). This stakeholder advisory group was created as a part of SB 604 to provide input to OHA on the implementation of a common provider credentialing solution.

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

Hewlett-Packard Company Corvallis, OR
1994–2005

Imaging and Printing Group Americas IT Director (2005)
Responsible for information systems for the customer-facing processes in the Americas.

Responsible for factory control and information systems across five inkjet supplies manufacturing factories including 290 engineers in the United States, Asia, and Europe.

Responsible for control systems on custom manufacturing equipment used to produce new inkjet cartridge components. Managed team of process, software and tooling engineers responsible for a manufacturing tool set and control systems used to manufacture inkjet cartridge components.

Education

Washington University, St. Louis, MO
Bachelor of Science in Electrical Engineering and Bachelor of Science in Computer Science, (1987)
Attachment 6, Section D.1.b: Informational Questions - Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract. (example of subcontracted work does not count toward page limit)

One example of subcontracted work is the contract PSCS has with the Central Oregon Intergovernmental Council (COIC), a 190 organization that provides NEMT brokerage services.

PSCS monitors subcontractor performance in a variety of ways. PSCS conducts annual audits of all subcontracted and delegated functions, including auditing compliance with NEMT policies and procedures, which incorporate requirements from the CCO contract. In addition, PSCS meets quarterly with COIC to review contract metrics, quality and customer service metrics, call service standards, and community needs. PSCS reviews grievances monthly and takes follow-up actions based on specific grievances and trending data over time. PSCS uses a corrective action process to remedy deficiencies in performance. In addition, PSCS uses robust analytics to monitor utilization, changes in modes, denials, and performance targets on a monthly basis.

PSCS expects to use the mandatory subcontractor and delegation oversight tools issued as part of this RFA and the 2020 CCO contract, as well as a combination of mandatory annual audits and more frequent oversight activities. PSCS will adopt a quality assurance program and corresponding policies and procedures to outline the activities for monitoring, evaluation, and improvement of the quality and appropriateness of NEMT services. PSCS will submit reporting to the OHA quarterly, and upon request. PSCS also expects to combine information from robust analytics, community engagement, the Community Advisory Council, compliance, contract oversight, the grievance system, and encounter data to monitor performance.
Attachment 6 - General Questionnaire

Attachment 6, Section A.1.1: Describe the Applicant’s Legal Entity status, and where domiciled. Applicant PacificSource Community Solutions (PSCS) is a non-profit corporation domiciled in the State of Oregon.

Attachment 6, Section A.1.a: Describe Applicant’s Affiliates as relevant to the Contract. The following entities are Affiliates of, or Affiliated with, PSCS as relevant to the Contract:

| PacificSource Community Health Plans (PCHP) | PCHP is the sole member of PacificSource Community Solutions. PCHP offers Medicare Advantage products. |
| PacificSource Health Plans (PSHP) | PSHP is the sole member of PCHP and is an Oregon non-profit corporation that offers commercial products. |
| PacificSource | PacificSource is the sole member of PSHP and is an Oregon non-profit corporation that serves as a holding company. |
| Pacific Health Associates | Pacific Health Associates has a 50% member interest in PacificSource. |
| Legacy Health | Legacy Health has a 50% member interest in PacificSource. |

Attachment 6, Section A.1.b: Is the Applicant invoking alternative dispute resolution with respect to any Provider (see OAR 410-141-3268)? If so, describe.

No.

Attachment 6, Section A.1.c: What is the address for the Applicant’s primary office and administration located within the proposed Service Area?

2965 NE Conners Ave., Bend, Oregon 97701.

Attachment 6, Section A.1.d: What counties are included in this Service Area? Describe the arrangements the Applicant has made to coordinate with county governments and establish written agreements as required by ORS 414.153.

Deschutes, Crook, Jefferson, and northern Klamath (zip codes 97731, 97733, 97737, 97739). PSCS has met with county representatives multiple times. County representatives have participated in community governance and in developing this Application. In each instance, PSCS has established written agreements as required by ORS 414.153.

Attachment 6, Section A.1.e(1): Prior History - Is Applicant the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019 (hereinafter called "Current CCO")?

Yes.

Attachment 6, Section A.1.f: Current experience as an OHA contractor, other than as a Current CCO. Does this Applicant (or an Affiliate of Applicant) currently have a contract with the OHA as a licensed insurer or health plan third party administrator for any of the following (hereinafter called “Current OHA Contractor”)? If so, please provide that information in addition to the other information required in this section. Public Employees Benefit Board, Oregon Educators Benefit Board, Adult Mental Health Initiative, Cover All Kids, Other (please describe).
Yes, PSCS is a Current OHA Contractor. PSCS also serves members through a Choice Model contract and through two Cover All Kids contracts. PSCS does not contract with the OHA to serve Public Employees Benefit Board nor Oregon Educators Benefit Board members.

Attachment 6, Section A.1.g: Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?
Yes, PCHP, an affiliate of PSCS, has experience as a Medicare Advantage contractor. PCHP has a contract with CMS as a Medicare Advantage contractor and offers Medicare Advantage plans in Oregon, Idaho, Montana, and Washington.

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Attachment 6, Section A.1.h: Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?
No.

Attachment 6, Section A.1.i: Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?
Yes, PSHP, an affiliate of PSCS, holds a Certificate of Authority from the Department of Consumer and Business Services (DCBS), Division of Financial Regulation (Cert No. 0108, since 1940). In addition, PCHP, an affiliate of PSCS, holds a Certificate of Authority from the DCBS, Division of Financial Regulation (Cert No. 956601, originally issued in 2006).

Attachment 6, Section A.1.j: Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January 1, 2019, with the Oregon Health Insurance Marketplace?
Yes. PSHP, an affiliate of PSCS, holds a contract effective January 1, 2019.
Attachment 6, Section A.1.k: Describe Applicant’s demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant’s enrollees and in Applicant’s Community.

In 2012, PSCS helped convene a local governing board, the Central Oregon Health Council (Health Council). The Health Council is comprised of community members and healthcare providers and is specifically designed to improve the health of the community and address regional, cultural, socioeconomic, and racial disparities in health care. The Health Council works in partnership with PSCS to facilitate a robust community process that informs CCO policy and direction. This relationship is upheld through a Joint Management Agreement, which delineates the role and function of PSCS as the CCO and its governing structure. The community governance model imposes a limit on PSCS’ margin, and any shared savings are returned to the community via the Health Council. The Health Council determines how to invest those shared savings to address regional, cultural, socioeconomic, and racial disparities that exist among CCO enrollees and in the community. We have successfully partnered with both clinical and non-clinical organizations and individuals and have a member focus at the core of our shared work. We understand that there is not one way to do business, that this work is complex and important, and that by having a heterogeneous group of individuals informing the work we do, it provides the opportunity for innovation, creativity, and meaningful output. We engage in our work using a health equity lens that is inclusive and takes into account the unique composition of our communities, which are urban, rural, and frontier, and include a significant population of Latinos and Native Americans.

Attachment 6, Section A.1.l: Identify and furnish résumés for the following key leadership personnel (by whatever titles designated): Chief Executive Officer, Chief Financial Officer, Chief Medical Officer, Chief Information Officer, Chief Administrative or Operations Officer. Please see attached.

Attachment 6, Section A.1.m: Provide a chart (as a separate document, which will not be counted against page limits) identifying Applicant’s contact name, telephone number, and email address for each of the following: The Application generally, Each Attachment to the RFA (separate contacts may be furnished for parts), The Sample Contract generally, Each Exhibit to the Sample Contract (separate contacts may be furnished for parts), Rates and solvency, Readiness Review (separate contacts may be furnished for parts), and Membership and Enrollment. Please see attached.

Attachment 6, Section B.1.a: Provide a certified copy of the Applicant’s articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office. Please see the attached document.

Attachment 6, Section B.1.b: Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.
Attachment 6, Section B.1.c: Describe any licenses the corporation possesses.
PSCS does not possess any licenses.

Attachment 6, Section B.1.d: Describe any administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract. Affiliate contracts are excluded in this item and should be included under Section C. Not applicable. Please see Section C for affiliate contracts.

Attachment 6, Section C.1.a: Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant’s ultimate controlling person, all subsidiaries of Applicant, and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two-character state abbreviation of the state of domicile, Federal Employer’s Identification Number, and NAIC code for insurers. Schedule Y of the NAIC Annual Statement Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Applicant, describe the functions in general terms. Please see attached Schedule Y with an explanation of business functions performed for PSCS.

Attachment 6, Section C.1.b: Describe of any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements.
There is an Administrative Services Agreement between PSCS and PacificSource, whereby PacificSource provides certain administrative services to PSCS; including, without limitation, data processing and storage, office equipment and furniture, and more. This Agreement is approved by the Board of Directors for both entities and is amended each year to update the agreement. Such amendments are also approved by the Board of Directors for both entities. Consolidating employees and various systems is a cost-savings measure implemented to allow the PacificSource companies to maximize its economies of scale. While this document is not approved by the Oregon Division of Financial Regulation (DFR), very similar documents are filed for approval with the DFR for PSHP and PCHP, and such documents have been approved. There is a Tax Allocation Agreement between the PacificSource companies that allocates taxes in accordance with IRS rules and proportionately based on each companies’ earnings. The PacificSource companies file as a consolidated group and PacificSource, the holding company, is appointed as the agent for the other PacificSource entities for purposes of filing taxes. The total amounts paid by PSCS under the intercompany arrangements for 2017 are $25,221,813 for administrative services and $4,435,337 for taxes; and for 2018 are $27,518,575 for administrative services and $3,291,238 for taxes. Please also see footnotes in Attachment 12, NAIC form 13H on the assumptions tab.

Attachment 6, Section C.1.c: Describe Applicant’s demonstrated experience and capacity for: Managing financial risk and establishing financial reserves; Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

The PacificSource family of companies manages premiums in excess of $1,697,800,000 and carries an AM Best rating of A-. PSCS has long-term experience in establishing and managing reserve accounts as a CCO, and in the past, as an MCO. PacificSource affiliates have significant experience establishing reserves under DCBS guidelines and reporting under statutory accounting principles. We employ a team of credentialed actuaries and actuarial analysts with experience and expertise in risk management, pricing, reserving, and other actuarial functions. The team is comprised of a total of fourteen actuaries, including three who are enrolled as Fellows of the Society of Actuaries (FSA), four enrolled as Associates of the Society of Actuaries (ASA), and seven actuarial analysts. The actuarial team is responsible for the monthly calculation of required reserves for incurred (but not reported) claims and other actuarial assets and liabilities. This team manages the enterprise risk management analysis. PSCS will prepare statutory accounting financial statements quarterly and an annual risk-based capital (RBC) report to evaluate solvency. The financial statements will differ from Exhibit L filings primarily in accounting for certain assets and categorization of certain income statement items based on Statements of Standard Accounting Practice (SSAP) statutory accounting rules. These financials will be prepared using the NAIC health statement template as well as the associated RBC report to show annual solvency requirements are met. In addition, PSCS has a strong balance sheet with cash and liquid investments available, as well as cash within the holding system if needed to pay obligations. The investment portfolio is diversified to minimize risk and operational results are monitored on at least a monthly basis.

Attachment 6, Section D.1.a: Informational Questions - Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.

There is an Administrative Services Agreement between PSCS and PacificSource, whereby PacificSource provides certain administrative services to PSCS, including data processing and
storage, office equipment and furniture, and more. This Agreement is approved by the Board of Directors for both entities and is amended each year to update the agreement. Such amendments are also approved by the Board of Directors for both entities. Consolidating employees and various systems is a cost-savings measure to allow the PacificSource companies to maximize economies of scale. While this document is not currently submitted to the DFR for approval, very similar documents are filed for approval with the DFR for PSHP and PCHP, and such documents have been approved.

Attachment 6, Section D.1.b: Informational Questions - What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract. (example of subcontracted work does not count toward page limit)
PSCS will subcontract for a variety of services, including pharmacy benefit management, non-emergency medical transportation (NEMT), and dental services. Subcontracted services will include care coordination, credentialing, grievance reporting, utilization management, and distribution of certain member materials. PSCS will continue to perform all such services internally as well and will not delegate ultimate authority or responsibility. One example of subcontracted work is the contract PSCS has with the Central Oregon Intergovernmental Council (COIC), a 190 organization that provides NEMT brokerage services. Details are attached as a separate document.

Attachment 6, Section E.1.a: Informational Questions - How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?
PSCS will update its TPL policies to ensure compliance with 2020 CCO contract requirements and will monitor adherence to the TPL policies. PSCS will update its systems to reflect any information provided by the OHA and will process any covered service that a member receives in accordance with the information provided. PSCS will continue to instruct providers to bill the member’s primary carrier prior to billing PSCS for the covered services provided. If PSCS does not have record of the primary payer upon receipt of the secondary claim, PSCS will update its systems to ensure that all claims are paid as secondary. Medicaid is always the payer of last resort. PSCS will continue to pend claims for follow up and where the claim indicates an accident or a diagnosis code where a third party may be responsible. PSCS will also require its providers and subcontractors to report to the OHA when they become aware that a member has other coverage. PSCS will also contract with a vendor to use its databases to identify any member with other coverage.

Attachment 6, Section E.1.b: Informational Questions - How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?
PSCS will follow the process set forth above for members with TPL. If any members are found to have other coverage, PSCS will update member records and report information to the OHA. For members whose primary carrier is Original Medicare or PacificSource Medicare Advantage, the provider need only submit the claim for the service to Original Medicare or Medicare Advantage. PSCS will receive the crossover claim automatically and will process the claim accordingly.
Attachment 6, Section F.1.a: Informational Questions – Please describe: Applicant’s governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.

The governing board is the Health Council and its articles of incorporation are on file with the Secretary of State. Members have been elected and appointed pursuant to the bylaws, which have been approved by the Health Council. The composition of the Health Council satisfies all requirements set forth in ORS 414.625 and the 2020 CCO contract. PSCS holds one seat on the Health Council. The Joint Management Agreement, which exists in executed form, governs the relationship between PSCS and the Health Council. A governing board with the community’s best interests in mind should operate in a largely consensus-driven decision-making model. When votes are called for, per the bylaws, most votes require a simple majority. PSCS holds no reserve powers. The decisions of the Health Council are not subject to approval by any other entity.

Attachment 6, Section F.1.b: Informational Questions - Please describe Applicant’s key committees including each committee’s composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.

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<tr>
<th>Key Committees</th>
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<tr>
<td><strong>Health Council Committees</strong> - <strong>Community Advisory Council (CAC)</strong></td>
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<tr>
<td>Described in Attachment 6, Section F.1.c: CAC</td>
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<tr>
<td><strong>Health Council Committees</strong> - <strong>Operations Council</strong></td>
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<tr>
<td><strong>Composition</strong>: Clinic administrators, PSCS staff, Health Council staff, public health staff, etc.</td>
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<td><strong>Reporting Relationship</strong>: Health Council</td>
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<tr>
<td><strong>Responsibilities</strong>: Work to promote success on the Quality Incentive Measures and managing regional quality improvement strategies.</td>
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<tr>
<td><strong>Oversight Responsibility</strong>: Regional quality improvement strategies.</td>
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<td><strong>Monitoring Activities</strong>: Performance metrics. Investments using shared savings.</td>
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<td><strong>Health Council Committees</strong> - <strong>Finance Committee</strong></td>
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<tr>
<td><strong>Composition</strong>: CFOs and executives from health care and community stakeholder organizations, PSCS staff, Health Council staff - <strong>Reporting Relationship</strong>: Health Council</td>
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<tr>
<td><strong>Responsibilities</strong>: Review CCO and Health Council financials.</td>
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<tr>
<td><strong>Oversight Responsibility</strong>: CCO and Health Council financials and annual budgets.</td>
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<td><strong>Monitoring Activities</strong>: Monthly, transparent CCO financials produced by PSCS and financial reporting produced by the Health Council. CCO actuals versus budget.</td>
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<td><strong>Health Council Committees</strong> - <strong>Provider Engagement Panel (PEP) (the Central Oregon version of the Clinical Advisory Panel)</strong></td>
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<tr>
<td><strong>Composition</strong>: PSCS clinical staff, community providers, public health directors, etc.</td>
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<tr>
<td><strong>Reporting Relationship</strong>: Health Council</td>
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<tr>
<td><strong>Responsibilities</strong>: Build and execute on clinical strategies, community standards of care, clinical investment opportunities, and a clinical review process for investments.</td>
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<td><strong>Oversight Responsibility</strong>: Engage the clinical community in the shared work of the CCO.</td>
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<td><strong>Monitoring Activities</strong>: Performance metrics and Quality Incentive Measures.</td>
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<tr>
<td><strong>Health Council Committees</strong> - <strong>Central Oregon Health Information Exchange</strong></td>
</tr>
<tr>
<td><strong>Composition</strong>: PSCS staff, Health Council Executive Director, information security and operational staff employed by community partners and providers across all domains.</td>
</tr>
<tr>
<td><strong>Reporting Relationship</strong>: Health Council</td>
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</table>
**Responsibilities**: Optimize the health of our communities, improve economic efficiencies for patient care, and bring value to stakeholders.

**Oversight Responsibility**: Provide leadership to enable comprehensive management of health information and its secure exchange between consumers, providers, government, quality entities, and insurers. Meets every other month.

**Monitoring Activities**: Closed loop referrals, community health records, and connectivity.

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<tr>
<th>Leadership Committees - Medicaid Leadership Team</th>
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<tbody>
<tr>
<td><strong>Composition</strong>: PSCS staff</td>
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<tr>
<td><strong>Responsibilities</strong>: Monitor performance and provide strategic and operational direction.</td>
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<tr>
<td><strong>Monitoring Activities</strong>: CCO performance, member engagement, Quality Incentive Measures, access to care, compliance, etc.</td>
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<tr>
<th>Leadership Committees - Executive Management Group</th>
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<tbody>
<tr>
<td><strong>Composition</strong>: PSCS staff</td>
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<tr>
<td><strong>Responsibilities</strong>: Provide strategic direction for the company, oversee major and critical initiatives, and monitor company performance.</td>
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<td><strong>Monitoring Activities</strong>: Financials, operational metrics, annual work plans, etc.</td>
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<tr>
<th>Leadership Committees - Corporate Compliance</th>
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<tbody>
<tr>
<td><strong>Composition</strong>: PSCS staff</td>
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<tr>
<td><strong>Responsibilities</strong>: Monitor performance of work plan, policies, FWA, and compliance plan.</td>
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<tr>
<td><strong>Monitoring Activities</strong>: CAPs, external audits, internal audits, and monitoring.</td>
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<tr>
<th>Quality Committees - Clinical Quality &amp; Utilization Management (CQUM)</th>
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<tbody>
<tr>
<td><strong>Composition</strong>: PSCS staff and external representatives</td>
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<tr>
<td><strong>Responsibilities</strong>: Monitor performance improvement projects, identify topics for quality and performance improvement efforts. Approves policies.</td>
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<tr>
<td><strong>Monitoring Activities</strong>: Grievance and Appeals, Care Management, Utilization Management, and Conditions Support program evaluation and effectiveness.</td>
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<tr>
<th>Quality Committees - Credentialing</th>
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<tbody>
<tr>
<td><strong>Composition</strong>: PSCS staff</td>
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<tr>
<td><strong>Responsibilities</strong>: Review and decision of credentialing applications, adherence with credentialing standards using NCQA requirements, and monitoring of delegated credentialing oversight.</td>
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<tr>
<td><strong>Monitoring Activities</strong>: Conducts annual audits of delegated credentialing entities, monitoring of provider rosters, and compliance with credentialing standards.</td>
</tr>
</tbody>
</table>
### Quality Committees - Quality Improvement

**Composition:** PSCS staff  
**Reporting Relationship:** Chief Medical Officer  
**Responsibilities:** Monitor performance of clinical and service quality for all lines of business.  
**Oversight Responsibility:** Oversight of the quality program.  
**Monitoring Activities:** Makes recommendations for new and changing technology, clinical medical policies and programs, member and provider satisfaction with processes and services, and quality initiatives, reporting, and outcomes.

### Pharmacy Committee - Pharmacy & Therapeutics

**Composition:** PSCS staff and external representatives  
**Reporting Relationship:** Chief Medical Officer and Medical Director (as needed)  
**Responsibilities:** Maintain drug formularies and reviews and approve pharmaceutical coverage policies. Drug Utilization Review (DUR) program review and compliance.  
**Oversight Responsibility:** Oversee the pharmacy program.  
**Monitoring Activities:** Review new drugs, therapeutic classes, new indications, and new safety information, coverage policies, and approves formularies.

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Attachment 6, Section F.1.c: Informational Questions – Please describe: The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant’s CAC.

### Community Advisory Committee (CAC)

**Composition:** Operates as a standing committee of the Health Council. Two members of the CAC sit on the Health Council Board of Directors, including at least one OHP consumer. CAC includes five consumer representatives and representatives from the United Way, the school district, social services, and an FQHC system, and ex-officio members from all three public health departments.  
**Reporting Relationship:** Health Council  
**Responsibilities:** Inform Health-Related Services investments, SDOH-HE investments, and other strategic initiative investments. The CAC provides guidance and feedback to the Health Council on the governing board’s work plan, CHA/CHP, and CCO services and programs. PSCS, in partnership with the Health Council, regularly provides education, analytics support, and performance information to the CAC so they can then make informed recommendations on such topics. The CAC informs Health-Related Services investments, SDOH-HE investments, and other strategic initiative investments. The CAC provides guidance and feedback to the Health Council on the governing board’s work plan, CHA/CHP, and CCO services and programs.  
**Oversight Responsibility:** Operations and community health, member engagement, member materials, performance on Quality Incentive Measures, Transformation and Quality Strategy Plan development, performance on elements related to health equity, and Community Health Assessment and Improvement planning.  
**Monitoring Activities:** PSCS reports, performance on annual work plans, progress updates.
Attachment 6, Section C.1.a: Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant's ultimate controlling person, all subsidiaries of Applicant, and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two-character state abbreviation of the state of domicile, Federal Employer's Identification Number, and NAIC code for insurers.

Schedule Y of the NAIC Annual Statement-Blank—Health is acceptable to supply any of the information required by this question. If a subsidiary or other Affiliate performs business functions for Applicant, describe the functions in general terms.
### SCHEDULE Y

#### PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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<th>Group Code</th>
<th>Group Name</th>
<th>NAIC Company Code</th>
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## SCHEDULE Y

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<th>Group Code</th>
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<th>NAC Company Code</th>
<th>ID Number</th>
<th>FEDERAL RSED</th>
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<th>Name of Securities Exchange if Publicly Traded (U.S. or International)</th>
<th>Name of Parent, Subsidiary or Affiliate</th>
<th>Relationship to Reporting Entity</th>
<th>Directly Controlled by (Name of Entity / Person)</th>
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**Asterisk**

**Explanation**

0000001  Footnote
**PacificSource performs certain administrative services and grants the right to use certain equipment, furniture, and leased office space to PacificSource Community Solutions. All employees in the PacificSource family of companies are employed by PacificSource and work for the various entities via an Administrative Services Agreement. The administrative services include things like customer service units, accounting services, data processing, etc.**
Attachment 7 – Provider Participation and Operations Questionnaire

Attachment 7, Section 1.a(1): Please describe: The proposed Governance Structure, consistent with ORS 414.625.

We will continue to utilize a unique, locally oriented governance structure. In 2012, we worked in partnership with the community to convene a Health Council. Health Council meetings are open to the public. The Health Council is a separate organization that works in partnership with PSCS to facilitate a robust community process that informs CCO policy and direction. We uphold this relationship through transparent community governance and a community shared savings agreement. The following individuals serve on the Central Oregon Health Council:

**Composition of the Health Council:**
- Leadership from hospitals or other large health care organizations
- At least two health care providers in active practice: a physician or nurse practitioner from primary care and a mental health or chemical dependency treatment provider
- At least two members from the community at large
- At least one member of the Community Advisory Council
- An OHP consumer
- Dental Care Organization leadership
- At least one designee chosen by commissioners from each county served

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<td>Tammy Baney, Chair</td>
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<td>Rick Treleaven, LCSW - Co-chair</td>
<td>Executive Director, BestCare Treatment Services, Inc.</td>
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<tr>
<td>Ellie Naderi</td>
<td>CEO, Advantage Dental Services, LLC</td>
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<td>Dan Stevens</td>
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<tr>
<td>Justin Sivill</td>
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<td>Joseph Sluka</td>
<td>CEO, St. Charles Health System</td>
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<td>Linda Johnson</td>
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<td>Linda McCoy</td>
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<td>Megan Haase, FNP</td>
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<td>Kelly Simmelink</td>
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<td>Divya Sharma, MD</td>
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<td>Paul Andrews</td>
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<td>Brian Barney</td>
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<td>Eric Alexander</td>
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Attachment 7, Section 1.a(2): Please describe: The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.

The PSCS CCO has an existing CAC, which operates as a standing committee of the Health Council. The CAC meets monthly and meetings are open to the public. The Chair of the CAC serves on the Health Council. The Health Council uses a standing Selection Committee and recruits CAC members consistent with OHA requirements as detailed in the Health Council bylaws. We will use a demographic report, sourced from OHA 834 data, to illustrate the current membership mix within the region, including information regarding race/ethnicity, sex, language, age, geographic location, and risk stratification. The Health Council will request CAC
members voluntarily submit information about REAL+D, age, rurality of residence, and county of residence during recruitment and on the CAC application. Race/ethnicity, age, gender identity, sexual orientation, disability, and geographic location will be used as criterion for the CAC Selection Committee. The Selection Committee will refer to the CAC Assessment Matrix to ensure adequate representation of the diversity of the community. CAC members should also possess a collaborative working style.

Attachment 7, Section 1.a(3): Please describe: 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 CAC is governed by the Health Council bylaws and meets monthly. The CAC ensures the Health Council is transparent, accountable, and responsive to consumer and community health needs. The CAC provides guidance and feedback to the Health Council and makes recommendations on the strategic direction of the organization. The CAC and Health Council will meet jointly during each calendar year to actively collaborate on consumer and community health needs and participate in joint strategic planning. To ensure transparency, the Health Council routinely includes CAC meeting minutes in the Health Council meeting packets for discussion of specific areas of interest. The CAC member(s) who also serve on the Health Council will be a conduit between both groups to ensure consistent accountability. Both the CAC and Health Council public meeting minutes will include CAC recommendations and the response from the Health Council. At least annually, CAC members will provide feedback on their role and relationship with the Health Council to ensure transparency and accountability for the Health Council’s consideration of CAC recommendations. CAC members will also play a key role in making decisions about funding SDOH-HE initiatives and Community Benefit Initiatives.

Attachment 7, Section 1.a(4): Please describe: 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.

Attachment 7, Section 1.b(1): If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure. The CAP, referred to locally as the Provider Engagement Panel, is governed by the Health Council bylaws and meets at least quarterly. Providers on the CAP represent a variety of health care organizations that serve members, including, but not limited to, public health, behavioral health, oral health, and physical health. The Health Council appoints the members of the CAP. Members of the CAP have direct experience relevant to the provision of health care in clinical settings and, where applicable, a direct connection to their organization’s quality committee.
Attachment 7, Section 1.b(2): If a Clinical Advisory Panel is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO’s entire network of Providers and facilities. Not applicable. Please see above.

Attachment 7, Section 1.c(1): Describe the Applicant’s current status in obtaining MOU(s) or contracts with Type B AAA or DHS local APD office.
PSCS has an MOU with DHS’ District 10 APD office. The MOU also serves CCO members residing in northern Klamath County. The most recent MOU was effective 1/1/2019.

Attachment 7, Section 1.c(2): If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU or contract.
Not applicable.

Attachment 7, Section 1.d(1): Describe the Applicant’s current status in obtaining MOU(s) or contract(s) with LMHAs and CMHPs throughout its proposed Service Area.

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Attachment 7, Section 1.d(2): If MOUs or contracts have not been executed, describe the Applicant’s efforts to do so and how the Applicant will obtain the MOU(s) or contract(s). Not applicable.

Attachment 7, Section 1.d(3): Describe how the Applicant has established and will maintain relationships with social and support services in the Service area.
PSCS has long-term relationships with social and support services in our service area. Many of these formed organically through ongoing partnership work. We will maintain these relationships through the care coordination process and through the community governance model and its committee structure. Please also see Table 1 in Attachment 10 Community Engagement Plan tables. We will continue to invest in our long-term relationships in the following ways:
- DHS Child Welfare and Self Sufficiency field offices in the Service Area. We regularly coordinate with local DHS District 10 partners to support care management and to facilitate member/provider coordination efforts. PSCS created the Community Resource Huddle, a community gathering that meets quarterly to connect resources within the region. There are close to 500 community partners that are invited and attend these huddles, including DHS’ District 10 Child Welfare and Self Sufficiency representatives. We will also continue to
coordinate our work on the Quality Incentive Measure to ensure that children in DHS custody receive timely physical, behavioral, and oral health assessments.

- **Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area.** We regularly coordinate with the OYA and our local juvenile department partners via care management practices and for member/provider coordination efforts. We will continue to have regular and targeted interactions with the OYA and our local juvenile department partners. We will also continue to connect with these partners at the Community Resource Huddle.

- **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.** We coordinate with the Department of Corrections, local law enforcement, and drug/mental health courts via care management practices and for member/provider coordination efforts. We recently assisted the Deschutes County District Attorney with care coordination efforts to implement a pilot program called Goldilocks, offering physical, behavioral, and oral health care to first time drug offenders. We will continue to interact regularly with our corrections, law enforcement, and problem-solving court partners. We will also continue to connect with these partners at the Community Resource Huddle.

- **School districts, education service districts that may be involved with students having special needs, and higher education in the service area.** We coordinate with our regional school districts, education service districts, and higher education facilities via care management practices and for member/provider coordination efforts. The High Desert Education Service District also received community reinvestment funds from the Health Council to train over 3,000 educators in our region on trauma-informed care practices. We will continue to interact regularly with our education partners and will continue to connect with these partners at the Community Resource Huddle. We will also evaluate the outcomes of the programs funded by the community reinvestment funds and collaborate on next steps. Representatives from these organizations serve on the Health Council, CAC, and CHP workgroups.

- **Developmental disabilities programs.** We coordinate with Full Access High Desert, Abilitree, Family Support Network, and Deschutes County Health Services’ developmental disabilities programs via care management practices and for member/provider coordination efforts. Abilitree received Quality Pool funds for a travel training program which teaches differently abled individuals how to navigate the public transportation system. We will continue to interact regularly with our partners. We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. Representatives from these organizations serve on the Health Council, CAC, and CHP workgroups.

- **Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives.** We regularly coordinate with our Confederated Tribes of Warm Springs partners via care management practices and for member/provider coordination efforts. Representatives from the Confederated Tribes of Warm Springs serve on our CHA/CHP Steering Committee. PSCS also participates in the Warm Springs Native Aspirations community group.

- **Housing organizations.** We coordinate with PacificCrest Affordable Housing and Housing Works. PacificCrest Affordable Housing received community reinvestment funds from the Health Council to support their operations of a 50-unit affordable housing project that is focused on health and access to care. We have an MOU with PacificCrest Affordable
Housing to support and advise their current and future projects. We will evaluate the outcomes of the programs funded by community reinvestments and collaborate on next steps.

- **Community-based Family and Peer support organizations.** We coordinate with our partners that employ THWs, including family and peer support, via care management practices and for member/provider coordination efforts. We will continue to interact regularly with developmental disabilities partners. Representatives from Cascade Peer and Self Help Center serve on CAC and CHP workgroups.

- **Other social and support services important to communities served.** Representatives from regional shelters, faith based networks, job connection services, and trauma-informed care organizations attend the Community Resource Huddle. We will continue to engage and collaborate with our partners at the Community Resource Huddle.

**Attachment 7, Section 2.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.

PSCS believes that meaningful member engagement takes place when there is two-way communication with a member. This type of engagement most often occurs between a member and a clinician at a health care appointment. PSCS works with providers to improve this experience and also works to meaningfully engage members at the plan level. From the moment a member is enrolled, PSCS works to engage them as partners in the care they receive. We provide a welcome packet with information about health benefits and care options within days of being assigned to our CCO. Within the first quarter of membership, we conduct a welcome call to every new member. During this call, Customer Service Representatives confirm that the member is assigned to a PCP of their choice, review benefit information, and address the member’s questions. PSCS also uses a continuous improvement process to improve member engagement and solicit input from members to inform Quality Improvement activities.

Our interaction with members is one element of meaningful engagement, but we know that members working one on one with a clinician is an even greater indicator that members are engaged in efforts to meet their personal goals. PSCS also understands that getting a member to a health care appointment is only the first step to ensuring meaningful engagement. Therefore, we work with providers in our network on continuous improvement of member experience. We offer technical assistance and incentivize clinics to work towards improving or maintaining higher PCPCH Tier levels and to integrate behavioral health care into PCPCH clinics and monitor those clinics to ensure they are meeting standards. We also conduct site visits to seek information about providers’ adherence to CLAS standards, implementation of person and family-centered engagement, and capacities to offer interpretation services, among other topics. In 2019 and 2020, PSCS plans to build a member engagement scoring methodology and corresponding dashboard that will incorporate activities in both the health care delivery setting and the health plan setting. Early proposals include tracking member engagement by analyzing PCP visits, dental visits, downloads of our mobile application, interactions with PSCS Customer Service, and survey completion. We may share this deidentified information on a regular schedule with the CAC to review trends and patterns and gather input on improvements. We will also continue to offer targeted interventions with providers and develop network-wide training programs that focus on evidence-based practices such as Motivational Interviewing, Patient & Family Engagement Strategies in Direct Care, Patient Activation, and Shared Decision-making.
Attachment 7, Section 2.b: Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, Behavioral Health and oral health services, including how it will:

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

PSCS offers a comprehensive communication program to engage and provide all members with information related to their benefits and how to access care. From the moment a member enrolls, we work to engage them as partners in the care they receive. For example, we supply local enrollment assisters with postcards to hand to members who enroll with PSCS to help them get started. The postcard offers contact information for our Customer Service Department, our website address where a member can print a temporary ID card, and instructions for downloading our mobile application to learn about benefits and search our provider directory. As discussed above, we also conduct welcome calls for every new member using bilingual and bi-cultural staff, as appropriate. We offer monthly newsletters and regular outreach to communicate wellness, prevention, and healthy lifestyle resources. We work closely with providers to ensure that members have access to their personal health information utilizing health information technology solutions. In addition, we collaborate with provider partners and Health Council workgroups to develop and launch community-based campaigns with targeted messaging. We have invested resources in training staff about plain language and culturally and linguistically appropriate messaging. We work with the CAC and seek their input on member-facing materials, including newsletters, welcome letters, postcards, the website, and mobile application. Going forward, we will leverage internal resources to develop and deploy a coordinated multi-media onboarding strategy that utilizes multiple channels to connect new members with information about their benefits and how to access care. This strategy may include the following:

- Continuing to make welcome call from PSCS orienting new members to benefits and programs as well as confirming assignment to their primary care provider
- 6-8 week drop campaign that includes:
  - Welcome packet, including key steps for getting started, care coordination, and information about THW resources
  - PCP welcome packet with key next steps and information
  - Health Risk Screening survey and appropriate follow-up protocol
  - Oral health welcome packet with key next steps and information
- 90-day data review of member engagement dashboard
- High touch care coordination outreach, including calls from Member Support Specialists and warm hand offs to a THW or Peer Support Specialist at the assigned PCP for outreach up to and including a home visit
- Coordinated multi-channel health campaigns, including messaging about wellness, prevention, and healthy lifestyle choices

Attachment 7, Section 3.a(1): Describe Applicant’s PCPCH delivery system.
We contract with a robust and diverse PCPCH delivery system to serve our members, including independent, hospital-owned, Rural Health, and Federally Qualified Health Centers (FQHCs). We support their initial recognition and later progress as PCPCH clinics through technical assistance and financial supports. We intend to contract and remain contracted with every PCPCH clinic in the region. As of January 2019, 95% of CCO members were assigned to a primary care clinic with a PCPCH level of Tier 3, 4, or 5. Of these members, 40% are served in a Tier 5 (“5 STAR”) PCPCH, with 42% served by Tier 4 clinics, and 13% served in Tier 3 sites. Ninety percent of members receive primary care from an organization with integrated behavioral health, and two PCPCH sites are developing on-site dental clinics as well.

Attachment 7, Section 3.a(2): Describe how the Applicant’s PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Providers and services.
As described in our MOUs with DHS Medicaid-funded LTC providers and services, PSCS partners with offices to coordinate care for members and works collaboratively with PCPCH providers. We hold care team meetings at least quarterly and include PCPCH providers for members identified as needing this level of coordination and planning. PSCS and APD staff use the processes detailed in our current MOU to coordinate outreach to PCPCH clinics at other times, for such member needs as preventive services visits, other health care, Health-Related Services, or engagement with PCPCH care team.

Attachment 7, Section 3.a(3): Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural Health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.
We encourage members to use these clinics through member assignment and listing them in our provider directory, and by partnering with the clinics in value-based payment models. We also work in partnership through other approaches, like the community governance model and in joint member engagement and outreach efforts. We have current contracts for clinical services that allow members to access services from every PCPCH-recognized FQHC, Rural Health clinic, migrant health clinic, and school based health clinic in the service area. Beyond CCO operations and contracting, an FQHC/migrant health clinic representative serves on the Health Council as well as on multiple workgroups. Finally, we include these clinics in targeted outreach.

Attachment 7, Section 3.b(1): If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient’s physical, oral and Behavioral Health care needs.
Not applicable.
Attachment 7, Section 3.b(2): Describe how the Applicant’s use of this model will achieve the goals of Health System Transformation.

Not applicable.

Attachment 7, Section 4.a(1): How does Applicant intend to assess the adequacy of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

**Adequacy Assessment.** To evaluate and determine the sufficiency of our Provider Network, we use Quest Analytics for geocoding and mapping as well as other network adequacy tools, like Excel pivot tables and Tableau reports, to compare the network to membership distribution for all required provider types. This includes an evaluation to ensure that, at a minimum, 90 percent of members have routine travel time or distance to the member’s PCPCH/PCP that does not exceed the community standard. The results of these analyses allow us to evaluate time and distance outcomes versus requirements as well as identify any gaps in the network. Going forward, we will evaluate our current reporting tools and provider reporting requirements to ensure we comply with new or updated regulations and CCO contract requirements.

**Assessment and Methodology.** We review and pre-authorize requests for services and referrals that would require members to use out-of-network providers. With the analysis tools noted above, such requests enable us to immediately identify and address any access deficiencies. This may include additional contracting and review of referral patterns. PSCS analyzes providers and specialist data for changes in utilization, performance, access to out-of-network providers, and grievances specific to member access for covered services. We leverage contracts to ensure sufficient access for all provider types. These analyses are reviewed by key leaders to determine any opportunities for improvement and we act on findings and opportunities. We have adopted Network Availability Standards - Medicaid and the Practitioner Availability Analysis policies that outline our process for evaluating network adequacy. We also send member and provider surveys to assess our network. We gather capacity information through quarterly reporting requirements, site visits, and ongoing provider communication.

**Across Care Domains.** PSCS has agreements with Dental Care Organizations (DCO) to assess access and availability. DCOs perform this assessment by monitoring enrollment, grievances (if any), provider capacity, and office limitations. Some DCOs employ a specific patient load target for their providers and make operational adjustments to maintain alignment with the desired target. These processes are monitored monthly and annually by both PSCS and the DCOs. Additionally, each DCO has implemented more robust appointment access monitoring systems such as reporting of Third Next Available Appointment (TNAA) and/or quarterly member appointment access surveys. PSCS maintains oversight via review of rosters and access reporting as well as review of DCO policies and procedures to ensure alignment between policy and practice. PSCS intends to analyze existing reporting tools and policies to ensure comprehensive oversight and monitoring, to ensure the data output is actionable, and that providers are compliant with access standards.

Behavioral health providers maintain their access and availability standards by measuring and reporting compliance with access standards for urgent, emergent, and routine appointments. Community Mental Health Program (CMHP) staff also report these standards to PSCS.
addition, PSCS performs regular telephonic audits to ensure that providers are communicating access information to members for care outside of regular office hours. We monitor access to primary care providers and specialty providers through clinic-level monitoring of wait times and appointment availability. We collect and monitor this information through surveys, outreach, phone calls, reporting expectations, etc. We put continuous improvement projects in place to evaluate and ensure adequate access. There are no time, distance, and practitioner to member ratios that apply to Non-Emergent Medical Transportation (NEMT), so we have adopted our own standards and monthly monitoring practices outside the Quest Analytics system. This evaluation includes monitoring of monthly and quarterly reports received from NEMT brokerage staff, as well as monitoring of Grievances and Appeals data. PSCS will increase the level of monitoring of the NEMT program to include additional data sets mandated in the 2020 CCO contract.

Data Points. We evaluate provider to member ratios, time and distance standards based on OAR 410-141-3220, provider capacity, appointment wait times and hours of operation, as well as: call center performance, percent of providers accepting new members, utilization, including prior authorizations and referrals, grievances and appeals, denial of services, and specifically for NEMT: call center monitoring, capacity denials, the reasons for the denials, average ridership, rides per member per month, complaints regarding availability, appeals related to denials, and various additional data points.

Attachment 7, Section 4.a(2): How does Applicant intend to establish the capacity of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated

Establish Capacity. To establish the capacity of our provider network, we will continue to evaluate member to provider ratios, time and distance standards, and provider capacity limits for access. This includes an evaluation to ensure that, at a minimum, 90 percent of members have routine travel time or distance to the member’s PCPCH/PCP that does not exceed the community standard. We will also continue to evaluate prior authorization utilization, out-of-network referrals, service denials, grievances and appeals, and provider status for new member assignment. PSCS will be evaluating current reporting tools and provider reporting requirements to ensure PSCS is in compliance with new or updated regulations and contract language.

Assessment and Methodology. PSCS establishes provider network capacity based on member to provider ratios. These ratios are informed by our experience serving Medicaid members as well as NCQA standards. We monitor these ratios monthly. We also survey providers to evaluate whether they can supply adequate services within the context of capacity defined by our policies. In addition to ratios, PSCS will continue to evaluate the network based on time and distance standards, as required in OAR 410-141-3220, and the 2020 CCO contract.

In order to understand how established capacity standards translate into member outcomes, PSCS also works to gather member feedback. We do this through grievances and appeals, reviewing out-of-network prior authorizations, and CAHPS results. PSCS is currently piloting a member survey that includes questions on appointment and care availability. We will share the results with our provider partners and community-based organizations and build region-specific access improvement plans.
Data Points. Data points include provider to member ratios, time and distance standards based on OAR 410-141-3220, provider capacity, appointment wait times and hours of operation, call center performance, percent of providers accepting new members, utilization, including prior authorizations and referrals, grievances and appeals, and denial of services. For NEMT, we also conduct call center monitoring and review capacity denials, the reasons for the denials, average ridership, rides per member per month, complaints regarding availability, appeals related to denials, and various additional data points.

Attachment 7, Section 4.a(3): How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?

PSCS is committed to prompt and thorough remediation of any provider network capacity deficiencies. Our contracting staff are located throughout the state, which enables collaboration and open communication with our provider partners. By maintaining an open panel and streamlined approach to credentialing and contracting, PSCS is able to quickly increase capacity and access when needed. Our approach to addressing capacity deficiencies includes, but is not limited to, evaluating the DSN report, member-to-provider ratios, grievance and appeal monitoring, CHA and CHP findings, and quality reviews. If we identify a deficiency, we share this information with our contracting team, so they can outreach with potential providers to close the gap or identify a common referral source that would meet the needs of the member.

Attachment 7, Section 4.a(4): How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected.

Data Collection and Data Points. PSCS currently requires DCOs to send monthly appointment availability reports and quarterly provider capacity reports. We collect wait time information from other providers using surveys and telephonic means. Going forward, we intend to scale our approach with DCOs to other providers so that we capture comparable appointment wait time data as required in OAR 410-141-3220. PSCS will continue to gather data from providers, through current mechanisms, such as provider surveys, as well as enhanced mechanisms going forward. Data points include percent of providers accepting new members, new patient appointment wait times, existing patient appointment wait times, 24-hour phone availability, and next available appointment.

Monitoring. PSCS sends out quarterly access surveys to physical and behavioral health providers. We compile the survey results and review them to determine compliance with contractual requirements related to access. We regularly analyze dental appointment availability and work collaboratively with DCOs to discuss results and trends. We conduct ongoing analyses of access to dental services through a variety of mechanisms including monitoring of monthly utilization trends, quarterly dental provider capacity reports (by DCO), and quarterly appointment access reports (by DCO). If we identify any issues, we require corrective action plans. Our Access Policy describes our process for working with the provider to remedy the deficiency. In addition, we research and act on access complaints and document them in the Provider Accessibility Report. The PSCS Compliance Department will continue to conduct internal and external audits to verify performance and compliance with contract standards.

Attachment 7, Section 4.a(5): How will Applicant ensure sufficient availability of general
practice oral health Providers and oral health specialists such as endodontists? Please provide
details on how the full time equivalent availability of Providers to serve Applicant’s prospective
Members will be measured and periodically validated.

On a frequent basis, PSCS requires DCOs to provide dental network and capacity reporting that
includes general and specialty care providers, like endodontists. We integrate this information
with our overall provider DSN analysis and reporting activities. As proof of sufficient capacity,
PSCS monitors and evaluates each DCO’s appointment availability to ensure timely access to
dental services. We validate this type of information in a variety of ways, such as through
comparison audits of provider capacity reports with provider directories, audits that include an
evaluation of length of time between scheduling and actual appointment, and member surveys
that include questions about timely access and receiving care when needed. Further, PSCS
maintains network adequacy policies that include dental provider ratios. PSCS will be able to
measure and periodically validate provider full-time availability equivalency by updating our
provider surveys. When the OHA releases standards related to full-time equivalency, PSCS will
update processes and provide notifications to the providers impacted by the performance
standards. We will perform this work at least as frequently as required by the OHA.

Attachment 7, Section 4.a(6): Describe how Applicant will plan for fluctuations in Provider
capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members
will not experience delays or barriers to accessing care

PSCS will plan for fluctuations in provider capacity using a variety of strategies. We will
monitor provider terminations (termed from locations, moved out of the area, etc.), analyze the
impact of the termination on the network, determine if there is a material change in the network
(and required reporting), and evaluate member impact of the termination. We have adopted
notice standards that exceed OHA requirements in order to give sufficient time for PSCS to
secure replacement services, as needed. PSCS has a robust system for evaluating capacity
changes by utilizing Quest Analytics to identify deficiencies, as well as our internal teams.

Attachment 7, Section 4.b: Requested Documents

Please see attached our DSN Provider Report.

Attachment 7, Section 5.a: Access to care (wait times, travel
distance, and subcontracted
activities such as Non-Emergent Medical Transportation).

PSCS uses information gathered from our Grievance and Appeal system to identify and resolve a
variety of issues. In particular, we use internal processes with multiple departments (and through
multi-stakeholder committees) and external interfaces with providers and the community to
capture information and build plans for resolution. PSCS captures all appeals and grievances in a
log at the point of receipt. We house this data in our centralized IT system. We review each
appeal or grievance, investigate it, and provide resolution to the member or representative. We
use a tracking system to categorize types, evaluate trends, and monitor access-related concerns.

On a monthly basis, we also work with subcontractors to submit logs to us for our review and
follow up. We monitor these logs to ensure timeliness and appropriate action in accordance with
OHA regulations and the CCO contract. We conduct monthly monitoring of logs for trends
related to member dissatisfaction with wait times, including, but not limited to, appointment
scheduling delays, rescheduled appointments, transportation issues, and dissatisfaction with a
service experience impacting a member’s access. We identify trends as an increase or decrease in volume of access complaints as well as volume increase or decrease related to specific providers, month over month and quarter over quarter. In addition, specific to transportation monitoring, our current practice is to hold quarterly operations meetings with NEMT staff. We use this meeting as an opportunity to evaluate data and discuss improvement opportunities. On a quarterly basis, we also report all appeals and grievance data to our Quality Improvement Committee and Clinical Quality Utilization Management Committee. These committees provide additional monitoring and strategic planning to address improvement opportunities. Going forward, we plan to continue and expand these practices. For example, we are working to establish baselines and targets for access complaints. We are also creating a subcontractor communication schedule to evaluate trends from monthly monitoring and establish next steps to meet baselines and targets for access to care improvements, consistent with our current practice with NEMT.

Attachment 7, Section 5.b: Network adequacy (including sufficient number of specialists, oral health and Behavioral Health Providers).

PSCS intends to follow the process set forth above in Section 5.a and use those same actionable strategies. In addition, we share network adequacy appeals and grievances on a case by case basis with our Provider Network Department. In cases where the root cause of a complaint, or an appeal of a denied service, is related to an out-of-network provider providing physical, dental, behavioral health, or transportation services, we work in partnership with the Provider Network Department to review the network and assess opportunities to expand. We work in partnership with our oral health and behavioral health providers to review grievance and appeal data and create improvement plans to meet member needs. Going forward, we plan to continue and expand these practices. For example, we are working to establish baselines and targets related to access so that we can close any gaps. This will allow us to set targets for grievances about travel times or distance to services, the number of in-network providers available, and the number of overturned appeals for out-of-network providers. In addition, we will develop a process to flag access complaints specific to specialists and oral health and behavioral health providers.

Attachment 7, Section 5.c: Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

We take steps to ensure consistent and appropriate application of Prior Authorization criteria and Notification of Adverse Benefit Determinations (NOABDs), for both our non-delegated services, and at the subcontractor level. Our Utilization Management (UM) Department documents all Prior Authorizations in our Dynamo system, which are evaluated by clinical staff when indicated using a variety of criteria, including the Prioritized List. For services that are not approved, we issue NOABDs according to the specified OHA content and timelines. We review delegated NOABDs for timeliness, letter content, and appropriate decision making using the same criteria PSCS utilizes. Going forward, we are building plans to increase the frequency of feedback with our subcontractors. During spring and summer 2019, we are also conducting an evaluation to determine if we should rescind any delegated authority to subcontractors. Upon receipt of an appeal from a denied prior authorization, PSCS begins to assemble a case file and identifies if there is need for additional information. We may need to request a meeting with providers and subcontractors to clarify any particular facts of the case and we may also request medical
records. We use this case file to review and document applicable regulations and data from the Prioritized List and the Medicaid Management Information System. We also identify all applicable decision making criteria. On a weekly basis, we review appeal data internally to identify activities and opportunities for improvement. If we identify deficiencies, we require education, increased oversight of performance management, and corrective action, as needed.

Attachment 7, Section 6.a(1): Describe how the Applicant will support the flow of information between providers, including DHS Medicaid-funded LTC care Providers, mental health crisis services, and home and Community-based services, covered under the State’s 1915(i) State Plan Amendment (SPA) for Members with severe and persistent mental illness, as well as Medicare Advantage plans serving Fully Dual Eligible Members, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.

We support the flow of information between providers in a number of ways, including Joint Operating Committee (JOC) meetings, clinical work stream reviews with provider partners, and in daily care management work. We use the JOC structure to work with our provider partners quarterly, where we review performance, financial, utilization, and care management data. As a part of these collaborative relationships, we meet on a regular basis with providers to share data via the Member Insight and Provider Insight reporting package, coordinate work flows, and improve service delivery to our members to avoid duplication of services and to prevent members from “slipping through the cracks.” In addition to the JOCs, we meet monthly with provider partners in each region to review clinical work streams, find and eliminate duplication of services, identify members in need of care coordination, and review member engagement and enhancements to coordination of care. The PSCS Care Management Team (CM Team) also meets daily to review member needs, address challenges to care coordination, and identify any missed opportunities to provide preventive or primary care. The CM Team will reach out to the PCP or other provider if we identify any missed opportunities. In addition, our pharmacy team offers a Medication Therapy Management service where a pharmacist meets with members to review their medications; one of the goals of these meetings is a reduction in medication errors.

PSCS works closely with community partners, including LTC providers, mental health crisis services and home and Community-based services to enhance coordination of care for our members including working with our regional APD offices and dual eligible members. Our specially trained CM Team for dual eligible members have extensive knowledge and expertise in both Medicaid and Medicare, including PacificSource’s own Medicare Advantage plans. Offering members a CM Team that is dually trained allows for seamless care coordination and a single point of contact for our members to receive care management services. Along with working closely with community partners, providers, and county organizations to identify members in need of care coordination services, PSCS care managers have access to EDIE/PreManage data to help inform real-time coordination of care/care planning and are able to target specific cohorts, such as members with Serious and Persistent Mental Illness (SPMI). PSCS meets quarterly, and when needed monthly, with the local APD office to discuss ways to enhance our work with members for whom we provide services. These meetings can be narrowed in scope to discuss the specific care needs of individual members or can expand to include community mental health providers and/or other key community stakeholders as warranted.
Attachment 7, Section 6.a(2): Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs.

PSCS works with community partners and providers to develop partnerships that allow for access and coordination with social and support services. Examples of how we achieve this goal include being an active member of acute care councils, participating in regularly scheduled APD meetings, and working in collaboration with prevention coordinators. Going forward, PSCS will utilize existing work stream meetings, such as the Community Huddle. This is a forum by which local community partners present and share resources and engage in coordinating service delivery, which includes telephonic and email connections. It is groups like this that allow the CM Team to enhance coordination of social and support services, including crisis management. Ideally, this work will lead to the possible collective development of a common “community” care plan for members.

Attachment 7, Section 6.a(3): Describe how the Applicant will develop a tool for Provider use to assist in the culturally and linguistically appropriate education of Members about Care Coordination, and the responsibilities of both Providers and Members in assuring effective communication.

We will develop multiple tools for providers that will facilitate culturally and linguistically appropriate education of members about care coordination and the responsibilities of both providers and members in assuring effective communication. PSCS intends to contract with a culturally responsive training vendor after measuring the number of CCO provider partners that have documented Culturally and Linguistically Appropriate Services (CLAS) policies related to cultural competency continuing education and access to interpreter services. We will then work with provider partners and an identified cultural responsive training vendor to provide education and resources to provider partners to fulfill CLAS standards and create a member education tool. In addition, we will use existing forums to educate provider personnel. We currently have Medical Assistant workshops, coding education, and health engagement collaboratives. We are also prepared to schedule education at individual clinics to best meet their schedules. Finally, we have training and educational resources available for providers regarding CLAS standards. During 2019, we have multiple webinars available to offer education on CLAS standards.

Attachment 7, Section 6.a(4): Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple health care and service systems.

By sharing data, PSCS and provider groups can use system logic to identify members with multiple health care and service needs to coordinate outreach. Together, we can help the member navigate the complexities of the health care industry, assist in referrals to community resources, and improve health outcomes. Our primary method of identifying members with multiple diagnoses is the Member Insight report. We distribute this report to provider groups on a monthly basis using data from a variety of sources. The Member Insight report contains information about diagnoses, hospital and PCP activity, risk scores, and identifies those eligible for ICC services. We use this report to work in dyad partnership with providers. We also support and help expand the use of PreManage and EDIE utility software that allow for uniform patient event notifications. The use of these tools has allowed PSCS to monitor and coordinate care with
members who present to emergency and inpatient medical departments by monitoring real-time notifications of events. Because these tools are in use throughout Oregon, we are able to identify members who are being served by multiple health care and service systems. We will continue to work with providers through our engagement structure and monthly meetings.

Attachment 7, Section 6.a(5): Describe how Applicant will implement an intensive Care Coordination and planning model in collaboration with Member’s PCPCH and other service providers such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities, that effectively coordinates services and supports for the complex needs of these Members.

We have an existing Intensive Care Coordination planning model used in collaboration with PCPCH providers and other community service providers, such as Community Developmental Disability Programs. We use a standard programmatic approach, including a comprehensive assessment and individualized care plan, as well as established outcome measures for working with ICC members. An integral part of this process involves ongoing communication (predominantly telephonic and secure email) and coordination of care with the member’s PCP, associated specialists, community providers and family, as indicated. Care plans are updated at least monthly. We also hold Integrated Care Meetings (ICMs) involving face-to-face interaction with members and key providers to develop coordinated care plans for our members with complex needs. We directly coordinate with Community Developmental Disability Programs to best utilize state funds including K Plan and Health Related Service funds to support ICC members. Through our coordinated care efforts with local program personnel and community resources, we effectively increased member engagement to drive better health outcomes. PSCS also leverages existing provider-payer partnerships to focus on members with developmental disabilities to ensure these members’ care needs are appropriately addressed and coordinated.

Attachment 7, Section 6.a(6): Describe how the Applicant will meet state goals and expectations for coordination of care for Members with severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) SPA and Members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from Global Budgets.

Because we are aware of the increased needs of members receiving LTC services, we have prioritized our relationships with state agencies. While we manage members with SPMI receiving home and community based services through the ICC services (ICCS), we are aware of the need to coordinate with these external agencies to optimize outcomes for the member. Early identification and intervention can positively impact the quality and cost associated with care, while also improving member satisfaction and overall health outcomes. ICCS is specialized care management that is trauma-informed and ensures coordinated and integrated person-centered care for all members. We create individualized care plans that are tailored to address member needs and goals. We develop care plans in concert with providers and community agencies, including DHS Medicaid-funded LTC services. We offer ICCS to youth according to presenting needs. In addition to providing ICCS, we manage and support members with SPMI through coordinating the care of those members transitioning through acute stabilization environments to step down facilities. By managing relationships, engaging CMHPs, and connecting our members with high-quality individualized community-based services, we are able to effectively transition members from facility-based support to the most independent environment.
Attachment 7, Section 6.a(7): Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.

PSCS intends to capitalize on our existing work to support Traditional Health Workers (THWs) and expand our efforts in several key areas. There is a growing body of evidence-based practices we intend to deploy to support THWs. We use both evidence-based and innovative strategies to ensure coordinated care, especially for Members with ICC needs. Examples include our support of the Bridges to Health (B2H) Pathways Hub and the transformative Accountable Health Communities project. B2H is a multi-sector collaborative approach to providing community care coordination that coordinates, tracks and measures both the process and the resources that enable distributed community care coordination. B2H ties payments to milestones that improve members’ health and well-being. THWs employed by community care agencies (clinics, schools, social service, and housing agencies) help coordinate services for members and their households. Agencies contract for payment when evidence-based outcomes are met. We are working to scale strategies like B2H to support our members. For more detailed information about our plans, please see our THW Integration and Utilization Plan.

Attachment 7, Section 6.a(8)(a): Describe the Applicant’s standards that ensure access to care and systems in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO.

Upon enrollment, we assign members to a primary care home that is responsible for coordination of care and transitional support. As part of our 2019 strategic plan, we are working to enhance the PCP attribution process across all lines of business. We are enhancing our matching logic to pair members with an identified cultural or language preference with a provider who is able to meet that need. PSCS processes new members through our enrollment management system when batch 834 files are received from the OHA. We immediately assign members to PCPs upon enrollment to ensure continuity of care across a broad network of PCPs. PSCS sends an initial welcome packet to all newly enrolled members that details initial steps of CCO enrollment, including a comprehensive benefits overview, a health risk screening survey, and information on how to access care management services. Survey results trigger a connection to the CM Team within 30 days (and often within 10 days). We also conduct welcome calls to all new members.

Attachment 7, Section 6.a(8)(b): Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

As discussed in our response to Section 6.a(8)(a), PSCS will match members with an identified language or cultural preference with a primary care provider meets that need. Those providers conduct culturally and linguistically appropriate health screenings as part of their primary care practice. In addition, as part of our onboarding process, we conduct screening assessments in each member’s preferred language. In addition, many of our provider partners are participating in the Accountable Health Communities screening for social determinants of health utilizing CLARA software and connecting members to community resources.

Attachment 7, Section 6.a(9)(a): Describe the Applicant’s plan to address appropriate Transitional Care for Members facing admission or discharge from Hospital, Hospice or other
palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, the Oregon State Hospital or other care settings. This includes transitional services and supports for children, adolescents and adults with serious Behavioral Health conditions facing admissions or discharge from residential treatment settings and the state Hospitals.

PSCS manages and supports members with severe and persistent mental illness through coordinating the care of those members transitioning through acute stabilization environments to step down facilities through our Integrated Care Management (ICM) approach and intensive care coordination. By managing relationships, engaging CMHPs, and connecting high quality individualized community based services to our members, we effectively transition members with SPMI requiring facility based support to the most independent environment, thereby limiting long-term institutional care. We also have a comprehensive strategy for proactively identifying members at high risk for readmission to an acute care facility. We utilize this program for members who are admitting to or discharging from the hospital, hospice, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or substance use disorder, or the Oregon State Hospital. We contact members telephonically at different times of day, on varying days of the week, at least twice and follow up by letter with detailed information on how to access the care team if phone outreach is unsuccessful. We also contact primary care providers and community agencies in order to coordinate care and attempt to connect the member with necessary services. We utilize customized member reports to provider partners to help proactively identify members with gaps in care, new diagnoses and other clinical indicators for needed care. We reinforce these reports with regular care management meetings to ensure we maximize care efforts, avoid duplication, and share best practice strategies for member outreach and engagement, track trends, and measure outcomes for ongoing process improvement. We adhere to evidence based practice guidelines (including utilization of the LACE index tool). Our integrated physical health/behavioral health care managers complete an initial member assessment, including social determinants of health, medication reconciliation and coordination with the PCP and/or specialty care, develop a care plan and track outcomes.

Finally, given our role as a Choice Model Services contractor, we actively participate in and manage a number of transitional services for members. We coordinate care and manage the referral process with receiving facilities for any member placed out of area. Our CM Team attends interdisciplinary meetings with stakeholders to discuss members, adjustments, improvements, and medication changes along with discharge planning and transition of care needs related to the Oregon State Hospital. We provide ICCS as a specialized care management service to members who are aged, blind, or disabled, or who have complex medical needs, multiple chronic conditions, severe and persistent behavioral health issues and those receiving Medicaid-funded long-term care or long-term services and supports. Early identification and intervention can positively impact the quality and cost associated with care, while also improving health care outcomes and member satisfaction.

Attachment 7, Section 6.a(9)(b): Describe the Applicant’s plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care.
PSCS care management leadership and APD managers and directors meet quarterly to assess whether the MOU commitments have been carried out, identify strengths of the MOU and partnership, and find any challenges or barriers to meeting MOU commitments and member’s needs. We also review unexpected opportunities and informal/anecdotal outcomes, monitor improved transitions of care for members and, if needed, revise the MOU to adjust for new information. We have established inter-disciplinary care teams, consisting of providers and partners, including PCPs, Long Term Support Services (LTSS), and APD representatives, as well as other agencies/service providers working with members. The interdisciplinary care teams coordinate care, monitor transitions of care and develop individualized care plans for mutual high needs members. We employ coordinated transitional care practices that incorporate cross-system education, timely information sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-social resources any time members experience a transition in their care setting. Finally, we collaborate through conducting educational activities to improve the information available to members during choice counseling and support client participation in Oregon’s coordinated care model for dual-eligible members.

Attachment 7, Section 6.a(9)(c): Describe the Applicant’s plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning.

PSCS has a comprehensive suite of programs in our integrated case management platform that serve to coordinate and track the movement of our members across the care continuum. All of our programs involve direct contact with the member and their identified source of support in assessing the member’s needs, identifying barriers to accessing appropriate care (including social determinants of health) and/or treatment adherence, gaps in care, goal planning and coordination of care with providers and community agency partners. We share provider-specific data in order to track, by individual provider practice, members engaged with our internal care management programs to better coordinate care. In collaboration with our community partners, we use a proactive approach to ensure members have access to appropriate coordinated care with their physical, behavioral, and dental health providers though our use of ICM meetings. Most importantly, PSCS invites members and identified lay caregivers to join ICM meetings to improve communication, coordination, and understanding of the care the member receives.

Attachment 7, Section 6.a(10)(a): Describe the Applicant’s standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State’s 1915(i) SPA.

Our care managers complete a comprehensive integrated initial assessment including medical, social, developmental, behavioral, educational, spiritual and financial needs in addition to an overall benefit review, which includes direct input from the member and/or the member’s family or representative whenever possible. We accomplish this within 10 days of enrollment for the ICC population, including members with SPMI receiving home and community-based services, and within 30 days of enrollment for all others. Our automated logic functionality identifies suggestions on a plan of care which is, in turn, prioritized and customized based on the member’s personal goals and input in order to achieve optimal health and wellness outcomes. The result is
an individualized, member-centric plan of care designed to address the member’s specific health needs and engagement level. The plan of care is shared and coordinated with providers and specialists to ensure consideration is given to a member’s unique needs, including cultural and linguistic factors as appropriate and in compliance with applicable privacy requirements. Care plans are monitored and updated to reflect the ongoing needs of the member, as well as to inform the appropriate time for case closure or transition to outside community or provider based care.

Attachment 7, Section 6.a(10)(b): Describe the Applicant’s universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.
PSCS ensures universal screening of members (including those receiving DHS Medicaid-funded LTC services) for care coordination needs in three ways. The first is through member rate group codes. We apply system flags for members who meet the definition of ICC. This prompts us to conduct additional outreach. Next, we generate a risk score for members using a variety of data points and use this to guide additional intervention. Lastly, we use screening surveys upon enrollment to assess individuals for critical risk factors.

Attachment 7, Section 6.a(10)(c): Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how they will communicate and coordinate with Type B AAA and APD offices.
PSCS factors in relevant referral, risk assessment, and screening information from local type B AAA and APD offices by using our comprehensive initial assessment process. Our care managers complete individualized care plans and prioritize needs based on diagnosis, prognosis, and overall member goals to meet the member at the most appropriate engagement level to impact health outcomes. We use a combination of motivational interviewing and a Patient Activation Measure tool to identify engagement levels of members and structure conversation, treatment planning, and goal setting specifically designed for each individual member. In addition, we also convene regular care management meetings to develop coordinated transitional care practices that incorporate cross system education, timely information sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-social resources at any time members experience a transition in care setting. We incorporate input from APD and AAA offices into our work during these meetings.

Attachment 7, Section 6.a(10)(d): Describe how the Applicant will reassess high-needs Members at least semiannually 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.
We work with APD and AAA partners regularly and assess and reassess high-needs members and engagement opportunities, identify strengths of the partnership, address any challenges or barriers to meeting agreements to effectively serve our members, review unexpected opportunities, and discuss outcomes related to how we serve our shared communities. At least monthly, PSCS reviews and updates care plans for all those enrolled in care management services, or more often when significant changes in status occur. This is done through a combination of outreach to the member, PCP, any specialist or behavioral health clinician involved, and local agency offices. We deploy interdisciplinary care teams to coordinate care and develop individualized care plans on a schedule more frequent than the OHA’s requirement.
Attachment 7, Section 6.a(10)(e): Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.

As discussed above, we work collaboratively to complete individualized care plans and prioritize needs based on diagnosis, prognosis, and overall member goals to meet the member at the most appropriate engagement level to impact health outcomes. We coordinate with APD and AAA staff telephonically and via email to share individual care plans both for members, including dual-eligible members, either on traditional Medicare or a Medicare Advantage plan.

Attachment 7, Section 6.a(11): Describe the Applicant’s plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.

PSCS plans to partner with DCOs to coordinate care for member oral health needs, prevention, and wellness, and to facilitate appropriate referrals. We utilize aligned value-based payment models to support appropriate coordination and referrals. For example, we have successfully incentivized dentists and PCPs (specific to children in foster care and oral health assessment in diabetics) to work collaboratively as a treatment team. We also intend to convene work groups to address the new diabetic quality measure over the next two months with a goal of increasing referrals from PCPs to dentists for diabetic members. In addition, we intend to introduce analytics tools for PCPs that identify oral health services gaps in care for members who are diabetic or pregnant, or are children. Because dentists are already incentivized for this work in their contracts, there are existing work flows in place. We also engage in ongoing monitoring and regular audits to ensure that DCOs are following appropriate policies and procedures to facilitate appropriate referrals. For more information about the HIT and HIE systems we helped put in place, please see our responses to Attachment 9. We are also working with community partners to pilot MORE Care, an intervention from Dentaquest that seeks to enhance oral health integration. We helped make a wide variety of HIE tools available, such as an eReferral platform and a community health record, to enable coordination among all types of providers and settings.

Attachment 7, Section 6.a(12): Describe Applicant’s plan for coordinating Referrals from oral health to physical health or Behavioral Health care.

PSCS currently works closely with our DCO partners, providing them with information about the physical and behavioral health conditions of their members. The DCOs use this information to identify specific populations that may require additional care, including diabetic and pregnant members. We also conduct trainings with DCOs pertaining to referrals to other systems of care, including encouraging dentists to document member blood pressure levels and encourage follow up with a PCP if needed. Given the outcome of the scope of practice questions addressed by the Oregon Board of Dentistry, we plan to support and incentivize dental providers to complete A1c/blood sugar screenings and collaborate with primary care providers on results. PSCS care managers support the DCOs in referring members to either physical or behavioral health services, and the DCOs participate in ICM meetings. We plan to continue and expand this work.

Attachment 7, Section 6.b(1)(a): Describe the Applicant’s plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

PSCS facilitates coordination of oral health care across care systems by leveraging analytics and health information technology, deploying contracting and payment strategies, supporting co-
location and integration of services, aligning investments and innovation with CCO, state, and local priorities, and through oversight and monitoring. We discuss each in turn and will expand on these strategies as part of CCO 2.0.

- **Analytics and Health Information Technology.** PSCS shares analytics tools with providers across all care domains that enable and facilitate oral health care coordination between providers. We use our InTouch Provider Portal to display a variety of types of member information, including the member’s PCP, behavioral health provider, and DCO assignment. We also share a PCP and Pregnancy Report with DCOs to facilitate care coordination during pregnancy. We promote oral health care delivery and coordination for members with complex care needs by sharing the Member Insight Report, which leverages a rich array of data such as risk scores and stratification, utilization patterns (emergency department usage, primary care and behavioral health visits, pharmacy spend, total costs, etc.), conditions (diabetes, heart disease, SPMI, etc.), and provider and DCO information. We work with DCOs to integrate this information into their case management and health record systems. One of our partners uses a health information exchange (HIE) to display this type of information to providers and the case management team. Another partner is augmenting their electronic dental record capabilities by adding information about complex care needs. We use dashboards with performance data to support care coordination and share them monthly. We also use PreManage to facilitate immediate notification of emergency department use. These tools enable proactive, patient-centered care management and coordination across populations, the dental care delivery system, and providers across the continuum of care. We are also promoting adoption and use of Reliance’s eReferrals platform and Community Health Record technology among providers, including specialty behavioral health providers.

- **Contracting and Payment Strategies.** We leverage dental contracting and payment strategies to promote care coordination. We contract with DCOs using performance measures intended to drive improved care coordination for all members and among prioritized member populations. Patient-centered oral care coordination begins with the completion of an oral health risk screening. Providers utilize risk status to build individualized care plans and coordinate efforts. Each respective performance measure necessitates coordination and use of the previously mentioned analytics tools.

- **Co-Location and Integration of Services.** We encourage coordinated delivery of dental and oral health services across care settings. Space constraints prevent us from sharing an exhaustive list of these partnerships, but we focus on helping our partners remove barriers for co-location, including exploring teledentistry opportunities. We also focus on opportunities to align and maximize internal and community resources and priorities to advance oral health care coordination. For example, we are working in partnership with the DentaQuest Institute and the MORE Care model to pilot integration of oral health care in primary care settings, create collaborative care models, and establish interprofessional referral networks.

- **Investments and Innovation Alignment.** Over the course of 2018, we built a dashboard that displays oral health assessments, caries risk assessments, and topical fluoride varnish data for children and pregnant members—by PCP, clinic, and DCO. We share this information with PCPs to facilitate care coordination, integration, and collaboration. Also, we built a dashboard specific to diabetic members that displays oral health visits, caries risk, and periodontal visits. Over the course of 2019, we plan to deploy a mechanism to efficiently disseminate this data to primary care providers. We also plan to use Transformation and Quality Strategy efforts to test the best way to disseminate information across care domains.
- **Oversight and Monitoring.** We use a robust array of monitoring and oversight strategies to assess how DCOs and integrated partners utilize analytics that we provide for the purpose of care coordination and to clarify coordination and collaboration expectations. For example, we are currently reviewing how analytics were used to support care for a cohort of members.

Attachment 7, Section 6.b(1)(b): Describe Applicant’s plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

PSCS promotes the provision of preventative oral health services through member engagement, contracting and payment strategies, analytics and health information technology, innovation and alignment, and co-location and integration. These strategies decrease the need for urgent and emergent care. We plan to continue using and expanding on these strategies during CCO 2.0.

- **Member Engagement.** We educate members on the importance of obtaining preventive oral health services and how to do so in several ways. For example, we send members a comprehensive new member handbook that explains the dental benefit (including preventive services), where and how to access preventive care, and messaging about the importance of initiating care right away. As discussed above, we also conduct welcome calls and review critical information about accessing care, including preventative oral health care. We also work in partnership with DCOs to target high-risk populations.

- **Contracting and Payment Strategies.** PSCS has used risk-based dental contracts to drive improvements in preventative care since 2017. Diagnostic services usually occur before delivery of preventative services. Thus, we also focus on increasing rates of diagnostic and preventative services. We incentivize the delivery of topical fluoride varnish and sealants to children as well as diagnostic measures designed to facilitate patient-centered preventative care, like oral health risk assessments, periodontal evaluations with diabetic members, and increasing dental visits (in general) for children, adults, and pregnant members. Beginning as soon as 2021, we plan to transform the current dental payment model to a tiered payment system tied to both utilization and performance measures, including those intended to further incentivize preventative care.

- **Analytics, Health Information Technology, and Innovation.** As discussed above, we make available a variety of analytics and health information technology tools that directly support identification of care gaps and the delivery of preventative oral health services. In 2019, we plan to deploy new oral health reporting tools.

- **Co-Location and Integration of Services.** The MORE Care Project is an example of the type of investments we will focus on in 2019 and beyond. In addition, we support our partners in creating additional access points in schools, at public health departments, and in social services settings. We are also evaluating emerging co-location pilots between oral care providers and multi-family housing and senior housing providers. These types of partnerships may prove effective in reducing demands for urgent and emergent oral health care.

attachment 7, Section 6.b(2)(a): Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address: (a) Coordination with a Member’s Patient-Centered Primary Care Home or Primary Care Provider.

Our contracts with hospitals and specialty care providers already address coordination with a member’s PCPCH or PCP. We set clear expectations in our policies and procedures, share them with providers in a variety of ways, and require providers to comply with these standards. We
work to encourage hospital discharge planners and specialty providers to communicate regularly with the member’s PCP or PCPCH. We built and deployed several value-based payment arrangements that incentivize this communication and coordination. In fact, follow up with PCP after hospitalization was a performance metric for one of our contracted providers in 2018. We also use technology to promote care coordination between PCPs and specialists. PreManage is available without charge across our provider network to facilitate immediate notification of ER use and care plan transparency. In addition, we actively promote the availability and adoption of health information technology among providers. For example, the Reliance eReferrals platform is used by many providers, representing a mix of primary, specialty, and hospital system care services. Please see our road map in Attachment 9 for more information about our work with this technology. Lastly, our CM Team is available to assist with transitions of care. For members identified as complex or needing additional assistance, or referred by providers or other stakeholders, our care managers reach out to members, specialists, PCPs, hospital personnel, dental care providers, and BH providers as needed to assist with care coordination.

Attachment 7, Section 6.b(2)(b): Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address: (b) Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.
We support a process where a PCP can either admit directly to the hospital when their member requires hospital admission, or can refer a member to the emergency department for evaluation, to determine need for hospitalization. Some PCPs maintain their hospital privileges and manage their own patients in the hospital. Others have arrangements in place with a hospitalist team to provide hospital care. PCPs often have their own care coordinators that assist with this process. For those who do not, or for particularly complex patients who need additional assistance with care coordination, the CM Team assists in this process.

Attachment 7, Section 6.b(2)(c): Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address: (c) Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.
All of our network PCP clinics have access to PreManage, and all of our participating hospitals have access to EDIE. This allows PCPCHs to use real-time notification of hospital and emergency department admissions, as well as discharge, including any care plans that are put into that system. As noted above, specialists and hospitals must provide timely documentation, including pertinent medical records to PCPs after a hospitalization or consult. We incentivize and monitor this communication and documentation.

Attachment 7, Section 6.b(2)(d): Describe how the Applicant’s agreements with its Hospital and specialty care Providers will address: (d) A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.
Please see above for information about how we have incentivized successful transitions of care. Our CM Team works in partnership with the PCPCH or PCP in central treatment planning roles. We review with PCPCH and PCP representatives all inpatient admissions for complexity and potential transition of care concerns. We offer care management intervention for members at high risk for readmissions. Members can enter this program in a variety of ways, including
through the following: readmission within 30 days, inpatient stays longer than 7 days (coordination with hospital RNs/Discharge planners), three or more admits within 6 months, three or more ED visits in the past 6 months, and members that are fragile, have any issues related to social determinants of health or other identified barriers prior to discharge, or issues related to unmanaged chronic conditions. These same criteria apply to members discharging from Post-Acute facilities and inpatient behavioral health facilities. Our Utilization Management Team (UM Team) may also refer members to care management. Ultimately, teams work together and in partnership with PCPs and PCPCHs to support improved health outcomes.

Attachment 7, Section 6.c(1)(a): Describe how the Applicant will: (a) Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, Community-based care or Nursing Facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including the role of Type B AAA or the APD office;

We provide health services to members receiving DHS Medicaid-funded LTC services through our broad network of contracted providers, enhanced by our care management department and our existing relationships with local AAA and APD offices and care management partners. By quickly identifying members using our Dynamo platform, which highlights and flags members receiving DHS Medicaid-funded LTC services, our CM Team works to coordinate care delivery. We also leverage existing work stream meetings on a monthly, quarterly, and as-needed basis with regional APD offices and provider partners to eliminate duplicative services and identify members in greater need of support. We focus on coordination and enhancement of care delivery whether members are served in their own home, Community-based care, or Nursing Facilities.

Attachment 7, Section 6.c(1)(b): Describe how the Applicant will: (b) Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care;

Our model of care management service delivery was developed utilizing a variety of evidence-based best practice models, including use of the LACE score to proactively identify members at risk for readmission, key elements of the Coleman Transitions of Care approach, and CMSA guidelines. In addition, we use best practice assessment tools such as the PHQ2 to assess for depression with every member who is referred into any of our care management programs. Positive screenings are referred for further assessment including utilizing the PHQ9 to complete a more detailed assessment and contacting the primary care provider to coordinate the member’s identified behavioral health needs. Additionally, it is our standard practice and an integral part of our initial assessment to capture SDOH-HE data for our members, coordinate appropriate service delivery with key community partners, and collaborate with the assigned PCP.

Attachment 7, Section 6.c(2)(a): Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care: (a) Co-Location: co-location of staff such as Type B AAA and APD case managers in health care settings or co-locating Behavioral Health specialists in health or other care settings where Members live or spend time.

PSCS continues to explore a variety of alternative models to improve access and coordination of care. We have invested in integration of behavioral health and physical health in the primary care
setting. Based on significant changes in the integration of physical and behavioral health, we plan to invite APD and AAA staff to work closely with us on CHA and CHP workgroups to identify opportunities to focus integration strategies on DHS licensed LTC settings. We have also partnered with OHSU’s Novel Interventions for Children’s Health care for the past three years. This program assigns an Interventionist to those children who require higher level of care management using a combination of family and system based interventions. All interventions are grounded in evidence-based practice and the Interventionist serves as a liaison between children, family members and care team. Often these Interventionists work in the home or leverage technology to reach out to children and families to provide 24/7 access.

Attachment 7, Section 6.c(2)(b): Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care: (b) Team approaches: Care Coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multidisciplinary care team including DHS Medicaid-funded LTC representation.

We have established interdisciplinary care teams, which consist of PSCS providers, PCPs, and Long Term Support Services (LTSS) staff, and AAA/APD representatives, as well as other agencies that work with our members. The interdisciplinary care teams coordinate care and develop individualized care plans for mutual high needs members. While these positions are not jointly funded, we will consider pursuing such an arrangement in the next few years.

Attachment 7, Section 6.c(2)(c): Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care: (c) Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as “in home” Personal Care Services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).

We partner to develop coordinated transitional care practices that incorporate cross-system education, timely information sharing when transitions occur, minimal cross-system duplication of effort, and effective deployment of cross-system nursing and psycho-social resources at any time members experience a transition in their care setting. We support this work by meeting monthly to discuss risks and member needs to reduce duplicative services. In addition, our teams identify any cross-system resources such as transportation, Skilled Nursing Facility, Durable Medical Equipment, or any Health-Related Services that will aid in the member’s care. While many communities do not offer facilities that provide LTC and health services in congregate settings, we will pursue such arrangements in the future should they become available.

Attachment 7, Section 6.c(2)(d): Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care: (d) Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform Assessments, plan treatments, and provide interventions to the person in their home, Community-based or Nursing Facility setting.
We plan to build on our relationships with AAA and APD staff, as highlighted above, and work to maximize the use of Registered Nurses to perform assessments, plan treatments, and provide interventions in home, community-based care, and in nursing facilities. We accept incident-to-billing from RNs to provide palliative care services. In addition to a robust home health network, we contract with Nurse Practitioners who perform assessments, plan treatments, and interventions in whatever setting the member resides. We also coordinate care with appropriate public health resources. Lastly, we use Matrix to provide home-based assessments conducted by Nurse Practitioners for Medicare members to close identified gaps in care and will explore leveraging this relationship for more members.

Attachment 7, Section 6.d(1): Describe how the Applicant will perform the following UM activities tailored to address the needs of diverse populations including Members receiving DHS Medicaid-funded LTC services, Members with Special Health Care Needs, Members with intellectual disability and developmental disabilities, adults who have serious mental illness and children who have serious emotional disturbance. (1) How will the authorization process differ for Acute and ambulatory levels of care; and 

Most specialty care requires a referral from a member’s PCP. The member handbook and provider manual outline services that do not require a referral. However, members who are designated as eligible for ICCS, including those that are 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, are not required to have a PCP referral for an initial specialist visit. In an attempt to expedite care for urgent conditions (acute care), members are automatically granted one follow-up visit to certain specialties if they pertain to an emergency department visit without PCP approval. We also communicate expectations concerning emergency and post-stabilization services via our contracts. In addition, we review DCO policies and conduct oversight and monitoring. DCOs may not require prior authorization for urgent or emergency services.

A referral is also not required for an initial below the line visit to any specialty type to establish an above-the-line condition. If it is determined after the initial visit that the diagnosis is truly below the line, a referral request is necessary. When performing UM activities (both inpatient and outpatient levels of care), referrals are made to the CM Team for members with identified care coordination and care management needs. Some of these referrals may be a result of transitions of care, members with special needs and disabilities, behavioral health needs, and acute care intervention needs. UM clinicians review co-morbid conditions, unique needs of an individual, special considerations, and exceptional circumstances, including ambulatory and acute levels of care. PSCS Medical Directors are also involved in non-coverage determinations and complex case reviews. In addition, we also use concurrent review of acute levels of care to identify care coordination and care management needs more quickly. For those members at high risk of readmission or post-discharge complications, the CM Team performs member outreach within 48 business hours post-discharge from an acute inpatient facility.

Attachment 7, Section 6.d(2): 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. (2) Describe the methodology and criteria for identifying over- and under-utilization of services.

PSCS uses multiple methods to detect over- and under-utilization of services, including analyzing experience reports and dashboards, convening committees for review, analyzing appeals and grievances, and analyzing UM data. We review reporting in a number of forums, including the Health Council and through an internal Cost of Care Committee, which includes our Medical Directors and line of business vice presidents. In addition, we review under- and over-utilization in a variety of quality committees with external providers. In general, the criteria for under- and over-utilization are defined by the type of service. We carefully evaluate preventive services for underutilization, along with benefits where changes may be confusing or unclear to members and providers, resulting in underutilization. In contrast, we evaluate services that may be lucrative for providers to deliver, or may signify poor access or care delivery in the health system, such as use of the emergency department or certain surgical procedures, for over-utilization. In both cases, criteria for valuing the result may be based on comparison to other geographic areas, delivery systems, or periods of time. In addition, we use ad hoc reports to assess trends that may be driven by payment methodology or market conditions and we develop reports to monitor VBP arrangements. Our CCO Quality Incentive Measure (QIM) Team also monitors for over- and under-utilization of services by evaluating monthly utilization data and target graphs to determine where to target their provider outreach. Targeted outreach to providers is needed and is done routinely. These reports are reviewed with external providers in other forums as well. Lastly, each year, the Medicaid Medical Director and representatives from a variety of departments meet to review data from the previous year in regards to utilization, costs, and decision status. This data helps to inform which services should require a preapproval.

Attachment 7, Section 7.a: Describe any quality measurement and reporting systems that the Applicant has in place or will implement in Year 1.

Quality Measurement and Reporting Systems, Generally. PSCS has adopted robust quality measurement and reporting systems to support accountability, transparency, and progress towards health system transformation. PSCS has these systems in place in-house and will continue to expand on them to meet any needs that emerge as part of CCO 2.0. In particular, PSCS builds reporting and monitoring systems to track the following and monitor quality of care, quality metrics, and service delivery across all lines of business:

- **HPQMC Core Measure Set Monitoring:** PSCS is currently able to report on over 86% of HPQMC metrics by leveraging established data sources as well as internally developed reporting. Ongoing work continues to expand reporting capabilities across the measure set.
- **HEDIS Metric Reporting:** NCQA-certified quality measure logic and reporting software allows tracking, monitoring, and collection of all HEDIS metrics including claims based medical record review and electronic clinical data systems reporting.
- **OHA Quality Incentive Metrics:** In-house repository based on OHA QIM specifications provides monthly performance reporting, trend analysis and gap in care data at the provider and member level.
- **CMS Star Performance Metrics:** Monthly performance and trend forecasting at the plan, provider, and member levels for all CMS Star Measures.
- **CPC+ Metrics:** Ability to deliver provider and member level gap in care performance for CPC+ measures.
• Medication Safety and Quality Measures: CMS patient safety reporting which includes measures specified by the Pharmacy Quality Alliance and CMS.

• Steering Committee Metric Monitoring and Dashboards (contract measures, cost of care monitoring, CCO quality performance, etc.): Visual monitoring provides efficient and effective identification of performance gaps, recent trends, and improvement priorities.

Quality Measurement and Reporting Systems, Specific to the OHA Quality Incentive Measures. PSCS has developed an in-house quality measurement and reporting system utilizing the OHA specifications to ensure compliance with the QIMs. Combining internal claims data with clinic EHR reporting, this multifaceted reporting platform provides proactive performance tracking at the CCO, clinic, provider and member level. Our customized approach allows for enhanced capabilities and functionalities, including, but not limited to:

• Intuitive Visual Reporting: Enhanced dashboards converts data to display meaningful and actionable information.

• Member Level Insights: Drill down capabilities provide insights into each member to help identify effective interventions to increase engagement and drive outcomes.

• Performance Trending: Predictive forecasting to ensure month over month performance is progressing at the appropriate rate.

• Individual Clinic-Level Insights and Performance Assessment: To identify key trends and drive more effective collaboration and focus to ensure provider partner success.

We update measure logic yearly to reflect the changes approved by the OHA Metrics and Scoring Committee. Reporting is available on a monthly basis and is shared both internally and externally with Provider Partners and Health Councils. PSCS actively solicits feedback and enhancements on our reporting suite from external stakeholders to ensure continuous improvement, increase partnership collaboration, and improve health outcomes.

Attachment 7, Section 7.b: Will the Applicant participate in any external quality measurement and reporting programs (e.g. HEDIS reporting related to NCQA accreditation, federal reporting for Medicare Advantage lines of business)?

Yes, we participate in external quality measurement and reporting programs. PacificSource Health Plans is NCQA accredited for our Commercial line of business, and we participate in the CMS Stars program for Medicare Advantage, including HEDIS and CAHPS. We have adopted many NCQA best practices related to quality data oversight across all lines of business.

Attachment 7, Section 7.c: Explain the Applicant’s internal quality standards or performance expectations to which Providers and Subcontractors are held.

PSCS is committed to providing access to quality care to all of our members in a safe and healthy environment. PSCS maintains various protocols to ensure participating providers and subcontractors are upholding standards set forth in their contractual agreements.

PSCS expects all contracted providers and subcontractors to meet or exceed regulatory and statutory requirements, contractual performance standards, and PSCS policies and procedures. Contracts executed with providers and subcontractors clearly articulate requirements and performance expectations. Providers and subcontractors are held to these requirements and expectations through a variety of oversight mechanisms. By way of example and not by way of
limitation, we set forth examples of the way providers and subcontractors are held to internal quality standards and performance expectations, below:

- **Contractual Performance.** PSCS uses both contract outcome and process measures to assist our provider partners in achieving continuous improvement while rewarding high quality care and performance. Contract metrics are identified and developed jointly between PSCS, providers, and other community partners (as appropriate) to help meet providers where they are and ensure we collectively execute on a shared commitment to health system transformation. We identify reporting mechanisms, analytics support, and provider needs during the contract negotiation process to monitor performance, promote transparency, and assist with collaborative strategies or mitigation planning as needed.

- **Delegated Services Oversight.** To assess adherence and compliance of delegated services, PSCS conducts annual formal reviews of subcontractor performance. The annual audit provides information on trends of non-compliance and areas that require improvement with the subcontractor. Technical assistance is provided to groups with low performance, and corrective action plans are implemented and executed for subcontractors that do not meet delegation requirements. Each contract details the escalation path for insufficient performance.

- **Regular Monitoring.** PSCS also monitors providers and subcontractors for quality and performance through monthly and quarterly deliverables. Ongoing monitoring covers contract and quality metrics, access to care, grievances and NOABDs, critical incidents, compliance reporting, and provider-generated reporting.

- **Access and Service Delivery Monitoring.** PSCS is committed to ensuring our provider network is sufficient for members to receive care in a timely manner. All provider and subcontractor agreements include access to care standards in accordance with OAR 410-141-3220. These standards ensure our members have timely access to routine, urgent, and emergent care and are able to receive culturally and linguistically appropriate services, in locations geographically close to where they reside. Access and service availability standards are monitored through quarterly access and capacity provider surveys, DSN reports, secret shopper calls, member grievances, CHA and CHP data, and subcontractor oversight monitoring to ensure they have mechanisms in place to measure and report adequate access. PSCS reviews all provider reports and compares them to the linguistic, ethnic, and racial composition in each service area to identify needs for additional contracting or practitioner recruitment.

- **Site Reviews.** As part of ongoing oversight and monitoring of larger, more high-risk providers, including CMHPs and providers with a Certificate of Approval (COA) from the Health Systems Division of the OHA, are required to participate in an annual site review conducted by PSCS. The site review focuses on ensuring compliance with regulatory requirements. Providers are expected to attest annually to having written personnel policies and specific procedures compliant with regulatory requirements specified in their agreement. If any policies and procedures are not in place, providers are required to provide a written plan to develop and implement these requirements to address any current deficiencies. Providers are asked to provide a random sample of twenty charts for review during their annual site review. The sample is expected to reflect all programs that provide services to members. The audit includes review of the assessment, service plan, and the five most recently billed service notes. The billed encounters are reviewed in each chart and validated against claims to ensure the furnished services were billed appropriately. PSCS provides a
final report to the provider, identifying findings associated with areas of non-compliance. We require that corrective action plans be developed to address these areas, with technical assistance provided from PSCS when appropriate.

- **Targeted Audits.** A targeted audit is performed once per year on all Behavioral Health Panel Providers with a COA that addresses Advanced Directives and Declarations of Mental Health. Providers are asked to complete a Self-Audit in which they audit a sample of three members through a supplied audit tool. Supporting evidence of the findings is submitted with the audit tool to ensure that all providers are completing this requirement.

- **Medical and Treatment Record Review.** Providers are required to maintain member health records in a current, detailed, and organized manner in order to facilitate appropriate communication and coordination of care. PSCS conducts chart audits to ensure adherence to these standards, including appropriate medical record content, ease of retrieving medical records, and appropriate maintenance of confidential information. We conduct annual randomized audits of medical charts and treatment records to ensure compliance with these standards. Audit scores are calculated for both administrative and clinical compliance. We work with providers to offer education, and, if necessary, corrective action plans with escalation pursuant to contractual provisions.

- **Self-Audit Checklists.** In addition to auditing and oversight of delegated functions and performance monitoring (and in addition to any OHA requirements), individual behavioral health providers must complete self-audit checklists to ensure non-delegated services and performance standards are being met. Self-audit checklists are administered at least once every three years. Upon identification of deficiencies or areas for improvement, PSCS works with providers to provide technical assistance and if necessary, corrective action plans with escalation pursuant to contractual provisions. PSCS may require more frequent self-audits based on the outcome of regular monitoring activities.

- **Adverse Events and Critical Incidence.** To ensure that serious events are addressed in a timely manner and to prevent future adverse events from occurring, PSCS requires all providers to notify the CCO upon learning of these events. Any events identified through other sources, including employees executing medical/hospital service reviews or through member/advocate complaints, are triaged immediately upon receipt. These critical incidents are reviewed by our Clinical Quality Improvement staff and the Medical Directors to identify quality improvement opportunities and determine if any corrective actions are required.

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Attachment 7, Section 7.d: Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

PSCS proactively shares reporting and performance information with our provider partners and subcontractors on a fixed interval, utilizing a variety of modes and collaborative efforts. These include, but are not limited to:

- **Monthly Performance Report Distribution.** Performance dashboards and member level gap in care reports are made available to clinics on a monthly basis. Reports are distributed to clinics directly and are also available for clinics to run and download as needed via the secure provider portal. Member level gaps in care reporting can be generated at both the clinic and the individual provider level.

- **Regular Meetings with Provider Groups.** The PSCS Quality team, including practice facilitators, meets with providers on a regular interval to review clinic level performance and assist with mitigation planning for potential barriers to gaps in care closure. Some mitigation
efforts include coordinated outreach to help augment clinic resource constraints and assistance with co-branded mailings to help encourage gaps in care closure.

- **Community Governance Structure.** PSCS leverages the Health Council as a prominent avenue for providing oversight, community and provider engagement, and transparency in CCO quality improvement and transformation initiatives.

- **Joint Executive Governance and Oversight.** In partnership with providers, PSCS employs joint executive level governance structures to monitor quality and contractual performance, oversee quality improvement strategies, and endorse mitigation and escalation plans.

**Attachment 7, Section 8.a: Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.**

PSCS maintains an organization-wide corporate compliance structure for all lines of business, including Medicare and Medicaid. The Corporate Compliance Officer leads the Corporate Compliance Department (Department). The Corporate Compliance Officer is responsible for reporting compliance activities to the CEO, the Board of Directors, and the Corporate Compliance Committee. We engage in a variety of cross-departmental activities designed to prevent and detect Fraud, Waste, and Abuse (FWA) across all lines of business.

PSCS ensures all employees, participating providers, and subcontractors participate in FWA training. This training addresses FWA, Code of Conduct, and Compliance Program Policies. The Compliance Department maintains and documents information for reporting known or suspected FWA. We monitor operational departments and subcontractors to confirm that exclusion checks are performed monthly. We review NBI MEDIC Outlier Prescriber, Quarterly Pharmacy Risk Assessment, and Truven/Watson Health Payment Integrity Reports regularly for member exposure and escalation to the Department for investigation. If we determine a provider is billing incorrectly and education is warranted, we send this information to our Provider Service Representatives. These representatives share content on our provider-facing web page, add education topics to provider workshops, send provider education emails, and discuss issues with providers individually. We also employ a Special Functions team comprised of nurses who play an integral role in identifying and preventing FWA. They conduct pre/post payment line item bill auditing, clinical review of identified quality events or never events, clinical review of appeals, and ad hoc clinical review. We escalate findings for further action, as necessary.

Through the activities summarized above, the Department tracks and participates in investigations of FWA, potential issues of non-compliance, and/or allegations of improper or illegal activities. The Department conducts the responsibilities generally conducted by a Special Investigations Unit in collaboration with various operational areas, including referring cases to the appropriate state or federal entity as needed, such as the Oregon MFCU and the OHA Program Integrity Audit Unit. When we receive a report of potential non-compliance or FWA, the Department begins an investigation into the matter. These reports can come to us in various ways, including self-reporting, audit or monitoring findings from a member or provider, or through our anonymous reporting system, EthicsPoint. Once an investigation is completed, the Department determines whether the issue was one of FWA or non-compliance. If we confirm FWA or non-compliance, then we execute on a corrective action plan. The Department oversees and tracks the corrective action plan from planning stages to completion and monitors adherence to the plan.
Attachment 7, Section 8.b: Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste, and Abuse activities.

PSCS intends to continue to monitor and audit its provider network, subcontractors, and delegated entities for potential FWA activities through dedicated internal staff, robust reporting and analytics, and dedicated oversight teams. In addition to monitoring and auditing for potential FWA activities, PSCS uses these same mechanisms to detect and prevent potential issues of non-compliance with contractual responsibilities. Each contract clearly describes the scope of work, including any delegated functions. Contracts also set forth performance standards and FWA requirements. PSCS conducts ongoing monitoring and annual audits of delegated functions and will report on such activities to the OHA using the required forms and schedules in the 2020 CCO contract. PSCS intends to continue its existing, robust compliance practices and will continue to execute an annual Compliance Plan that meets the requirements set forth in 42 CFR 438.608. In particular, using dedicated internal staff and in no case delegating or subcontracting compliance functions, PSCS will continue to execute on policies and procedures to address the requirements of Exhibit B, Part 9, subsections (a)-(n) of the 2020 CCO contract. These policies and procedures will drive robust reporting to the OHA, including quarterly and annual reports of oversight, monitoring, and auditing functions and subsequent outcomes.

In addition to the oversight and monitoring activities discussed above, PSCS will continue to employ dedicated staff to engage in routine internal monitoring and auditing of compliance risks and prompt resolution of compliance issues. The Department will follow up on investigations and review self-evaluations and annual audits. Consistent with current practice, the Department will produce annual work plans to promptly resolve issues and prevent reoccurrences. PSCS will use a variety of mechanisms (both internal and external) to monitor and audit via an annual schedule and work plan, including claims monitoring, report monitoring, and annual audits. In particular, we will monitor claims edits within our processing database, which evaluates claims on a pre-payment basis to prevent improper payments. We also monitor claims through our payment integrity vendor, which reviews claims for improper payments using specific algorithms. Dedicated staff will continue to review these reports.

Attachment 7, Section 9.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.

We have a vast array of policies, processes, practices, and procedures in place that serve to improve member outcomes, including evidence-based and innovative strategies. PSCS engages in a comprehensive annual strategic planning process that includes all lines of business and includes strategic objectives, major initiatives, critical initiatives, and strategic evaluations. We have prioritized two major initiatives designed to develop and implement enterprise-wide strategies to impact SDOH-HE and significantly improve member experience. Our Transformation and Quality Strategy (TQS) and Performance Improvement Projects (PIP) help drive our progress towards Health System Transformation and allow us to test strategies and activities related to member engagement.
PSCS supports this work through our internal Quality Department, which leads the development and implementation of annual TQS work plans and long-term PIPs. We support this work across the organization through a series of committees. We work in partnership with the Health Council to ensure collaborative community influence in all aspects of quality improvement strategies and activities. We bring discipline to this work through project and committee charters to outline processes, procedures, practices, and responsibilities that guide the planning and development of the TQS. Each TQS project is informed by research on evidence-based practices, emerging best practices, innovative strategies, and member input and feedback. One example of the way we use evidence-based practices, along with input and feedback from OHP members to inform a TQS Project is the Bridges to Health (B2H) Program that we helped launched in the Columbia Gorge. This project uses the evidence-based Pathways Model to address SDOH-HE. The B2H program defines its target population as housing-challenged members because consumer CAC representatives have identified housing as a major priority through the CHP process. We plan to capitalize on this solid foundation and make improvements in 2020-2024 to advance our shared commitment to Health System Transformation.

Attachment 7, Section 9.b: Please describe your experience and plan to emphasize and implement wellness and health improvement activities and practices within your organization for Members and staff, including partners and contracts in place to strengthen this aspect of health care.

PSCS supports a wide array of wellness and health improvement activities and practices for both members and staff. For our members, we have established contracts with fitness centers to allow members to utilize Flexible Services to meet their physical fitness goals. For staff, we deploy a robust suite of wellness activities and update our work annually to meet emerging needs. For example, we contract with Active & Fit to give our staff access to a variety of fitness centers for just $25 per month. We also work in partnership with the Health Council to support local stakeholders to direct funding to support healthy lifestyle activities that are best suited to the local population. For example, in the Columbia Gorge, we used CCO shared savings to support LatinXplorers, a program that uses THWs to lead group hikes that reduce stress and build social capital for underserved populations. In Central Oregon, we used CCO shared savings to support and implement The Friendship Line, an accredited crisis hotline targeting older adults and adults with disabilities. CCO shared savings have also been used to support Veggie Rx and farmers markets. We plan to expand on this work during CCO 2.0.

Attachment 7, Section 9.c: Outline your experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data that will be required for meeting regular performance benchmarks to evaluate the value of Health Services delivered by your CCO. Describe how CCO accountability metrics serve to ensure quality care is provided and serve as an incentive to improve care and the delivery of services

PSCS has significant experience in managing data and using it for performance improvement and achieving strong financial and quality outcomes. We will continue to use data from a range of sources, from claims data to conversations with members, to assess performance against targets and ensure that health services are delivering added value.

- **Experience and Capacity.** We maintain an internal Analytics team with significant training and experience to serve internal departments and the community governance model. In addition, we employ actuaries with expertise in publicly funded health programs, five
Medical Directors who are licensed physicians, and internal IT staff expertise in the software platforms used for their work. We do not outsource this work and use vendors only for a very limited scope where contracting for the service is cost-effective and the best way to achieve overall goals. We have the capacity to obtain and report on data sourced from claims, chart reviews, provider submissions, health information exchange platforms, and the Emergency Department Information Exchange. We use a robust internal quality structure with multiple quality committees, as well as provider work streams and a Finance Committee through the community governance model, in order to interpret the meaning of data and plan action. PSCS has made and continues to make significant investments in data infrastructure to be able to receive clinical data feeds directly from provider partners or Health Information Exchanges to assess performance on quality metrics, contract accountability metrics, utilization, and other key indicators. We maintain a central repository of all gaps in care data across multiple lines of business. We consolidate this information into Member Insight and gap reports, as well as the Member 360 profile in our case management platform. We execute on provider partnership procedures to distribute this information and work collaboratively with providers.

- **Accountability Metrics.** PSCS maintains Tableau workbooks with real-time reporting on Quality Incentive Metrics at the CCO level, clinic level, and member level. This resource supports quality and performance improvement by enabling performance tracking and also action for improvement as needed. These accountability metrics are tied to financial incentives or requirements in provider contracts to improve alignment across the payer-provider continuum. We produce reports that we share with the community on a regular schedule, including a CCO dashboard that summarizes our performance across a number of domains including financials, quality, utilization, and other indicators of CCO performance. We are aware that this level of transparency and accountability is unique, but we believe it is an essential foundation for a successful CCO in order to align efforts to promote Health System Transformation.

Attachment 7, Section 9.d: Describe your policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorization.

PSCS adheres to the process described in OAR 410-141-3170 to ensure continuity of care. Because of our experience as a CCO, we have a robust set of policies and procedures in place to ensure continuity of care and a well-established system for documenting our referrals and Prior Authorizations. We plan to expand on those procedures and refine them as needed to meet 2020 CCO contract and performance requirements. In providing care coordination and transition of care services to members, our integrated CM Team is proactive to ensure our members receive comprehensive and seamless services. Our care managers perform all job duties in compliance with HIPAA and organizational policies and procedures, working within their scope of practice as Registered Nurses and Licensed Behavioral Health Clinicians with Masters’ Degrees.

Members who have special health care needs, require extensive use of resources, or have limited or no primary care engagement are prioritized for care management services. PSCS identifies members for outreach through Health Information Technology, reports, prior authorization requests, claims, medical records, and health risk screenings. In addition, members can request services directly from PSCS as described in the member handbook, and providers and
community partners may request services from PSCS on behalf of their patients. CM activities are logged in the PSCS health management technology platform, Dynamo, to track outreach attempts, service requests, and care management activities. All referral and prior authorization requests for physical and behavioral health services are also logged and tracked in the Dynamo system, providing integrated information that facilitates communication and effective services across CM and UM activities. The Dynamo system provides reporting on aggregate data about referral or prior authorization requests, informing internal process improvement and monitoring for systemic issues in the provider network. For example, this reporting is used on a daily and monthly basis for monitoring turnaround times, request volumes, and performance trends.

With respect to referrals and prior authorizations for dental services, PSCS delegates referral and prior authorization management to DCOs. In turn, PSCS requires scheduled reporting on these activities and conducts annual auditing. PSCS establishes policies and procedures for referrals and prior authorizations and conducts oversight on policies and procedures of DCOs. These activities, in addition to ongoing quality oversight and other types of monitoring, ensure that DCOs are complying with contractual requirements. With the exception of ambulance services, Non-Emergency Medical Transportation services do not require preauthorization. Transportation brokerages determine eligibility and appropriate mode through an intake assessment, and PSCS has developed policies and procedures to govern this process. In addition, we conduct annual audits of brokerage activities as well as ongoing oversight of member experience, operations, and other aspects of the services provided.

Attachment 7, Section 10.a: Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?
No.

Attachment 7, Section 10.b: Is Applicant currently Affiliated with a Medicare Advantage plan? If no, how will Applicant ensure they are contracted or Affiliated with a Medicare Advantage plan prior to the Effective Date of the Contract?
Yes. PacificSource Community Health Plans (PCHP) (an Affiliate of PacificSource Community Solutions) currently offers the following qualifying Medicare Advantage (MA) plans in Oregon and will continue to offer MA HMO plans (plan number H3864): PacificSource Medicare Essentials Rx 6, Rx 26, Rx 27, and Rx 36 (HMO) and PacificSource Medicare MyCare Rx 39 and 40 (HMO). PCHP has also filed for a service area expansion to serve northern Klamath County. CMS has issued preliminary approval for this expansion. PSCS also intends to affiliate with other MA plans as needed to promote continuity of care, and to meet the requirements in the 2020 CCO contract. We intend to affiliate with Kaiser Permanente Senior Advantage (HMO) (plan number H9003), which is available to residents of Marion and Polk counties.

Attachment 7, Section 11.a: List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant’s Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.
Attachment 7, Section 11.b: Does Applicant propose a Service Area to cover less than a full County in any County? If so, please describe how: (1) Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:

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

We are proposing to serve Central Oregon as a cohesive region, which includes the communities of northern Klamath County. This proposal is consistent with our existing regional approach to community engagement, governance, and accountability. The Klamath County Commissioners support our application and desire to retain the current CCO service area boundaries in CCO 2.0 because residents in northern Klamath County benefit from receiving care in our service area due to geographic proximity and because of our commitment to provide the same quality of care to members in rural and frontier areas as those in urban areas.

- **Community engagement, governance, and accountability.** In partnership with the Health Council, the community governance structure provides for enhanced community engagement opportunities. Representatives from southern Deschutes County (i.e.: La Pine), which borders northern Klamath County, serve on the Health Council, CAP, CAC, and CHP workgroups. The Health Council and the CAC meet at least annually in southern Deschutes County to engage with the community in public meetings. We have a strong relationship with the regional Federally Qualified Health Center (FQHC), La Pine Community Health Center. We contract with this FQHC system to serve southern Deschutes County and northern Klamath County. These clinic sites are within 1-20 miles of all Klamath County zip codes we currently serve and propose to continue to serve in this Application. The FQHC runs a school based health center in one of the Klamath County zip codes we serve, which is the only site of care for residents in the town of Gilchrist, and the FQHC is very active in Health Council subcommittees as well as in the development of the CHA and CHP. Klamath County residents that live south of Crescent participate in governance and community engagement to the south with Cascade Health Alliance due to the natural geographical divide.

- **Behavioral Health integration and access.** The FQHC discussed above offers integrated behavioral health services and employs Behavioral Health Consultants in their clinics. Members have shared positive feedback about their services on member satisfaction surveys regarding access to all services, including behavioral health. The clinics also provide walk-in services after regular business hours. Additionally, the FQHC offers the only health care services available in zip code 97737. In our 2016 Access Study, the FQHC’s consumer quantitative results were also positive: their assigned members rated access more favorably than members across the region as a whole. In addition, Deschutes County Health Services operates a clinic in southern Deschutes County and provides public health, behavioral health, and safety net services to members in northern Klamath County. Residents in northern...
Klamath County benefit from receiving care in our Service Area due to geographic proximity and ease of access. Similarly, residents south of the Klamath County zip codes we are proposing to serve benefit from receiving care and ease of access in the southern part of the County due to their geographic proximity. CCO members that reside in northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship, particularly during inclement weather.

- **Social Determinants of Health and Health Equity.** Both the FQHC discussed above and Deschutes County Health Services serve individuals seeking care in northern Klamath County, regardless of insurance status or any other factor, to ensure equitable access. Both organizations participate actively in Health Council committees as well as in the development and implementation of the regional CHA and CHP. Both organizations screen for SDOH-HE factors, such as transportation, within their patient population and connect members to such services. CCO members in northern Klamath County have interacted far more, if not exclusively, with providers and community-based organizations in the PSCS CCO versus Cascade Health Alliance. The model currently in place addresses SDOH-HE factors that are unique to northern Klamath County residents who, based on geography, naturally identify more with Deschutes County than southern Klamath County.

- **Value-Based Payments and cost containment.** PSCS contracts with the providers serving the zip codes in northern Klamath County that we propose to serve. Both the FQHC discussed above and Deschutes County Health Services have been parties to value-based payment arrangements with the PSCS CCO for over five years. We have also provided funding to the FQHC to increase PCPCH tiers and to integrate behavioral health services in their clinics. These agreements have proven effective for both parties in expanding access, containing cost, and improving quality. In addition, some providers have satellite offices located in the zip codes in northern Klamath County, but their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in the rest of Klamath County are based in Klamath Falls. Residents of northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship particularly during inclement weather. As discussed above, members residing in these four zip codes in northern Klamath are already being served by providers in southern Deschutes County and Bend. We will continue to explore the possibility of expanding value-based payments and further cost containment measures with these other providers.

- **Financial viability.** Our request to retain the existing boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or risk. Instead, it is driven by our ability to best serve the community. We have existing contractual arrangements to serve members in northern Klamath County and do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of rate setting. We have made investments to expand access to residents of southern Deschutes County and northern Klamath County based on emergency department utilization and the request of the FQHC, which serves members on a walk-in basis if they can accommodate the level of care. Any residents of southern Deschutes County or northern Klamath County who need a higher level of care than can be provided in a primary care setting are referred by their provider to Bend and not to Klamath Falls.

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county; and
Northern Klamath County residents in zip codes 97731, 97733, 97737, and 97739 tend to seek care in Deschutes County because it is significantly closer, geographically, than available services in Klamath County. We have been serving this community for over five years. This partial county service area will promote ease of access and expanded access for members, improve continuity of care for our members, increase meaningful provider interaction, and reinforce current patterns of travel that align with utilization of health care services, employment, and social services. As discussed above, PSCS already contracts with the providers that serve the four zip codes listed above. Some providers have satellite offices located in the zip codes in northern Klamath County but maintain their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in Klamath County are based in Klamath Falls. CCO members residing in northern Klamath County are already being served by providers in southern Deschutes County and Bend. With respect to referral patterns associated with provider affiliations, providers in southern Klamath County refer to the Sky Lakes Medical Center in Klamath Falls. In contrast, providers in northern Klamath County refer to providers available in La Pine and Bend. There are no services available in Klamath Falls that are not available in Bend. Because Bend is a larger community than Klamath Falls, more services are available in the Central Oregon region than the southern Klamath Falls region.

Members in northern Klamath County have interacted far more, if not exclusively, with providers and communities in the Central Oregon CCO than with the Klamath County CCO. The model currently in place has been effective in addressing and providing appropriate access with more meaningful provider interaction opportunities and less travel restrictions than heading south to southern Klamath County. Community members in northern Klamath County naturally, based on geography, identify and more easily connect to services in Deschutes County than southern Klamath County. Based on this same rationale, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.

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

Our request to retain the existing CCO boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or designed to minimize risk. Instead, our request is driven by our ability to best serve a community that more naturally fits within the Central Oregon service region. We have existing contractual arrangements to serve members in northern Klamath County and do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of provider rate setting and our proposal to the OHA does not create adverse selection. As discussed above, consistent with this assertion, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.

Please see the attached Service Area Table in Excel.

Attachment 7, Section 12.a: Standard #1 – Provision of Coordinated Care Services: The Applicant has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable.
Attachment 7, Section 12.b: Standard #2 – Providers for Members with Special Health Care Needs.
Attachment 7, Section 12.c: Standard #3 – Publicly funded public health and Community mental health services. Please see attached Publicly Funded Health Care and Service Programs Table.

Attachment 7, Section 12.c(1): Standard #3 – Publicly funded public health and Community mental health services. (1) Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application. During 2018, prior to the CCO 2.0 procurement process, PSCS facilitated education about the CCO 2.0 for regional stakeholders, including informational presentations to the Health Council, the Provider Engagement Panel, and the CAC. The Health Council approved a letter of support for this Application in January 2019. Since January 2019, PSCS has convened a series of informational with relevant stakeholders. We have engaged with staff from Aging and People with Disabilities, LMHAs, LPHAs, CMHPs, and public health departments. In addition, these publicly funded organizations participate in community governance. Please see below for particular meetings:

- April 2019: Presentation and consultation with the Health Council on application content and plans related to CHA/CHP, CAC operations, value-based payments, and spending plans for the Quality Pool and SDOH-HE funds. The Health Council further approved submission of this Application and the proposed contents and commitments.
- March and April 2019: Provider meetings to plan Value Based Payment models.

Attachment 7, Section 12.c(2): Standard #3 – Publicly funded public health and Community mental health services. (2) Describe the agreements with counties in the Service Area that achieve the objectives in ORD 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.
PSCS conducted internal development work to create documents that aligned with the requirements of ORS 414.153(4) and well as the other requirements related to LMHAs and LPHAs in the CCO 2.0 contract and Request for Application. We shared MOUs with staff during the week of March 11. Each LMHA and LPHA has signed an MOU. We have executed provider agreements with each public health department and CMHP.

Attachment 7, Section 12.c(3): Standard #3 – Publicly funded public health and Community mental health services. (3) If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible.
Not applicable. Please see above.

Attachment 7, Section 12.d(1): Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.
As discussed in our response to Attachment 10, PSCS is committed to providing culturally relevant Coordinated Care Services for the AI/AN population. Along with tribal-specific initiatives, grant funds, and focused workgroups, PSCS ensures that all services and communications are provided in a culturally relevant manner and are accessible to all members. In order to improve our ability to serve our culturally and linguistically diverse membership, including those of the AI/AN population, PSCS undertakes the following efforts and initiatives:
• Work to improve the completeness and accuracy of the information on members’ race, culture, ethnicity, language spoken, and geographic location, in order to understand and respond to the diversity in our membership.
• Analyze CAHPS data and other data as appropriate, to identify gaps in access and quality of care based on culture, race, ethnicity, language spoken, age and other characteristics.
• Monitor cultural and language assessments from federal, state, census and other data sources.
• Assess the language spoken by our network practitioners, provider staff, and internal customer-facing staff, and the adequacy of the telephonic interpreter services available, to identify and address any gaps related to the language needs of our membership.
• Assess the geographic adequacy of our practitioner network for groups who speak languages other than English.
• Adjust the practitioner network access to the types and numbers of practitioners necessary to meet the cultural, ethnic, racial, and linguistic needs of our members within their defined geographical areas.
• Ensure diverse member representation to reflect the diversity of our membership’s culture and language in all advisory committees when possible and ad hoc work groups to help ensure that all members’ needs are being considered.
• Develop member materials that are targeted to the expected reading level and the languages preferred by our members.
• Supply customized member materials in non-English languages when requested.
• Foster organization-wide commitment to diversity of staff and management.
• Provide webinar and in-person trainings and education on culturally and linguistically appropriate standards to provider offices.

Attachment 7, Section 12.e(1): From among the Providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638
facilities.
PSCS has worked diligently and over the course of many years to offer participating facility contract proposals to both Indian Health Service facilities in Oregon: Warm Springs Health & Wellness Center and Chemawa Health Center. We followed up in person and over the phone. Next, PSCS enlisted the assistance of the OHA as outlined in the Oregon Health Plan 1115 Waiver Tribal Protocol instructions. We are hopeful that the OHA will provide assistance and facilitation, but we assume this work is on hold within the OHA due to procurement work. At the time of this submission, work is still pending. As a result, PSCS has not listed IHS or Tribal 638 facilities in the DSN Provider Report, although we treat both facilities as participating providers.

Attachment 7, Section 12.e(2): Please describe your experience working with Indian Health Services and Tribal 638 facilities.

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

We have significant experience working with IHS and Tribal 638 facilities. For example, we work with the Warm Springs Health & Wellness Center and accept and pay claims at a participating provider level on a fee-for-service basis despite not having an executed participating provider agreement. Provider Network Service Representatives also continue to develop relationships with the facility to educate the facility on billing, claims payment, authorizations, and other health plan functions and OHA requirements. In addition, we offer transportation for members to Tribal health facilities, and they are not restricted to the nearest (non-tribal) facility to meet the member’s medical needs.

PSCS works diligently in our local communities to ensure our policies and procedures address AI/AN population needs. One example of our efforts is through the Community Resource Huddle (originally formed by PSCS staff), which meets every other month to offer collaboration opportunities and guest speakers to increase awareness and resource availability. The group includes members of the AI/AN population. As a part of this work, we developed a Community Resource email chain to connect those in need with others who have access to resources. A few recent examples of the assistance provided as a result of this facilitated correspondence include supplying a washer and dryer to a tribal member and distributing snowshoes to members on the Confederated Tribes of Warm Springs Reservation that were snowed in. We also attend and provide support to the monthly Native Aspiration meetings in Warm Springs, where the community discusses events, opportunities for volunteer work, connections with the local tribal partners, and Medicaid-specific issues. PSCS employees regularly volunteer at events held on the Confederated Tribes of Warm Springs Reservation. Current work on the Community Health Assessment includes representatives from the Tribes, which will help inform the Community Health Improvement Plan. Lastly, we are forming an internal Tribal Steering Committee, with a charter in progress. This will ensure full compliance with CCO 2.0 2020 requirements. Tribal liaisons have indicated their full support.

PSCS does not require a referral to or from a Tribal Health provider, regardless of PCP or participation status. If the IHS or Tribal 638 facility is not a participating panel provider, a referral request may be submitted to an in-network specialist but is not required for the services
to be considered as participating. All IHS and Tribal 638 facilities are treated as a participating panel provider, regardless of our contractual relationship. If the service or item is subject to Prior Approval, PSCS will work with the IHS or Tribal 638 facility to ensure necessary authorization prior to providing services, regardless of the facility’s participation status. PSCS does not restrict receipt of non-participating referrals from IHS or Tribal 638 facilities.

Attachment 7, Section 12.f(1): Describe Applicant’s experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs. The Pharmacy Department has over 10 years of experience administering Medicaid pharmacy benefits. The Pharmacy Department manages preauthorization requests, clinical review, formulary management, and the Prioritized List requirements for formulary and pharmacy network composition. We partner with our pharmacy benefit manager (the PBM) to administer point of sale pharmacy claims and reporting requirements. We have an integrated system for embedding the Prioritized List in the PBM processing system. We work closely with the PBM and our internal teams to stay current and monitor the line for funded services. We regularly monitor guidelines and Health Evidence Review Commission (HERC) updates through our independent Pharmacy and Therapeutics Committee (P&T Committee).

Attachment 7, Section 12.f(2): Specifically describe the Applicant’s:
- Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as Prior Authorization.
- Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of Pharmaceutical Services, e.g. pharmacies.
- Development of clinically appropriate utilization controls.
- Ability to revise a formulary periodically and a description of the evidence-based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated) and whether this work will be subcontracted or performed internally.

PSCS maintains a comprehensive closed (also known as “managed”) formulary including generic, brand name, and specialty drugs. Some drugs on the formulary have utilization management restrictions requiring provider supporting documentation prior to coverage. We review these restrictions, including prior authorizations, step therapy, quantity limits, and specialty pharmacy access, against OHA requirements to maintain appropriate drug access. For drugs not listed on the formulary that require a Prior Authorization, we encourage providers and members to submit documentation that the drug is treating a covered condition, medical necessity to avoid other formulary alternatives, and other information to support an exception. PSCS regularly audits clinical decision making. This ensures that our decision makers are reviewing appropriate criteria, creating accurate letters, and are consistent with policies. Each reviewer receives feedback on the review, including what they are doing well and what can be improved. These reviews are tracked monthly for overall department performance.

A dedicated team of clinical pharmacists and certified pharmacy technicians within PSCS actively tracks all new to market drugs for unique class or therapeutic advantage. New to market drug reviews are prioritized based on market launch, category, and anticipated member needs.
All reviews are completed no later than 180-days post-market launch. PSCS reviews the entire prescription formulary on an annual basis. This review ensures adequate representation of at least one product from each unique class including coverage of over-the-counter products. This review ensures drugs are classified correctly, have correct restrictions, and coverage is based on the most up to date guidelines. The P&T Committee, comprised of local practicing physicians and pharmacists, also conducts reviews. After the P&T Committee evaluates each product for appropriate access, the Pharmacy Department promptly updates the drug formularies to include all positive changes, including additional drug access. PSCS maintains a closed formulary based on recommendations from our P&T Committee. The P&T Committee takes into consideration Oregon P&T committee and HERC recommendations. Drugs that have been identified with potential for inappropriate use have targeted restrictions. These restrictions include prior authorization, step therapy, quantity limits, and specialty pharmacy access. These restrictions are reviewed against OHA requirements to maintain appropriate access consistent with regulations.

Attachment 7, Section 12.f(3): Describe Applicant’s ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make nonformulary, i.e. Prior Authorization, requests.

PSCS contracts with the OHA pharmacy network via our PBM. By contracting with the OHA pharmacy network, members have consistent access to pharmacies across the state. Members also have access to the PBM mail order service that offers free shipping to the member. Members get personalized service with the ability to speak privately to a pharmacist. Refills can be ordered by phone, mail, or through the 24 hour online service. For specialty medications including high-cost injectable medications and biotech drugs, PSCS contracts directly with the PBM Specialty Pharmacy to provide access at competitive rates and to minimize waste for these expensive medications. We post formulary documents, utilization management criteria, and any upcoming changes on our website and make them publicly available. We also post instructions on how to request preauthorization and formulary exceptions on our website. Providers and members may access the list of covered drug on the member-friendly drug search tool, along with a search tool to locate a nearby contracted pharmacy. We also post all upcoming change notices and updates on our provider home page. Providers may submit authorization requests, upload documentation, and check status via the InTouch Provider Portal 24 hours/7 days a week.

Attachment 7, Section 12.f(4): Describe Applicant’s capacity to process pharmacy claims using a real-time Claims Adjudication and Provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.
Attachment 7, Section 12.f(5): Describe Applicant’s capacity to process pharmacy Prior Authorizations (PA) within the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit.

Attachment 7, Section 12.f(6): Describe Applicant’s contractual arrangements with a PBM, including:

- The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.
- The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).
- The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.
Attachment 7, Section 12.f(7): Describe Applicant’s ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

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

Attachment 7, Section 12.f(8): Describe Applicant’s ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home.

Attachment 7, Section 12.f(9): Describe Applicant’s ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).
Attachment 7, Section 12.f(10): Describe Applicant’s capacity to publish formulary and Prior Authorization criteria on a public website in a format useable by Providers and Members. PSCS plan documents are available to members requesting communication in alternate formats. Our public website has searchable drug features to search by drug name and drug therapy class. We also make a text readable and searchable versions of the drug list available for easy provider and member accessibility. The prior authorization and step therapy criteria are also published on our website for all users to access. The drug list and posted criteria are available at https://communitysolutions.pacificsource.com/Search/Drug. Members can also call our Customer Service and Pharmacy Helpdesk teams if they have any questions.

Attachment 7, Section 12.g(1): Describe how the Applicant will assure access for Members to Inpatient and outpatient Hospital services addressing timeliness, amount, duration and scope equal to other people within the same Service Area.

PSCS analyzes our provider network to ensure adequate member access to covered health care service providers, including but not limited to inpatient and outpatient hospital facilities. PSCS utilizes Exhibit G of the CCO contract along with OAR 410-141-3220 to define time or distance standards for network adequacy. PSCS evaluates and monitors our inpatient and outpatient hospital services network on a regular basis, verifying that at a minimum, 90 percent of our members travel does not exceed routine travel times and distances. If there are deficiencies identified within the review, all necessary efforts are made to address and eliminate the deficiency. Should a deficiency exist, PSCS may refer members to an out-of-area facility, however, PSCS has consistently met or exceeded these access requirements. PSCS does not discriminate against any hospital or facility acting within the scope of its license or certification.

PSCS includes provisions in all participating hospital contracts requiring that the facility will not discriminate in its provision of services because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or any reason or purpose prohibited by applicable federal or state law. In addition, the facility must agree to make services available to Medicaid members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-Medicaid patients.

We develop and communicate preauthorization and referral requirements to providers. PSCS adheres to regulatory timelines and notice requirements established by OHA for completion of pre-authorization/pre-approval requests. In all cases, a request to provide, authorize, or discontinue a service to a member is made as expeditiously as possible to ensure timely access.

- Indicate what services, if any, cannot be provided locally and what arrangements have been made to accommodate Members who require those services.

The hospital system in Central Oregon does not offer the following services, but they are contracted and available in the tri-County metro region: pediatric intensive care, pediatric inpatient psychiatry, neonatal intensive care greater than level III, pediatric immunology, services requiring a burn unit, and transplants.
PSCS case managers work closely with our members and providers to ensure that members can access care at one of the following hospitals:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Health Sciences University</td>
<td>Transplants, intensive care, neonatal intensive care, wound care, burns</td>
</tr>
<tr>
<td>Legacy Health System</td>
<td>Intensive care, neonatal intensive care, wound care, inpatient psychiatry (Unity)</td>
</tr>
<tr>
<td>Providence Health System</td>
<td>Inpatient psychiatry, intensive care, wound care, neonatal intensive care</td>
</tr>
<tr>
<td>Seattle Children’s Hospital</td>
<td>Pediatric immunology</td>
</tr>
<tr>
<td>Lucile Packard Children’s Hospital- Stanford</td>
<td>Transplants</td>
</tr>
</tbody>
</table>

Based on available services described above and a member’s acuity, PSCS uses our extensive provider and facility relationships throughout our service areas to ensure that quality and timely access is guaranteed for all members. To further support access to these services, we will provide and arrange for transportation needs of members. This includes transportation using the most appropriate mode, mileage reimbursement, and meals and lodging reimbursement.

- Describe any contractual arrangements with out-of-state hospitals.
  PSCS contracts with Lucile Packard Children’s Hospital- Stanford as negotiated by the OHA for transplant care. In addition, we contract with Legacy Salmon Creek Medical Center in Washington, which offers services such as joint care, obstetrics, imaging, emergency, and cancer treatment. PSCS also enters into one-time contractual agreements with out of state hospitals as necessary to ensure timely and quality access for members.

- Describe Applicant’s system for monitoring equal access of Members to Referral Inpatient and outpatient Hospital services.
  Our methods for monitoring members’ equal access to such services include monitoring through internally built reporting and third party tools that track age-specific utilization rates for populations of interest based on member demographics, geography, risk factors, diseases, race/ethnicity, language, and disability, etc. PSCS monitors facility and provider capacity and network adequacy, monthly. In addition, PSCS monitors member grievances, to identify any indication that access to care for our members may not be equal to other populations. PSCS has an access to care team to identify opportunities and propose targeted improvement initiatives.

Attachment 7, Section 12.g(2): Describe how the Applicant will educate Members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics, and less intensive interventions other than their Primary Care home.

PSCS works in partnership with provider partners as our primary way to support effective patterns in accessing and using health care services. This includes training and supporting PCPCH providers to use HIT platforms such as PreManage/EDIE to provide timely information about emergency department use patterns. PSCS has a 2019 TQS project to provide technical assistance to PCPCH and Community Mental Health (CMHP) providers to develop workflows utilizing data from PreManage/EDIE to streamline targeted outreach strategies to educate
members about how to appropriately access care from ambulances, emergency rooms and urgent care/walk-in clinics and other less intensive interventions.

We will also continue to use a variety of member-facing communication strategies to educate members about how to appropriately access care. We regularly seek input and guidance from the CAC to understand the factors driving high ED utilization and design strategies to educate members on how to access less intensive services. We have received positive feedback on our mobile application, which provides convenient access to member ID cards, a provider directory, and the 24-hour nurse line—the information that they need to be able to make informed decisions when and where members need to seek care. In addition, we plan to continue using the following strategies to support member engagement in accessing high value care: member handbooks, member newsletters, resources on our member website, our integrated Customer Service Department, new member welcome calls, 24-hour nurse advice line, community campaigns such as flyers (e.g. “Where to Get Your Care”) and community events (e.g. member education series), and training emergency department staff who interact with members.

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.

PSCS takes an active role in tracking inappropriate use. We use a suite of analytics to track inappropriate use of ambulances, emergency rooms, and urgent care/walk-in clinics, including:

- Utilization monitoring through our Member Insight Provider Insight reporting tool, which includes ED and urgent care utilization monitoring, tracking of potentially avoidable ED utilization using both the NYU algorithm and Medi-Cal methods. The report provides information on member utilization along with demographics, risk factors, risk scores, comorbidity risk scoring, gaps in care, and disease information.
- Waste reporting using the Milliman Waste Calculator. The Milliman Waste Calculator is based on Choosing Wisely guidelines and assists with identifying opportunities for member and provider education on proper sites of care and increased efficiencies.
- At least quarterly, a Medicaid Cost of Care group meets and reviews several reports, including experience and utilization reports to identify any areas with potential utilization trends of concern or areas that may require additional follow-up analyses.

This suite of reporting allows for interactive, self-service data exploration as well as automated alerts and subscriptions. We summarize trends and work these reports in dyads with our provider partners. The reports include data for all our members including co-morbidities, ICC member flags, number of PCP visits, and emergency department visits. The CM Team also monitors monthly and annual metrics and claims data (unnecessary utilization and provider engagement) over time for reporting and to determine needs for targeted interventions and processes. Because one of the goals of care management is to promote and facilitate better member engagement with their PCPs and appropriate specialists, the claims data is helpful in identifying changes in the number of visits before and after intervention. We also monitor metrics linked to ICM meetings and members served by resource-intensive interventions. These ICM meetings involve members transitioning between levels of care or experiencing other complex care needs, such as services from multiple systems of care. The CM Team and community providers use the PreManage system in this process. This is a complementary product to EDIE that relays hospital events on a
real-time basis for specified members or patient populations. We use PreManage to develop cohorts and track patients who are rising risk or considered over/super utilizers.

Specifically, please discuss: Procedures for improving appropriate use of Ambulance, Emergency Rooms, and urgent care/walk-in clinics.

PSCS has taken effective steps to improve inappropriate utilization in these settings. In addition to the work set forth above, PSCS runs a series of workgroups with community stakeholders to build community models to address the needs of the SPMI population, which uses the emergency department at a higher rate compared to the general population. We also routinely monitor emergency department use for non-traumatic dental reasons. Rates continue to trend down. Our Analytics Department is in the process of developing dashboards and routine reports needed to track the effectiveness of a variety of workgroup interventions. We have also deployed the following interventions and tools and will continue to use similar procedures:

- Hire dedicated clinical staff to support providers in intervening
- Member education, including newsletters, new member outreach phone calls, care management outreach, and ICC interventions
- Predictive data modeling
- Active outreach to members to support PCP changes
- Care management and care coordination
- Community paramedicine programs in rural communities
- Implementation and use of diversion technologies
- Targeted community work groups
- Access to a 24-hour nurse line
- Letters of agreement signed with primary care clinics in rural locations to eliminate access barriers such as preauthorization and referral requirements for non-assigned members during extended hours. This has resulted in greater access within PCP clinics.

Attachment 7, Section 12.g(3): Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following: Adverse Events; and Hospital Acquired Conditions (HACs).

PSCS has experience with Medicare guidelines and has processes in place to monitor and adjudicate claims because our Affiliate, PacificSource Community Health Plans, offers Medicare Advantage (MA) plans. We have an experienced claims staff who have an average of approximately 12 years of claims experience. We have administered MA plans since 1999.

“Never Events/Serious Avoidable Events” are significant and costly health care errors that should never happen. HACs are treated the same as Never Events with respect to identification and disposition. To be classified as a never event, the error in medical care must be clearly identifiable, be usually preventable when evidence-based practices are followed, have serious consequences for the patient (e.g. resulting in death, loss of a body part, disability, or more than transient loss of a body function), and indicate real problems in the safety and credibility of a health care facility. In these events, the precipitating condition(s) are not present when the patient is admitted to a facility, but present during the course of the stay. Such events can be identified by members, providers, PSCS staff, or through claims submission. Our Special Function Nurses review events identified by members, providers, or health plan staff. After reviewing charts, they create case summaries and work in partnership with the Medicaid Medical Director for final determination. The Medicaid Medical Director will take the following action:
- Track for further occurrence
- Individual verbal/written counseling
- Request explanation from provider
- Provider submission of corrective action
- Refer to credentialing for appropriate action
- Refer SRAE/Never Event to NPDB and Claims for appropriate action

If the event is an Adverse Event, our Claims Department reduces or recoups payment. Claims procedures include the identification of specific diagnostic codes that may indicate an adverse occurrence and oversight of the Present on Admission (POA) codes submitted on claims. Our software is configured to evaluate the following: POA = N (Not present at time of inpatient admission), Diagnosis Code (as listed on the OHA HCAC), and ICD 10 Procedure Code System codes. If an above scenario is identified, the system will fire a warning stating “Never Event Review.” Our staff review the claim to determine that all requirements of an adverse event are met. If the claim is truly an adverse event, the system will apply a lower ranking DRG to reduce payment. Going forward, we intend to continue using this process and will refine it.

Attachment 7, Section 12.g(4): Describe the Applicant’s Hospital readmission policy, and how it will enforce and monitor this policy.

PSCS has adopted a policy titled “Readmission-Acute Hospitalization.” Hospital readmission, for any reason, is disruptive to patients and caregivers, costly to the health care system, and puts patients at additional risk of hospital-acquired infections and complications. Some readmissions are unavoidable and result from inevitable progression of disease or worsening of chronic conditions. However, readmissions may also result from poor quality of care or inadequate transition of care. For the purpose of this policy, readmissions to the same acute care hospital occurring less than 31 days from date of discharge for the same or similar condition or diagnoses will be reviewed. Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred. We will review acute hospital readmissions to determine 1) medical necessity, 2) if readmission was the result of premature discharge, 3) if readmission was the result of the lack of care coordination between acute care, skilled, the outpatient setting, or 4) if the care rendered on readmission could have been provided during the first initial hospitalization. A patient whose discharge and readmission to the hospital is within thirty days for the same or related diagnosis must be combined into a single billing. A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. One payment will be made for the combined service. We use prospective and concurrent review, claims review, case management, and Dynamo reporting to monitor and enforce this policy.

Attachment 7, Section 12.g(5): Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization.

We employ several strategies and are considering additional strategies to decrease unnecessary hospital utilization. While CCOs are built on a strong primary care system, we are aware that it can still be improved. Although we have incentivized primary care home access in a variety of ways over the last four years, we intend to expand our use of THWs in order to extend the capacity of the primary care home. We have supported THWs in a number of ways, including stationing them in a small emergency department to assist with care coordination. We also
participate in the Bridges to Health Pathways Hub in the Gorge, which could potentially be expanded to other regions to support care coordination and identification of non-clinical resources. We have also supported outreach to pregnant women with substance abuse using a Peer Support Specialist and through another program that embeds a certified recovery mentor in the emergency room. While we will satisfy the VBP road map requirements established by the OHA, we are also exploring adopting a specialty care services VBP. We would like to develop an orthopedic VBP, possibly patterned on the CMS bundled care initiative. An article just published in the New England Journal of Medicine evaluated this program and found a modest savings to the program, without any increase in complications or shift in percentage of high risk patients who participated. Based on our existing experience with hospital capitation, we have seen positive impacts on limiting unnecessary hospital utilization. We will consider expanding this model to other hospitals used for tertiary care. While more challenging with smaller hospitals, we have been successful in adding metrics to contracts that are payable based on limiting readmissions. We will continue to pursue this approach with additional facilities.

Attachment 7, Section 12.g(6): Please describe how you will coordinate with Medicare Providers and, as applicable, Medicare Advantage plans to reduce unnecessary ED visits or hospitalization for potentially preventable conditions and to reduce readmission rates for Fully Dual Eligible Members.

We have experience coordinating with Medicare providers and other Medicare Advantage (MA) plans, given our in-house experience offering MA plans. As discussed above, we deploy a variety of strategies to reduce unnecessary emergency department visits and hospitalizations. They apply equally to dual-eligible members. PSCS has several initiatives aimed at reducing unnecessary ED visits, hospitalizations and readmissions. We take the following coordination steps specific to dual-eligible members:

- Our care team calls every member 48 to 72 hours after discharge from the hospital. Our goal is to ensure the member received the appropriate medications, has a follow-up appointment with his or her PCP, and appointments with appropriate specialists. The case manager also goes over a sick-day plan with members. In the event a member cannot get into his or her PCP, the case manager finds the nearest urgent care clinic and secures transportation.
- Our team also coordinates with other providers and payers to determine who is performing post-discharge follow up. We work together in collaborative care team meetings.
- We use these meetings with providers and other payers to focus on high emergency department utilizers and those at high risk for readmission or preventable conditions.
- We deploy specific policies that encourage efficient use of health services, such as not requiring a three-day qualifying hospital stay prior to a SNF admission, and dedicate a pharmacist to performing medication reconciliation.
Attachment 8 – Value-Based Payment Questionnaire

Attachment 8, Section C.1: Submit two variations of the information in the supplemental baseline RFA VBP Data Template: a detailed estimate of the percent of VBP spending that uses the Applicant’s self-reported lowest Enrollment viability threshold, and a second set of detailed and historical data-driven estimate of VBP spending that uses the Applicant’s self-reported highest Enrollment threshold that their network can absorb.

Please see attached.

Attachment 8, Section C.2: Provide a detailed estimate of the percent of the Applicant’s PMPM LAN category 2A investments in PCPCHs and the plan to grow those investments.

PSCS estimates that approximately 1.5% of overall CCO payments will be in the form of capacity payments tied to PCPCH Tiers 1-5 with additional payments for integration of behavioral health, which substantially increases our overall investment. As set forth in Table 1, below, payment rates range from $0.50 PMPM to $15 PMPM. If most clinics meet criteria for the highest payment, spending would be approximately 3% of overall CCO payments. We predict that payments made by PSCS will increase year over year due to four trends: clinics moving to higher Tiers, clinics moving from base payment to program payment levels by incorporating high-value elements, clinics incorporating fidelity integrated behavioral health, and annual increases in base payment amounts. The vast majority, if not all, of these payments will not be categorized as 2A because they are part of a higher-category payment model, such as one including quality performance payments and/or payments tied to financial and quality performance. We will predominantly make PCPCH payments in connection with Category 3 or 4 VBP arrangements, but we understand that without this context, they would be 2A payments.

Attachment 8, Section C.2.a: Payment differential across the PCPCH tier levels and estimated annual increases to the payments

<table>
<thead>
<tr>
<th>Tier</th>
<th>Payment Rate (PMPM)</th>
<th>Estimated Annual Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$0.50</td>
<td>$1.00</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$1.00</td>
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<td>Tier 3</td>
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<tr>
<td>Tier 4</td>
<td>$10.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>Tier 5</td>
<td>$15.00</td>
<td>$30.00</td>
</tr>
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</table>

If most clinics meet criteria for the highest payment, spending would be approximately 3% of overall CCO payments.
Attachment 8, Section C.2.b: Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity)
PSCS established payments by benchmarking against the Oregon Health Plan Fee-for-Service PCPCH payments distributed in the CPC+ program. For clinics to earn maximum payments, they must attest to PCPCH standards and also incorporate fidelity behavioral health integration and the identified high-value elements of the PCPCH model: team-based care, planned management of chronic care, expanded care hours, quality improvement infrastructure, and performance monitoring. We identified these high-value PCPCH elements using local experience and the findings of the PCPCH Evaluation Team at Portland State University, as published in their September 2016 Implementation Report.

In setting PCPCH Tier payments, we do not adjust rates based on member attributes such as rural, urban, or social complexity. When we have more data available on these factors generated from sources like the pediatric health complexity data set, we will be able to assess the degree to which provider populations vary by region and what adjustments should be made for social need and complexity. Given our long-established process of broad and robust collaboration with providers in crafting payment models and contract terms, we are optimistic that we will be able to incorporate differential payment rates for PCPCH as we learn what important factors to incorporate in the model and gain access to reliable data about the attributes of individual members or communities. The base rate payments are for clinics that have attested to PCPCH standards, but do not demonstrate incorporation of these high-value elements.

Attachment 8, Section C.3: Describe in detail the Applicant’s plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well as populations at the intersections of these groups.
PSCS will adopt a variety of strategies to mitigate any adverse effects that VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population. Using existing forums and partnerships between the PSCS Medicaid Medical Director, Analytics Department, Actuarial Department, and provider partners, PSCS will develop and propose (or select in alignment with metrics menus distributed by the OHA) performance measures that support health equity. PSCS Analytics and Actuarial Department subject matter experts will also analyze each proposed performance measure and proposed VBP arrangement as a whole to identify the degree of risk of adverse effects associated with each measure. PSCS will discuss these risks with provider partners during the contract negotiation process. Ultimately, if subject matter experts determine that a particular measure poses an unacceptable risk of adverse effects, PSCS will develop and propose alternative measures as part of contract negotiations. If the subject matter experts identified above determine that the risk of adverse effects associated with proposed performance measures and VBP arrangements is minimal, PSCS subject matter experts in SDOH-HE, Culturally and Linguistically Appropriate Services standards, and complex health care needs will conduct a next-level review to assess the risk of adverse effects. If these experts support the use of proposed performance measures and VBP arrangements, contract negotiations may proceed. These experts may also recommend particular mitigation plans or monitoring plans for the parties to consider.
PSCS will monitor each VBP arrangement to evaluate health outcomes, utilization, cost, and grievance and appeals measures based on SDOH-HE and REAL+D data, by prioritized population, geography, and provider. We will use this reporting to monitor for adverse effects on an ongoing basis. We also believe that member satisfaction is a primary indicator of any adverse effects of VBP. PSCS will continue to monitor member satisfaction and, depending on the structure of the VBP arrangement, we may implement arrangement-specific monitoring tools. PSCS will develop standard contractual language as part of our provider service agreement template that sets forth a clear process for raising and escalating concerns about unintended or adverse effects associated with VBP arrangements. Clear process information will help support timely resolution. Strategies may include facilitated discussions, alternate metrics, or renegotiation. PSCS intends to work in partnership with the Community Advisory Council (CAC) to assess any risks of adverse impact of VBPs, either as proposed or as implemented. In order to support this dialogue, PSCS will update the CAC at least twice annually with any changes in local VBP arrangements and corresponding performance measures. Based on recommendations of the CAC, PSCS and provider partners will reconvene to discuss the VBP arrangements and necessary next steps.

Mitigation plans could include, but shall not be limited to:

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

PSCS will review all available benchmarking and consider the appropriateness of the benchmarks relative to the population being measured. In terms of considering the appropriateness of any given benchmark, PSCS will evaluate the following: population size within the benchmark, population size of the provider being measured, geographic considerations (urban versus rural, regional variations, etc.), any large changes in population, provider group size, provider group type (FQHC, etc.), member risk, and variation in any member demographics to the extent data is available. PSCS will consider information within PSCS data warehouses, claims systems, and population health assessments and associated data sets. In addition, PSCS will work collaboratively with provider partners to evaluate data and risk profiles shared by provider partners. PSCS will also explore new methods to measure the complexity of patient mix in building VBPs with provider partners. To the extent there is a risk model available that incorporates SDOH-HE data, we will also explore how that could be beneficial in evaluating effects of VBPs and provider performance. In addition, if we determine that patient mix is more complex, we will compare provider performance against that provider’s historic performance rather than national benchmarks.

Mitigation plans could include, but shall not be limited to:

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

PSCS will consider the applicability of risk adjustment models to VBP. PSCS has significant experience building risk models and rates from the ground up versus passing through rates generated by the OHA. In some risk models, a VBP will cover the entire population served in the service area. In such cases, no risk adjustment is needed to consider social and medical complexity due to differing provider-patient mix as the provider would have responsibility for the entire population. In other cases, adjustments for different membership mix may be made through payment differential by rate category or in response to other assessments of risk and
complexity. If a region is shared with other CCOs or amongst multiple providers, PSCS will consider if risk adjustment within a VBP could address different patient mix inequities while also considering the need to align any risk adjustment with the OHA’s risk adjustment and payment methods. PSCS recognizes the link between social complexity and medical costs. We will explore options to use any available data to help ensure appropriate care and target cost-effective services. We welcome the opportunity to participate in an OHA-sponsored work group or multi-CCO pilots to help advance the use of such models across multiple CCOs.

Mitigation plans could include, but shall not be limited to:

c. Monitoring number of patient that are “fired” from Providers.

PSCS will monitor the number of patients discharged from providers. We have started to build new reporting to accelerate our efforts in this area, and we will test these reports and system updates during 2019. We will also continue to monitor grievances and appeals, as well as member communications via our internal Customer Service Department. When members are “fired” from a PCP office, they are typically in contact with our staff to assist with finding a new PCP, which allows us to monitor and track these terminations. In the process, we help members understand their options and listen to their concerns. In 2019, we will begin tracking whether members fall into one of the categories set forth in this question, and will also begin tracking which members are “fired” by providers. If a provider has a high number of discharges relative to the volume of patients, or we hear any concerning comments, we will reach out to the provider to better understand the situation and provide education if applicable. In addition, if we identify concerning information while investigating a member grievance, we may treat that information as an adverse event. In these cases, the PSCS Medicaid Medical Director investigates the incident, and action may include education, requesting an explanation, referral to the Credentialing Committee, and when severe, termination of the provider contract.

PSCS continues to support Bridges Health, a complex care coordination and clinical hub operated by Mosaic Medical, which plays a unique role in serving members, particularly those who need specialized and peer support that may not be available in their current clinic. Reporting available from Bridges gives us additional information about patients “fired” from providers or otherwise referred to Bridges on the basis of medical complexity.

Attachment 8, Section C.4: Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two. The two new VBPs must be in two of the following care delivery areas: Hospital care, maternity care, children’s health care, Behavioral Health care, and oral health care; noting which payment arrangement is either with a Hospital or focuses on maternity care, as required in 2021. The description will include the VBP LAN category 2C or higher, with which the arrangement aligns; details about what quality metrics the Applicant will use; and payment information such as the size of the performance incentive, withhold, and/or risk as a share of the total projected payment.
Attachment 8, Section C.5: Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant’s current VBP agreements. The plan must include at a minimum information about:
a. The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)
b. The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>LAN Category</th>
<th>Focus on VBPs</th>
<th>Payment Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>Mostly Pay for Performance</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Mostly Shared Savings</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>Mostly Shared Risk</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
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<tr>
<td>Q15</td>
<td>Answer15</td>
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</table>

Note: The table is truncated for brevity. For more detailed responses, please refer to the full document.
Attachment 9 – Health Information Technology Questionnaire

Attachment 9, Section A.1.a: What challenges or obstacles does Applicant expect to encounter in signing the 2020 HIT Commons MOU and fulfilling its terms?

PSCS does not expect to encounter any challenges or obstacles in signing the 2020 HIT Commons MOU and fulfilling its terms. We are a current CCO participant in the HIT Commons, have experienced no difficulty in complying with the current MOU, and intend to sign the 2020 MOU. We consistently pay our dues and plan to do so in the future. In relation to the OHA’s expectations of CCOs, we participate in HIE Governance and will continue to engage with the Health Information Technology Advisory Group (HITAG). Our VP of IT, Infrastructure, and Analytics, Brian Wetter, has participated in HIT Commons and its predecessor organization, the EDIE Governance Board, since inception. Mr. Wetter holds the commercial health plan seat on the HIT Commons and has been the Vice Chair since December 2018. PSCS is committed to quarterly or more frequent participation in HITAG meetings and sees them as a valuable opportunity to include Providers and CCO community governance participants, as well as PSCS staff, in contributing to the state’s vision and strategy for Health Information Technology (HIT).

Attachment 9, Section B.1.a: How will Applicant support increased rates of EHR adoption among contracted physical health Providers?

PSCS encourages and supports adoption of Electronic Health Record (EHR) technology by the providers serving its members as a strategy to improve individual care and also improve population health and health equity. Widespread adoption of EHR technology by physical health providers has already demonstrated how such technology enables providers, CCOs, and others to generate native digital data on important aspects of member health, improve transmission and aggregation of clinical information, query data about individuals to improve health care and address disparities in receipt of services, and aggregate data for population health and systems planning. Members accessing care in organizations with patient portals are more able to engage in their own care. PSCS strongly supports adoption of EHR and other technology appropriate to the patient, provider, setting, and sector.

Current Operations

After early work by providers and with support from PSCS, primary care and other physical health practices in existing CCOs enjoy high rates of EHR adoption. Over 99% of members in the Central Oregon CCO are served by a PCPCH clinic using either a 2014 or 2015 Certified EHR Technology (CEHRT). As a result of high adoption rates, CCO staff and community governance structures refocused their work starting in 2014 on Health Information Exchange (HIE) solutions and supporting augmented use of EHRs by practices that had already adopted them, such as the integration of PDMP data and improving clinic-based workflow, reporting, and analytics capabilities. PSCS has maintained registries of EHR adoption, in large part to support HIE initiatives and collection of clinical data. PSCS already tracks EHR program and versions for clinics participating in eCQM reporting, which represents 90% of primary care capacity, and program and version tracking for all hospitals in the region and a substantial number of specialty physical health providers. We will use this information to help establish a baseline.
By the Contract Effective Date and Future Plans through the Five-Year Contract
During the five-year contract, PSCS will expand the focus of its work with providers and community governance to advance this work. The Roadmap summary below lays out our plans to support increased rates of EHR adoption by physical health providers.

**Goal: Increase rate of EHR adoption among contracted physical health providers**

**Strategy 1 (EHR Physical Health)**
Identify gaps in EHR adoption by physical health providers and scope needs to address gaps

<table>
<thead>
<tr>
<th>Milestones and Activities</th>
</tr>
</thead>
</table>
| **By 12/31/19** | Determine data collection format  
| | Collect data on EHR status across range of physical health providers  
| | Calculate baseline across service area |
| **By 12/31/20** | Establish threshold above which non-EHR clinics receive adoption support  
| | Complete scoping analysis of resources needed to address gaps in EHR adoption |
| **During 2021-2024** | Complete annual update to baseline assessment, including all OHA-specified data elements for reporting |
| **Activities:** | This strategy includes activities related to Assessment and Governance. For details, see attached HIT Roadmap. |

**Goal: Increase rate of EHR adoption among contracted physical health providers**

**Strategy 2 (EHR Physical Health)**
Encourage and support EHR adoption by physical health providers

<table>
<thead>
<tr>
<th>Milestones and Activities</th>
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<tbody>
<tr>
<td><strong>By 6/31/20</strong></td>
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<td><strong>By 8/31/20</strong></td>
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</table>
| **By 12/31/20** | Complete deployment of at least one resourcing strategy listed above with 5 non-adopting providers  
| | Set numeric targets for future change in adoption rates |
| **During 2021-2024** | Complete annual update of resources available and needs  
| | Update and achieve numeric targets |
| **Activities:** | This strategy includes activities related to Assessment, Education, Peer Learning, and Technical Assistance. For details, see attached HIT Roadmap. |

Attachment 9, Section B.1.b: How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?

PSCS encourages and supports adoption of EHR technology by Behavioral Health (BH) providers. Our general reasons for this are described in **Section B.1.a**, above. For the BH sector specifically, preliminary analysis indicates that professionals working in this area have a significantly lower EHR adoption rate than physical or oral health clinicians. While many Certified Community Behavioral Health Clinics (CCBHCs) have EHRs in place, there are few platforms appropriate to the needs of these clinics and the functionality of available options is inconsistent. For specialty mental health and substance use disorder providers in smaller
organizations or solo practice, adoption rates and the range of cost-effective and appropriate platforms are even more limited.

**Current Operations**
PSCS has the staff and partnerships to support BH providers in adopting EHRs. PSCS has focused on interoperability of existing platforms and use of HIE. We have supported onboarding through OMUTAPP and currently engage with the HIE Onboarding Program. PSCS has worked to improve the usefulness of existing EHRs to allow onboarding of integrated BH staff in primary care and other physical health settings, in collaboration with providers in Central Oregon. PSCS also adopted payments tied to fidelity integration, and we require that integrated providers chart in the same system in order to be eligible for these augmented payments. We conduct readiness reviews through a scan of state-level data and assessed providers using CEHRT. In preparation to support practices that may need extensive assistance, the PSCS HIE program manager initiated contact with regional consultants to identify resources and worked with an Independent Practice Association that is willing to offer recommendations and support clinics working to meet the unique requirements of BH and substance abuse configuration in EHRs.

**By the Contract Effective Date and Future Plans through the Five-Year Contract**
The Roadmap summary below lays out our plans to support increased rates of EHR adoption by BH providers

<table>
<thead>
<tr>
<th>Goal: Increase rate of EHR adoption among contracted Behavioral Health providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 3 (EHR Behavioral Health)</strong></td>
</tr>
<tr>
<td>Identify gaps in EHR adoption by Behavioral Health providers and scope needs to address gaps</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td>By 12/31/19</td>
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<td></td>
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<tr>
<td>By 12/31/20</td>
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<tr>
<td>During 2021-2024</td>
</tr>
<tr>
<td><strong>Activities:</strong></td>
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<table>
<thead>
<tr>
<th>Goal: Increase rate of EHR adoption among contracted Behavioral Health providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 4 (EHR Behavioral Health)</strong></td>
</tr>
<tr>
<td>Encourage and support EHR adoption by Behavioral Health providers</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td>By 6/31/20</td>
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</tbody>
</table>
By 8/31/20  Complete assessment of available resources and respond as needed
By 12/31/20  Complete deployment of at least one resourcing strategy listed above with 5 non-adopting providers
             Set numeric targets for future change in adoption rates
During 2021-2024  Complete annual update of resources available and needs
                  Update and achieve numeric targets
Activities:  This strategy includes activities related to Assessment, Education, Peer Learning, and Technical Assistance. For details, see attached HIT Roadmap.

Attachment 9, Section B.1.c: How will Applicant support increased rates of EHR adoption among contracted oral health Providers?
PSCS encourages and supports adoption of EHR technology by oral health providers. Our general reasons for this are described in Section B.1.a, above. For the oral health sector specifically, we know that interfacing with both Dental Care Organizations (DCOs) and practices will be necessary, given the intertwined nature of dental practices, various DCO contracting models and direct service delivery, integrated care settings, business operations, care coordination practices, and use of IT platforms. Because of the significant influence DCOs have with contracted and employed oral health providers, we work closely with DCO leadership. We understand that statewide solutions may be most attractive in this sector, given the multi-CCO footprint of each DCO. Our work leading up to 2020 and during the 5 years of this contract will be grounded in this perspective.

Current Operations
We surveyed DCOs in early 2019 and used this information to build a baseline. Across multiple sites in Oregon, approximately 70% of clinic sites utilize an EHR of some kind, and approximately 25% of those EHRs are CEHRT. Clear feedback and takeaways included addressing financial assistance, change management with practice workflows, training assistance, and educating on how EHR aligns with improved member health. There is a strong presence of proprietary systems in DCOs, especially in the practices that they own.

By the Contract Effective Date and Future Plans through the Five-Year Contract
The Roadmap summary below lays out our plans to support increased rates of EHR adoption by oral health providers through the end of 2019 and throughout the Five-Year Contract period.

Goal: Increase rate of EHR adoption among contracted oral health providers
Strategy 5 (EHR Oral Health)
Identify gaps in EHR adoption by oral health providers and scope needs to address gaps
Milestones and Activities
By 12/31/19  Determine data collection format
              Collect data on EHR status across range of oral health providers in collaboration with Dental Care Organizations (DCOs)
              Calculate baseline across service area
By 12/31/20  Establish threshold above which non-EHR clinics receive adoption support
              Complete scoping analysis of resources needed to address gaps in EHR adoption
During 2021-2024

Complete annual update to baseline assessment, including all OHA-specified data elements for reporting

Activities: This strategy includes activities related to Assessment and Governance. For details, see attached HIT Roadmap.

Goal: Increase rate of EHR adoption among contracted oral health providers

Strategy 6 (EHR Oral Health)

Encourage and support EHR adoption by oral health providers

Milestones and Activities

By 6/31/20

Complete inventory of resources available for educational, financial, and technical support

Identify 2-4 EHR solutions appropriate to needs of oral health providers

By 8/31/20

Complete assessment of available resources and respond as needed

By 12/31/20

Complete deployment of at least one resourcing strategy listed above with 5 non-adopting providers

Set numeric targets for future change in adoption rates

During 2021-2024

Complete annual update of resources available and needs

Update and achieve numeric targets

Activities: This strategy includes activities related to Assessment, Education, Peer Learning, and Technical Assistance. For details, see attached HIT Roadmap.

Attachment 9, Section B.1.d: What barriers does Applicant expect that physical health providers will have to overcome to adopt EHRs? How do you plan to address these barriers?

While the Health Information Technology for Economic and Clinical Health (HITECH) Act and the provisions around Meaningful Use over the last decade have largely promoted high adoption rates, we anticipate those operating without EHRs now will face larger hurdles because program supports and incentives are no longer available. The barriers that providers face in adopting EHR technology include industry, financial, functional, and legal issues.

The industry barriers facing physical health providers include instability in the EHR industry, the shift to cloud-based services, and data-security concerns. The EHR industry continues to experience consolidation and changes in product lines. We anticipate that at least 20% of primary care clinics will have a significant change in their existing system over the next five years. We will continue to provide technical assistance and shared learnings from previous conversions. For example, a regional hospital system converted to EPIC and ported the last three years of colonoscopy screening information to EPIC, leaving the balance of information on the old system. When we conducted the colon cancer screening chart audit, we discovered it was more complicated than we expected to work with the provider and pull charts. We will share these types of learnings with the provider community to assist with streamlined conversions.

EHR providers are moving to cloud-based solutions. While these solutions reduce the cost of entry for small and solo practices, the risk of patient data in the cloud raises concerns for some providers after national news of hacked servers and ransomware situations. Our approach to address this is to partner with the OHA on toolkits for safe harbor practices and sample patient forms to ease the glide path for small and solo practices.
With respect to financial barriers, providers cited the cost to acquire, implement, and maintain an EHR. Other financial barriers include skepticism about return on investment, the time investment required for staff to implement and support the systems, and the sunset of Meaningful Use incentive payments. Functional barriers include the need to redesign workflows, divided provider attention between the patient and the computer, and concern about provider burnout from the additional time required to document in most EHRs compared to paper-based processes.

With respect to legal barriers, providers raised concerns about security and an increased chance of data breaches or Health Insurance Portability and Accountability Act (HIPAA) violations, along with the need to train staff to avoid the types of errors that become more likely when using an EHR. In conjunction with errors, providers raised concerns about malpractice liability associated with increased exposure. Successful adoption will involve tipping the balance among these factors so that the promise of adoption outweighs the barriers.

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**Potential Barriers and Mitigation Plans – Physical Health and Across All Care Domains**

<table>
<thead>
<tr>
<th>Barrier:</th>
<th>Mitigation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHIO catalog not available or missing necessary data fields</td>
<td>Work with RHIO and OHA to align data elements to be collected and reported</td>
</tr>
<tr>
<td></td>
<td>Maximize use of other data sources such as CHPL</td>
</tr>
<tr>
<td>Clinics unwilling or without time to respond</td>
<td>Consolidate inquiry with other CCO interactions such as provider contract negotiation or provider service representative site visits</td>
</tr>
<tr>
<td></td>
<td>Align with other vendors or CCOs who need the same data from providers to make a single inquiry</td>
</tr>
<tr>
<td>Community partners involved in decision making may have conflicts of interest</td>
<td>Ensure that decision making forums have conflict of interest policies in place and that participants explicitly disclose any potential conflicts or relationships that might affect their vote, recusal</td>
</tr>
<tr>
<td>Clinic readiness to adopt may be impaired by technological, industry, functional, financial, and legal barriers</td>
<td>Use educational materials, technical assistance, on-site coaching and peer learning to mitigate functional barriers</td>
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<tr>
<td></td>
<td>Identify acceptable EHR options across a range of pricing</td>
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<td>Connect providers with large systems willing to add others to their EMR</td>
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<tr>
<td></td>
<td>Use financial incentives initially then contract metrics or requirements to overcome financial barriers</td>
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</tbody>
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Attachment 9, Section B.1.e: What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to address these barriers?

As discussed above, although we observe a high rate of EHR adoption by BH providers in integrated settings, most BH providers working in other settings do not use EHRs, and they face significant barriers to adoption. BH providers face the industry, financial, functional, and legal issues outlined above, with some particular distinctions of note.
With respect to technological barriers, Klas Research (https://klasresearch.com/report/behavioral-health-2018/1264) recently ranked the BH EHR vendor market segment in the bottom 2nd percentile for vendor performance across all EHR segments. They cited a lack of choices and few effective solutions. Widely-adopted EHRs that were developed for physical health providers often do not meet BH-specific needs or requirements, such as SUD confidentiality provisions. In addition, available EHRs are often costly and far more expensive than needed by therapy providers who have a scope of practice that does not include activities like prescribing or reviewing test results. For these providers, we acknowledge that useful functions may be limited to viewing data from other providers plus generating encounter data, engaging in referrals, and storing chart notes.

With respect to financial barriers, providers cited the cost to acquire, implement, and maintain CEHRT. While the HITECH Act subsidies achieved high adoption rates in physical health, the vast majority of BH professionals were ineligible for Meaningful Use incentive payments. For BH practitioners that operate independently or in smaller practice settings, this can translate to a lack of sufficient financial resources or technical support for the adoption and maintenance of electronic health systems.

BH providers face the barriers listed above in Section B.1.d and may benefit from the same mitigation strategies. In addition, we identified the following barriers and mitigation plans:

**Potential Barriers and Mitigation Plans – Additional Items Specific to Behavioral Health**

<table>
<thead>
<tr>
<th>Barrier:</th>
<th>Mitigation:</th>
</tr>
</thead>
</table>
| Financial incentives for adoption were never available for most Behavioral Health provider types | Prioritize cost-effective EHR solutions  
Support the creation of financial incentives specific to EHR adoption, for example through federal/state programs like the HIE Onboarding Program |
| Behavioral Health services typically need a very limited range of functionality, making comprehensive systems most costly than the benefit they provide | Work with providers and experts to determine right-size software solutions |
| Behavioral Health providers are less organizationally aligned than other sectors, with no common structures like a DCO or Independent Practice Association | Use CCO community governance or other regional structure to assist Behavioral Health providers in organizing to allow activities such as bulk purchase of one vendor’s product or shared IT support |

Attachment 9, Section B.1.f: What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to address these barriers?

As discussed above, although we observe a moderate rate of EHR adoption by oral health providers, adoption is inconsistent, often tied to DCO contracting, and often using non-certified technology. Even when working in integrated settings where physical health EHRs are employed, oral health providers often do not have well-functioning dental modules to use within
these systems. Oral health providers face the industry, financial, functional, and legal issues outlined above.

Many oral health providers across the state have not adopted EHRs. For the 70% who have, most are using non-certified technology. We expect to partner with strong DCO leaders to influence this dynamic, and we are uniquely positioned to address it through our footprint across, through multiple lines of business, and through existing, strong relationships with four DCOs. In addition, we have worked to identify providers and influential subject matter experts who might be able to represent their oral health peers in various committees, such as HIT Commons, Central Oregon Health Information Exchange, and the Health Information Technology Advisory Group (HITAG), so that their perspective shapes the planning process.

Oral health providers face the barriers listed above in Section B.1.d and will likely benefit from the same mitigation strategies. In addition, we identified the following barriers and mitigation plans:

<table>
<thead>
<tr>
<th>Potential Barriers and Mitigation Plans – Additional Items Specific to Oral Health</th>
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<td><strong>Barrier:</strong></td>
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<td><strong>Mitigation:</strong></td>
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<tr>
<td><strong>Barrier:</strong></td>
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<tr>
<td><strong>Mitigation:</strong></td>
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Attachment 9, Section B.2.a: What assistance you would like from OHA in collecting and reporting EHR use and setting targets for increased use?

PSCS appreciates the opportunity to partner with the OHA to create effective and efficient processes to support EHR adoption across the state. Aligning the efforts of CCOs, providers, the OHA, and health IT organizations will ensure the best outcomes for Oregonians. We believe that the following assistance from the OHA would be helpful:

Create Unified Standards and Sources for Information about EHR Adoption

- Articulate a unified list of data elements to be collected and reported to OHA or other large statewide enterprises
- Collaborate with large-scale HIE entities such as Regional Health Information Organizations. For example, Reliance eHealth Collaborative could collect information from practices through their HIT Onboarding Program work and add it to their catalog of connected organizations.
- Facilitate statewide strategies for DCO reporting, since each DCO works with multiple CCOs
- Aggregate various sources of information about adoption of EHRs
- Maintain or facilitate creation of a state-level EHR adoption directory with logic in place to capture and manage duplicates and recent updates
Assist in Setting Targets for Increased Use

- Share benchmarks of adoption in high-performing regions and other states by sector
- Identify information about adoption rates and promising practices for small practices and rural, frontier, and tribal settings

Partner in Addressing Policy and Regulatory Barriers

- Advocate for federal changes to address regulatory and administrative limitations that force clinicians to spend increasing amounts of time operating EHR systems
- Share information about safe harbors and best practices, including sample data releases that comply with FERPA, HIPAA, and other sources of applicable law, as well as template data security policies and procedures for small practices
- Continue to support HIE Onboarding Program engagement with health care providers in neighboring states if meaningful numbers of Oregonians receive care in those states

Attachment 9, Section B.2.b: Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

Initial Plans for Collecting Data

PSCS plans to use the data elements specified by the OHA as the foundation to gather as much EHR-related information as possible with automated strategies that will make more effective use of CCO resources and avoid redundant reporting by providers. We plan to work with other CCOs to make best efforts to collaborate in any direct inquiries of providers. We plan to collect data on EHR use via the following methods:

- **Vendor Reports.** We already received an initial update from Collective Medical Technologies and Reliance eHealth Collaborative. We use these lists to target providers and address connectivity gaps. We also work directly with the HIE Onboarding Program and EHR vendors who can share information about provider status with us.
- **Clinical Messages and Documents.** We gather EHR system and version information from data sent from Collective Medical Technologies and Reliance eHealth Collaborative, in which HL7 message formats and clinical summaries contain fields that identify the sending manufacturer of the EHR system and the product version number.
- **Direct Provider Inquiry.** We plan to use a variety of strategies to collect information directly from providers through community forums as well as via email or in-person surveys of individual sites.
- **Certified Health IT Product List (CHPL).** Our experience using CHPL data from the Office of National Coordinator indicates that it lacks recent updates, but it is a useful tool to supply a baseline of historic systems in use. For example, providers who were using CEHRT in the past are good early targets for reassessment.

Initial Plans for Setting Targets for Increased Use

Going forward, we will consider these perspectives in setting targets for increased use of HIE:

- **Tracking Dashboard:** PSCS maintains an internal dashboard that tracks the adoption of EHR use by physical health practices. We are currently in the process of developing a version that details the adoption of EHR by other types of providers. The dashboard will be updated at least bi-annually from EHR surveys, and we will update improvement targets annually.
• **Context.** PSCS will use information collected during 2019 and 2020 to determine the relative saturation or opportunity for improvement in a specific sector, organizational size, or community.

• **Opportunity for Improvement.** We will consider a variety of factors and set an improvement target, such as annually closing half of the gap or increasing by 10%. We may consider the following:
  - Number and proportion of clinics and providers who have not adopted EHR by region and sector
  - Number and proportion of clinics and providers who meet CCO-specific criteria for support
  - Number of providers without EHR serving high-priority populations or sectors

• **Gaps by sector.** PSCS will direct resources to areas where improvement in adoption is most likely and most beneficial to members. This will likely include prioritizing the BH sector, because less technical assistance and fewer incentives have been offered there in the past.

Attachment 9, Section B.2.c: Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

Please see our response to **Section B.2.b,** above. We plan to adopt the same strategies across care domains.

Attachment 9, Section B.2.d: Please describe your initial plans for collecting data on EHR use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

Please see our response to **Section B.2.b,** above. We plan to adopt the same strategies across care domains. In addition, given the strong role that DCOs play in delivering and paying for dental care in Oregon, PSCS will query DCOs as an interim step between vendor reports and direct outreach to providers.

Attachment 9, Section C.1.a: How will Applicant support increased access to HIE for Care Coordination among contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

**Current Operations**

PSCS understands the importance of support for increased access to HIE for care coordination among providers. Increasing access will improve the movement of data among organizations delivering health care and related services and the aggregation of data to serve individual care needs and learn about the health of populations. PSCS uses the following key strategies to support increased access to HIE for care coordination:

• Employ an HIE Program Manager to organize corporate and community HIE strategies and execute on our strategic plan
• Participate in leadership roles in community, state, and national HIE discussions
• Engage in an organized way with providers and partners to support data sharing, adoption of compatible technology, and other interoperability
Adopt tools and methods internally and externally to accomplish robust HIE across the communities that we serve

Prioritize activities to increase the value of HIE use, such partnering to add health plan information to the systems

In our experience as a CCO, we have worked with providers and community governance structures to establish Regional Health Information Organizations, using Reliance to provide communication and data aggregation through their Community Health Record. Central Oregon and the Columbia Gorge have also widely adopted PreManage and other portals to obtain EDIE data, as well as Clara from Vistalogic, used by health care and social service organizations for care coordination and assessment of clients’ social needs.

We have also developed a variety of provider use cases. For example, if a small, rural practice connects with a community HIE like Reliance via the Community Health Record, even if that practice does not have an EHR, the HIE portal alone has the potential to provide significant value and improvements in quality of care and administrative simplification. We have also developed and piloted use cases involving closed loop referrals, including projects with public health and primary care clinics to verify core functions of the tool. A variety of clinics have adopted the Reliance eReferrals platform. We have also invested in our own HIE tools to improve the flow and measurement of data.

Lastly, we recognize the value of CCOs sharing medical and pharmacy claims, eligibility status, risk stratification, and other relevant information back to community HIEs. In 2018, we began successfully sharing medical claims and prescription drug information to Reliance HIE. Our goal is to encourage adoption of HIE by providers through improving its usefulness to them.

By the Contract Effective Date and Future Plans through the Five-Year Contract
The Roadmap summary below lays out our plans to support increased HIE access for care coordination by physical health providers through the end of 2019 and throughout the five-year contract period.

<table>
<thead>
<tr>
<th>Goal: Providers in all sectors improve their ability to provide coordinated care through use of HIE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy 7 (HIE Care Coordination)</td>
</tr>
<tr>
<td>Increase the number of providers connected to Health Information Exchange (HIE) and improve the value of using HIE for care coordination</td>
</tr>
<tr>
<td>Milestones and Activities</td>
</tr>
<tr>
<td><strong>By 12/31/19</strong></td>
</tr>
<tr>
<td>Define process for establishing baseline by provider type physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings.</td>
</tr>
<tr>
<td>Introduce non-adopting providers to basic HIE functionality</td>
</tr>
<tr>
<td><strong>By 6/31/20</strong></td>
</tr>
<tr>
<td>Determine baseline by provider type: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings.</td>
</tr>
<tr>
<td>Create early opportunities for providers to use HIE through use of eReferrals</td>
</tr>
<tr>
<td>Date</td>
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<tr>
<td>--------------</td>
</tr>
</tbody>
</table>
| **By 12/31/20** | Increase number of providers that start contributing ADT and CCD documents to a Regional Health Information Organization  
Increase use of eReferrals by providers |
| **By 12/31/20** | Set targets for the number of providers able to use eReferrals, view data, and/or contribute data  
Identify additional tools to incorporate in HIE  
Explore expanded use of HIE to simplify provider workload |
| **By 12/31/21** | Increase number of providers contributing ADT and CCD documents to Regional Health Information Organization operating in region |
| **During 2021-2024** | Complete bi-annual updates to baseline assessment  
Set targets for connected providers  
Set targets for tools available and/or in use  
Add additional strategies, such as contract language, if adoption is lagging |

**Activities:** This strategy includes activities related to Assessment, Technical Assistance, Peer Learning, and Resourcing. For details, see attached HIT Roadmap.

Attachment 9, Section C.1.b: How will Applicant support increased access to HIE for Care Coordination among contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

**Current Operations**
Please see above in Section C.1.a for a description of our current operations and strategies. In addition to the text discussed above, PSCS intends to support increased access to HIE for care coordination among BH providers because it is critical to providing comprehensive care to our members. We have developed and tested BH-specific uses cases related to closed loop referrals, Community Health Records, onboarding via the OHA Health Information Exchange Onboarding Program, PreManage, and our own HIE tools.

By the Contract Effective Date and Future Plans through the Five-Year Contract
The Roadmap summary for Strategy 7, listed with our response to Section C.1.a, above, lays out our plans to support increased HIE access for care coordination by BH providers through the end of 2019 and throughout the Five-Year Contract period.

Attachment 9, Section C.1.c: How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, any HIE tool(s) or HIE methods included, and the actions you plan to take.

**Current Operations**
Please see above in Section C.1.a for a description of our current operations and strategies. In addition to the text discussed above, PSCS intends to support increased access to HIE for care coordination among oral health providers because it is critical to providing comprehensive care to our members. We have developed and tested oral health-specific uses cases related to closed loop referrals, Community Health Records, onboarding via the OHA HIE Onboarding Program, PreManage, and our own HIE tools.
By the Contract Effective Date and Future Plans through the Five-Year Contract
In regions where Reliance operates, we plan to contribute dental claims to the HIE starting in 2020. In addition, the Roadmap summary for Strategy 7, listed with our response to Section C.1.a, above, lays out our plans to support increased HIE access for care coordination by oral health providers through the end of 2019 and throughout the five-year contract period.

Attachment 9, Section C.1.d: How will Applicant ensure access to timely Hospital event notifications for contracted physical health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

Current Operations
PSCS ensures that physical health providers have access to timely hospital event notifications about members who use emergency room and inpatient services. As an early adopter of the hospital event notification capabilities provided by the EDIE/PreManage system across all lines of business, we have applied four primary strategies to help improve access to timely hospital event notifications for contracted physical health providers:

- Support clinics with notification technology and reporting. We provide services to clinics at no cost (with significant financial support from the OHA), which has greatly increased adoption and usage over the past three years. To date, 73% of PCPCH clinics in Central Oregon use real-time hospital notification technology. In the Columbia Gorge, the rate is as high as 91%. We also work with providers to provide technical assistance with implementation. We intend to continue our support of this program.
- Leadership. PSCS participates at a high level in Oregon Health Leadership Council (OHLC) collaboratives and HIT Commons. This work has helped us promote the adoption of HIE tools supporting hospital event notifications and advocate for the needs of our provider partners.
- Provider partnerships. We pair team members from PSCS with provider partners to lead initiatives regarding hospital notification capability, EHR adoption, interface development, HIE adoption and use, and development of use cases.
- Meaningful contribution of data. As discussed above, we are committed to sharing information to increase the value of HIE connectivity and support our providers’ ability to improve the care they deliver to members.

We developed use cases that support providers in scaling their maturity to manage hospital event notifications. For example, we recommend starting with a manageable number of notifications and then refining cohorts to cover an increasing number of notifications. We recommend eventually moving to a model to outreach to all members with emergency department visits for non-emergent reasons. We also helped clinics build cohorts of members with severe and persistent mental illness in order to focus on meeting the needs of this population. We also use our proprietary report, the Member Insight report, to aggregate information from hospital event notifications and update risk scores accordingly.

By the Contract Effective Date
We intend to continue our efforts to expand the use of real-time hospital event notification platform adoption with our provider partners. We also plan to work with platform vendors to improve participation from all entities to ensure fidelity to best practices, including frequency of
use, contribution to care guidelines, and other interactive features, including a refresh of eligibility on recommended cycles.

**Future Plans through the Five-Year Contract**

The Roadmap summary below lays out our plans to ensure access to timely hospital event notification by physical health providers through the end of 2019 and throughout the five-year contract period.

<table>
<thead>
<tr>
<th><strong>Goal:</strong> Increase use of HIE for hospital event notification by providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 8 (HIE Hospital Event Notification)</strong></td>
</tr>
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</table>

Increase the number of providers receiving hospital event notification (HEN) and support them to make use of the information

<table>
<thead>
<tr>
<th><strong>Milestones and Activities</strong></th>
</tr>
</thead>
</table>

**By 12/31/19**
- Define process for establishing baseline by provider type: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings
- Introduce non-adopting providers to basic HEN functionality

**By 12/31/20**
- Increase the access and use of HENs by all provider types: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings

**During 2021-2024**
- Increase the access and use of HENs by all provider types: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings

**Activities:**
- This strategy includes activities related to Education, Technical Assistance, Peer Learning, and Incentives. For details, see attached HIT Roadmap.

Attachment 9, Section C.1.e: How will Applicant ensure access to timely Hospital event notifications for contracted Behavioral Health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

**Current Operations**

Please see above in Section C.1.d for a description of our current operations and strategies, as well as a variety of use cases applicable across care domains. As discussed above, we provide these notifications at no cost to providers. We plan to continue this no-cost support to providers anticipating continued support from the OHA.

**By the Contract Effective Date**

We will continue our efforts to expand the use of real-time hospital event notification platform adoption with our network of BH providers, including CCBHCs. We also plan to work with platform vendors to improve participation from all entities to ensure fidelity to best practices, including frequency of use, contribution to care guidelines, and other interactive features, including a refresh of eligibility on recommended cycles.
Future Plans through the Five-Year Contract

The Roadmap summary for Strategy 8, listed with our response to Section C.1.d, above, lays out our plans to ensure access to timely hospital event notification by BH providers through the end of 2019 and throughout the five-year contract period.

Attachment 9, Section C.1.f: How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers? Please describe your strategy, including any focus on use cases or types of Providers, which HIE tool(s), and the actions you plan to take.

Current Operations

Please see above in Section C.1.d for a description of our current operations and strategies, as well as a variety of use cases applicable across care domains. As discussed above, we provide these notifications at no cost to DCOs. We intend to continue providing this support throughout the contract period. In addition to what is described above, we also provide a variety of technical supports to assist in implementing real-time notifications. For example, we built reports for DCOs to help them simulate the alerting they would receive in the Collective Medical platform. Each DCO ultimately went forward to contract directly with Collective Medical for PreManage. We also built a foundation of performance metrics in Value-Based Payment (VBP) arrangements with DCOs and expect this will support a glide path for HIE mechanisms to play a role in VBP in the future. Each DCO we partner with is connected directly to PreManage to provide “real time” reporting when members access the emergency department. They are testing a use case for non-traumatic dental concerns and completing outreach to educate members on appropriate use.

By the Contract Effective Date

We will continue our partnership efforts to promote increased adoption and high-value uses of the technology. We also plan to work with platform vendors to improve participation from all entities to ensure fidelity to best practices, including frequency of use, contribution to care guidelines, and other interactive features, including a refresh of eligibility on recommended cycles.

By the Contract Effective Date and Future Plans through the Five-Year Contract

The Roadmap summary for Strategy 8, listed with our response to Section C.1.d, above, lays out our plans to ensure access to timely hospital event notification by oral health providers through the end of 2019 and throughout the five-year contract period.

Attachment 9, Section C.1.g: How will Applicant access and use timely Hospital event notifications within your organization? Please describe your strategy, including any focus areas and methods for use, which HIE tool(s), and any actions you plan.

Current Operations

PSCS was an early adopter of hospital event notifications starting in 2016 under the support of the OHA to onboard the PreManage platform, and we have been active participants and leaders since. In 2016, the OHLC, along with Collective Medical, recognized Central Oregon as an early adopter of care management tools, including EDIE. Since those early beginnings, PSCS led and participated in a community development and collaboration to develop a clear understanding of the technology, workflow, and roles involved with reducing potentially avoidable emergency department utilization. Today, PSCS has over 60 employees who are active users across our care
teams and the system includes 25 member cohorts. We currently use this technology in the following ways within our organization:

- Leverage notifications of emergency department and inpatient activities for near real-time engagement with members and their care teams. Our care management staff review all inpatient discharges via PreManage. We have also implemented a single sign-on feature to increase our utilization and efficiency with the platform.
- Harness EDIE data for improved predictive risk stratification and care program matching. We integrate a daily feed from PreManage with our risk stratification process and use a proprietary algorithm to use this information to match members with care management programs. EDIE data gives us early insight into a member’s needs, particularly when the member is new to the CCO and no claims data is available.

By the Contract Effective Date and Future Plans through the Five-Year Contract
We plan to deploy several new strategies in 2019 to make best use of timely hospital event notifications within PSCS by our care coordinators. We will expand the data available within our platforms and assess new technology that we expect to release in 2019.

<table>
<thead>
<tr>
<th>Goal: Improve CCO contribution to hospital event notification</th>
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<tbody>
<tr>
<td><strong>Strategy 9 (HIE CCO Hospital Event Notification)</strong></td>
</tr>
<tr>
<td>Build on pervasive use of EDIE data by CCO staff through submission and use of additional clinical data through PreManage</td>
</tr>
</tbody>
</table>

**Milestones and Activities**

| By 12/31/19 | Execute a data sharing agreement with Collective Medical |
| By 12/31/20 | Test feasibility of data sharing from PSCS to Collective Medical to increase the amount of useful data in the PreManage platform |
| By 12/31/21 | Evaluate the ability to provide alerts and notifications directly to provider organizations |

**Activities:**

- Evaluate use of EDIE data for at least two CCO use cases such as:
  - Use real-time emergency department notifications to replace hospital reporting of inpatient stays
  - Use EDIE data to improve predictive risk stratification modeling, care program matching, and efficiency with hospital notifications

**During 2022-2024**

- Annually assess opportunities to interface and exchange data with platforms, both Regional Health Information Organizations and other HIE platforms

**Activities:**

- This strategy includes activities related to Governance and Infrastructure. For details, see attached HIT Roadmap.

Attachment 9, Section C.2.a: What assistance would you like from OHA in collecting and reporting on HIE use and setting targets for increased use?

The challenges around collecting information about providers’ use of HIE are in many cases the same as those around collecting information about EHR adoption. The types of assistance that we suggested in our response to **Section B.2.a** also apply here. In particular, PSCS would appreciate assistance from the OHA in collecting information from providers about their connections and use of HIE platforms, and we welcome statewide solutions to making this information available to CCOs and other interested parties.
PSCS also believes there is value in the OHA facilitating the creation of a framework to assess the quality of information contributed to an HIE. We believe there may be opportunities to improve the quality and consistency of HIE data. We would also like to learn more about how to work with the Trusted Exchange Framework and Common Agreement framework and how this structure might affect data sharing standards applied by Regional Extension Centers and Qualified Health Information Networks.

We also support the development of metrics to measure adoption and use of HIE and we would value the OHA’s help with setting targets. For example, we appreciate the metrics generated by Apprise during the EDIE/PreManage deployment, but they are challenging to operate at the CCO level. Consistent with our experience with the eCQM program, state standards will support CCO requests to engage providers in using and finding value in HIE. Today, providers often cite HIE connection as an additional and optional expense.

Attachment 9, Section C.2.b: Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted physical health Providers. Include data sources or data collection methods.

Initial Plans for Collecting Data
PSCS has strategic goals around the planning and expansion of HIE connectivity. We use the following strategies and intend to continue using them going forward, starting with those that yield the most data with the least provider impact:

- **Vendor Reports.** We have already received an initial update from Collective Medical Technologies and Reliance eHealth Collaborative in our existing CCO regions. We use these lists to target providers and address connectivity gaps. We also work directly with the Health Information Exchange Onboarding Program and EHR vendors who can share information about provider status with us.

- **Direct Provider Inquiry.** We plan to use a variety of strategies to collect information directly from providers through community forums as well as email or in-person surveys of individual sites.

- **Assessments from State and National Networks.** In addition to our long partnership with the OHA, we follow national data sources such as carequality, Commonwell, eHealth Exchange, SHIEC, and Open Notes, to evaluate engagement in broader data-sharing technologies.

Initial Plans for Setting Targets for Increased Use
Going forward, we will consider these perspectives in setting targets for increased use of HIE:

- **Context.** PSCS will use information collected during 2019 and 2020 to establish baselines. Targets will be used to prioritize resources to areas where improvement in adoption is most likely and most beneficial to members. For example, focusing on BH sector where relatively less technical assistance and fewer incentives have been offered in the past.

- **Opportunity for Improvement.** For example, considering the following factors and then setting an improvement target such as annually closing half of the gap or increasing 10%:
  - Number and proportion of clinics and individual providers who have not adopted EHR by region and sector
- Number and proportion of clinics and individual providers who meet CCO-specific criteria for support
- Number of providers without EHR serving high-priority populations or in high-priority sectors

- **Regional Goals.** We will consider targets for increasing HIE use that have been set by local and regional partnerships. For example, the Central Oregon Health Information Exchange (COHIE) and its vendor partners have developed community-level targets to increase HIE adoption rates and use. COHIE has set targets for closed loop referrals, connectivity, and Community Health Record usage.

**Attachment 9, Section C.2.c:** Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted Behavioral Health Providers. Include data sources or data collection methods.

Please see our response to **Section C.2.b,** above. We believe these strategies, sources, and plans are equally applicable across care domains. As discussed above, we are also in the process of deploying a comprehensive survey for BH providers to assess HIE and HIT connectivity, capabilities, and specific use cases.

**Attachment 9, Section C.2.d:** Please describe your initial plans for collecting data on HIE use, and setting targets for increased use by contracted oral health Providers. Include data sources or data collection methods.

Please see our response to **Section C.2.b,** above. We believe these strategies, sources, and plans are equally applicable across care domains. As discussed above, we are also in the process of deploying a comprehensive survey for DCOs to assess HIE and HIT connectivity, capabilities, and specific use cases. We will expand on the results we gather in this survey.

**Attachment 9, Section D.1.a:** If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.

While we are prepared to move forward and are well acquainted with the metrics, we respectfully request technical assistance to implement the Health Plan Quality Metrics Committee Aligned Measure Menu as we onboard provider organizations that are new to reporting the measures or who have limited resources. We welcome support that we can deploy to our clinical partners. We also welcome any guidance on other VBP models related to HIT, best practices, or potential new learning collaboratives to support improvements in our existing HIT infrastructure, particularly around risk stratification of social complexity where data sources and published, peer-reviewed methods are less common. We would welcome technical assistance and learning collaborative opportunities June-December 2019 and on an ongoing basis thereafter.

**Attachment 9, Section D.1.b:** What plans do you have for collecting and aggregate data on SDOH&HE, that may be self-reported or come from providers rather than be found in claims? Can you match demographic and SDOH&HE-related data with claims data?

PacificSource and PSCS have developed an enterprise-wide major strategic initiative to collect and aggregate data on SDOH&HE that includes information that is self-reported and from providers, and, yes, we can match demographic and SDOH&HE-related data with claims data. This strategic initiative is not constrained to Medicaid but instead seeks to incorporate data...
across business lines and geographies and aims to build a comprehensive population database with regards to SDOH-HE.

**Current Plans and Activities**

We are currently collecting, storing and aggregating member-level SDOH-HE data from OHA enrollment files as well as consumer data that we purchase on our adult population from Acxiom. We maintain robust capabilities to integrate and match this data to a number of sources, including medical and prescription claims. We collect data about education, Lifestage cluster, occupation, estimated household income, home owner/renter and property type, home value, and vehicle ownership. This third-party data source is not necessarily populated for every member or household, but the information has proven fairly complete. In our initial assessment, this data has proven helpful in understanding our members and the barriers they face. In addition, PSCS is actively seeking sources to augment existing data. Our Care Management team is now collecting self-reported SDOH-HE data that they gather via member interactions. They store this information in our care management platform. We are also actively exploring tools to support care managers in soliciting this information directly from members using assessments delivered via alternative formats like text messages and mobile applications.

**By the Contract Effective Date**

We will complete many significant efforts by the beginning of the contract period. These efforts are focused on capture and storage of preliminary SDOH-HE data available from current sources. Once these data are placed into production, Analytics team members will use them to support specific regional initiatives.

**Future Plans through the Five-Year Contract Period**

Many of our longer-term goals focus on identification of opportunities to capture additional SDOH-HE data from sources such as non-clinical partners and the Accountable Health Communities project. We also are working to determine the feasibility and value of developing a stratification model derived from SDOH-HE data. We intend to collaborate and align with provider partners and community organizations to collect SDOH-HE information consistently.

**Attachment 9, Section D.1.c: What are some key insights for population management that you can currently produce from your data and analysis?**

We can currently produce insights for population management based on geography, race/ethnicity, language, disability, dual eligibility, rate category, age, sex, primary care provider, risk score, comorbidity index, SPMI diagnosis, substance use disorder diagnoses, chronic conditions, utilization of primary care, emergency department utilization, inpatient utilization, etc., and other demographic and risk factors, including REAL+D from the OHA. We share information with Health Council committees, internal committees, workgroups that focus on population management, and providers. Examples include the following:

**Chronic conditions:**

- Members with chronic conditions have high rates of comorbid depression.
- Hispanic/Latino and Caucasian members have the highest age-adjusted rates of diabetes in the last 4 years.
Utilization of services:
- Members residing in Jefferson County are at highest risk of high ED utilization as well as the highest rates of potentially avoidable ED utilization, even after adjusting for age.
- Members who identify as Native American/American Indian are more likely to have higher rates of ED utilization, a higher ratio of ED visits for every PCP visit, and a higher rate of potentially avoidable ED utilization.
- On average, members living in more rural areas tend to have higher rates of ED utilization than members living in more urban areas.

In addition to the work described above, we also conduct an annual population assessment with a special focus on SDOH-HE. We complete this assessment consistent with NCQA-recommended practices to assess the characteristics and needs of the population and subsets of the population, such as child and adolescent members, members with disabilities, and members with serious and persistent mental illness. The assessment aggregates, analyzes, and presents data from internal sources. We are also able to identify lists of high-priority populations for intervention, and we are improving our ability to include SDOH-HE data in the process. For example, we include the medical and social complexity files supplied by OHA for OHP children into algorithms in development that identify potential members for program interventions and case management services.

Attachment 9, Section D.2.a: Describe how Applicant will use HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). Include in your description how Applicant will implement HIT to administer its initial VBP arrangements and how Applicant will ensure that it has the necessary HIT as it scales its VBP arrangements rapidly over the course of 5 years and spreads VBP arrangements to different care settings. Include in your description, plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements over the 5-year contract, including activities, milestones, and timelines.

Current Operations
Given our experience administering transparent and high-functioning VBP arrangements, the HIT infrastructure to administer VBP arrangements is already in place. This includes employed staff groups, proprietary programs and reports, vendor-provided reports, provider portals, secure file transmission mechanisms, secure email, algorithms, data storage technologies, and reporting tools. We have implemented VBP arrangements in many care settings, including primary care, non-emergency medical transportation, oral health care, BH, substance use disorder residential, detox services, and inpatient and outpatient.

To scale and spread VBPs arrangements, we invest significant staff time and organizational resources each year to support the financial and clinical performance of providers in evolving VBP models. We review contract terms and metrics as they are being developed, and we build annual work plans to ensure that the necessary HIT, infrastructure, and reporting mechanisms are in place prior to the start of the measurement year. This preparation phase—often several months or a year leading up to distributing payment through a VBP arrangement—involves workflow development, HIT implementations, and regular reporting to support the new arrangement or measure.
We use HIT throughout the process of administering VBP arrangements, such as to store non-claims data, calculate metrics, and make payments. We use HIT to build a suite of performance reports that analyze claims and enrollment data monthly. In several VBP models, we build clinic-based measures to report on data generated by providers about their performance. For example, we have built HIT systems to receive and report on electronic clinical quality measure data from clinics on a monthly basis. In other VBP arrangements, we calculate “hybrid” measures that require us to join provider data from EHRs with claims data. For example, we have built the HIT to support certain BH arrangements where we receive lists of members who receive non-encounterable services to integrate with claims data to calculate the population reached by the service. Lastly, we have built the HIT infrastructure necessary to administer retrospective and prospective capitation adjustments in VBP arrangements.

By the Contract Effective Date
PSCS uses HIT to administer VBP arrangements, meeting needs for transparent financial reporting and actionable performance information. All existing processes will remain in place at the start of contract Year 1 in 2020

Future Plans through the Five-Year Contract Period
Given the significant variability in clinical information exported from EHRs, such as in the form of HL7 messages and Consolidated Clinical Document Architecture documents, we started data normalization efforts in 2018 and will continue this work through 2024 in a pilot program between PSCS, Reliance eHealth Collaborative, and Diameter Health. The early stages of this pilot allowed us to calculate a complete set of clinical measures from the HIE and validate these measures against the source EHR systems. These ongoing efforts will help ensure that fragmented values and clinic code set information from HL7 sources can support standard NCQA certified measures. This work will broaden the reach of reportable data, especially in situations where clinics do not have the EHR reporting infrastructure in place to support custom measures. If successful, this pilot will lay the foundation for transparency in measure performance at a system level and dramatically improve the timeliness of reporting.

**Goal:** HIT supports Value Based Payment (VBP) arrangements through scale and spread of performance measurement in VBP strategies.

**Strategy 10 (HIT VBP and Metrics)**

Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements

**Milestones and Activities**

| By 12/31/19 | Complete trial of Diameter Health in partnership with Reliance eHealth Collaborative  
Determine if the Diameter tool will transform and standardize clinical data to use alongside claims information for quality measure calculation |
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<tr>
<td>By 12/31/20</td>
<td>Implement Diameter Health tool or identify alternative strategy to integrate clinical data obtained through HIE in databases used for performance measurement and feedback</td>
</tr>
<tr>
<td>By 12/31/22</td>
<td>Integrate Reliance HIE Clinical data as a supplemental source of encounter data in applicable measures such as eCQM, Quality Incentive Measures, HEDIS, and other measures from Aligned Measure Menu</td>
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</table>
During 2023-2024 | Expand integration of clinical data as a source to calculate additional measures from existing sets in use, such as eCQM, Quality Incentive Measures, HEDIS, and Aligned Measure Menu, consistent with the requirements set forth the in the OHA VBP Road Map

Activities: | This strategy includes activities related to Infrastructure. For details, see attached HIT Roadmap.

Attachment 9, Section D.2.b: Describe how Applicant will support contracted Providers with VBP arrangements with actionable data, attribution, and information on performance. Include in your description, plans for start of Year 1 as well as plans over the 5 year contract, including activities, milestones, and timelines.

Current Operations
PSCS supports contracted providers in VBP arrangements with actionable data, attribution, and information on performance, both financial performance and contracted quality and performance measures. We continue to work with our provider partners to standardize and align approaches across regions. We create standard reporting processes and options and then customize which are delivered to each recipient based on their internal analytics capacity, the nature of their participation in VBP, and the preferences of their staff. Much of this information is proactively delivered via secure transfer processes and is also available on demand through our provider portal. For more sophisticated providers, we provide data interfaces to transfer claims, eligibility, and provider information into their own population health management systems.

By the Contract Effective Date
PSCS has solid capacity to provide actionable data, attribution, and information on performance to providers. All existing processes will remain in place throughout 2019 and 2020.

Future Plans through the Five-Year Contract Period
A significant portion of our work will focus on decreasing the time to receive, calculate, and report on clinical performance, as well increasing the amount of actionable information available at the point of care within the EHR. In addition, we believe that the conduit that HIEs like Reliance e-Health Collaborative provide presents significant opportunity for sharing VBP information between plans and providers. We are actively pursuing a number of opportunities to share actionable information back to provider partners via HIE platforms.

Goal: Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers on a consistent and timely basis.

Strategy 11 (HIT for VBP Action-Attribution-Performance)
Provider attribution supports accurate payment incentives for primary care and specialist physical health providers

Milestones and Activities

| By 12/31/19 | Complete a thorough evaluation of existing PCP assignment and attribution processes to identify where improvements need to be made. |
| By 12/31/19 | Develop attribution capability to inform specialists about their performance related to peers |
| | Implement software to attribute specialist providers to members for procedures and condition-based episodes of care |
By 12/31/20

Improve from 2019 baseline of existing PCP assignment and attribution

Produce monthly specialist performance reporting

**Activities:** This strategy includes activities related to Assessment, Education, and Infrastructure. For details, see attached HIT Roadmap.

| **Goal:** Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers on a consistent and timely basis. |
| **Strategy 12 (HIT for VBP Action-Attribution-Performance)** |
| Implement and develop measures for VBP arrangements that focus on provider efficiency to give providers the information they need to address areas of inefficiency and potential waste

**Milestones and Activities**

| **By 12/31/19** | Integrate Milliman MedInsight software in PSCS IT environment |
| **By 12/31/20** | Develop Phase 1 reports for use in 2021 VBP contracts  
Deliver reports to providers on a monthly basis |
| **During 2021-2024** | Develop later phase reports for use in 2022-25 VBP contracts, including member level detail |
| **Activities:** This strategy includes activities related to Assessment, Education, and Infrastructure. For details, see attached HIT Roadmap.

**Goal:** Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers in a consistent and timely basis.

**Strategy 13 (HIT for VBP Action-Attribution-Performance)**

Implement and or develop a comprehensive list of measures that align with state efforts to standardize measures in VBP arrangements to share with provider partners in VBP arrangements

**Milestones and Activities**

| **By 12/31/19** | Align at least 60% measures in our VBP arrangements with the OHA Aligned Measures Menu where applicable measures exist for particular providers or care domains |
| **By 12/31/20** | Continue to align measures in our VBP arrangements with the OHA Aligned Measures Menu |
| **During 2021-2024** | Continue development to align measures in our value based arrangements with the OHA Aligned Measures Menu as measures are added or changed |
| **Activities:** This strategy includes activities related to Assessment, Education and Infrastructure. For details, see attached HIT Roadmap.

Attachment 9, Section D.2.b(1): Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:

1. Timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers;

**Current Operations**

We provide timely financial and performance reports including member-level detail to providers on monthly and quarterly schedules. We will continue to do this at the start Year 1 and
throughout the five years of the CCP contract. Prior to the start of every measurement year, we program our reporting platforms and adapt dashboards or reports to reflect the measures. This allows us to inform providers of current performance and typically includes historic baseline performance going back at least two years at the start of the measurement year. In addition, we send monthly financial reports to contracted that include revenue, claims expense, administrative expense, health services costs, and estimated upside and downside risk, along with relevant quality and utilization detail. Since 2018, PSCS has received clinical data from provider EHRs on a monthly basis. This process allows us to identify problems with clinical workflows or data quality early in the year, support providers to remedy identified problems, and produce a comprehensive set of timely reports and dashboards that are used internally and shared with provider partners and key stakeholders.

By the Contract Effective Date
PSCS has solid capacity to provide actionable data, attribution, and information on performance to providers. All existing processes will remain in place throughout 2019 and 2020.

Future Plans through the Five-Year Contract Period
Through 2024, PSCS will continue to develop quality reporting that reaches beyond individual provider EHRs and data systems to integrate data from multiple organizations that have provided services to members in common. We will continue our partnership with Reliance to develop Reliance Insight, a comprehensive tool that provides reports, analytics, and data for our member population. We hope that this tool will form a foundational component to allow providers to evaluate programs and services for effectiveness and to raise quality scores by breaking down information silos.

Attachment 9, Section D.2.b(2): Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:

(2) Accurate and consistent information on patient attribution; and

Current Operations
PSCS provides accurate and consistent information on patient attribution on a monthly or more frequent basis to providers with assigned populations. We will continue to do this at the start Year 1 and throughout the five years of the CCO contract. We currently provide, and will continue to provide, regular reports on patient attribution which undergo internal quality checks to ensure that they accurately represent our internal data. Providers may also lookup a member’s attribution at any time through our provider portal. Some examples of patient attributions that we store and maintain are primary care assignment, assignment to community mental health provider, and DCO assignment. In additional to primary care assignment tracking, we have developed claims-based attribution logic as a comparison to verify the accuracy of the PCP assignment.

By the Contract Effective Date
PSCS has solid capacity to provide actionable data, attribution, and information on performance to providers. All existing processes will remain in place throughout 2019 and 2020. In addition, the current enterprise strategic plan element around improving the process for PCP attribution or assignment will be completed and improvements implemented internally in the processes, quality checks, and workflows that pair each member with their primary care provider.
Future Plans through the Five-Year Contract Period
As summarized in Strategy 11 above, we are currently pursuing a strategic initiative to improve provider attribution. This initiative has two foci: continued improvement in primary care attribution and attribution of patients to specialists, care teams, and groups of providers involved in an episode of care. In support of this initiative, we recently acquired new episode grouper algorithms that connect providers of any type with specific episodes of care. Using this tool, we will be able to inform providers of their performance compared to others and benchmarks, to inform where they need to focus to improve quality and efficiency of care. These new models not only support providers in understanding opportunities for performance improvement, but also provide opportunities for evolution of VBP arrangements during the contract period.

Attachment 9, Section D.2.b(3): Include an explanation of how, by the start of Year 1, the Applicant will provide contracted Providers with VBP arrangements with each of the following:
(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

Current Operations
PSCS provides contracted providers on a monthly basis with information about specific patients who need intervention through the year to enable them to take action before year end. We will continue to do this at the start of Year 1 and throughout the five years of the CCO contract. To assist providers in identifying patients who need intervention, we provide them with measure-specific information, flagging members with gaps in care “Gap lists,” and with more general information about the health status and possible needs of their assigned population of members via a proprietary report, the Member Insight report. This member-level report includes prospective risk scores and risk stratification, demographics, flags for community or PSCS program involvement, presence of diagnosed chronic conditions, primary care and dental care assignment, and historical costs and utilization including PCP visits, emergency department visits, and hospitalizations. The data is updated and published for providers monthly.

As a complement to Member Insight reporting, we provide gap lists for performance measures. For example, providers might receive a list of members who are eligible for developmental screening but have not received one. When information is not claims-based but is instead EHR-based, such as results on the Hemoglobin A1c test in diabetics, we work with organizations to ensure they have the capability to report and identify members of interest in their own internal reporting. We work with providers in these situations to ensure that they have ways to access their own member level data and route the data to clinical care teams, as well as supporting them with quality review and technical assistance.

By the Contract Effective Date
PSCS has solid capacity to provide actionable data, attribution, and information on performance to providers. All existing processes will remain in place throughout 2019 and 2020.
In addition, we will complete a 2019 Transformation and Quality Strategy project that involves augmenting the data sources that providers use to identify members who may need intervention. In this initiative, PSCS is supporting providers to use reports from the CMT PreManage platform to identify patients who may need intervention, for example members with SPMI and/or Special Health Care Needs who seek care in emergency departments.
Future Plans through the Five-Year Contract Period

PSCS will augment its clinical data warehouse starting in 2020 to allow generation of member lists that go beyond those tied to existing Quality Incentive Measures and contract metrics. Our plans include incorporating additional SDOH-HE information and enhanced REAL+D data beyond what is currently available. Finally, PSCS will continue to refine the recently implemented algorithm to augment the current, manual process to identify members for care management programs. This proprietary algorithm integrates demographics, risk score methodology, SDOH&HE data (where available), utilization, diagnosis information, and other factors to identify members eligible for specific health promotion and care management programs. When members are identified through this process, our Care Management Team works with the member and provider to assess eligibility and appropriateness for the program and ascertain the member’s interest in engaging in programs.

Attachment 9, Section D.2.c: Describe other ways the Applicant plans to provide actionable data to your Provider Network. Include information on what you currently do, what you plan to do by the start of the Contract (Jan. 1, 2020), and what you intend to do in the future. Please include a narrative as well as a roadmap that includes activities, milestones and timelines.

While information on clinical metrics and financial performance is crucial for our providers, especially for those in payment models that tie payment to performance, PSCS also provides actionable data to our Provider Network to achieve broader goals. Our experience has shown that organizations are receptive to good quality data that, for example, identifies patients who will most benefit from outreach or specific assistance, demonstrates patterns in care and utilization, and illustrates ways to control costs that stem from low-value care and unexplained variation.

Current Operations

In 2018, we developed and deployed a tool that complements Member Insight, the Provider Insight report suite. This proprietary set of reports provides feedback on practice performance and individual providers. Together, Member Insight and Provider Insight make up “MiPi,” which provides a robust information sharing platform that supports population analysis and member-specific information sharing.

By the Contract Effective Date

PSCS uses multiple reporting mechanisms and delivery methods to provide actionable data to providers. All existing processes will remain in place at the start of contract Year 1 in 2020.

Future Plans through the Five-Year Contract Period

During 2020-2024 PSCS will augment its ability to provide partners with information that supports them to act in ways that improve quality of care for members, engage individuals in appropriate outreach and programs, and incorporate clinical, social, and consumer information with claims and demographic data.
**Goal: Providers have information to improve care for individuals and populations and control costs**

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<thead>
<tr>
<th>Strategy 14 (HIT VBP General)</th>
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<tbody>
<tr>
<td>Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support</td>
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<tr>
<th><strong>Milestones and Activities</strong></th>
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<tr>
<td><strong>By 12/31/19</strong></td>
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<tr>
<td>Implement reporting of additional information to provider partners that supports population health management and quality of care</td>
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<td><strong>By 12/31/20</strong></td>
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<tr>
<td>Add new information based on new reporting capacity based on growth in scope of available information</td>
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<tr>
<td><strong>During 2021-2024</strong></td>
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<tr>
<td>Annually implement new tools and algorithms</td>
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**Activities:** This strategy includes activities related to Assessment, Technical Assistance, and Infrastructure. For details, see attached HIT Roadmap.

Attachment 9, Section D.2.d: Describe how you will help educate and train Providers on how to use the HIT tools and data that they will receive from the CCOs.

In addition to pairing PSCS and provider IT leadership and meeting quarterly, we have tasked specific staff members with supporting and training individual provider groups and back office teams. We plan to continue our educational efforts and expand them.

**Education and Training: In Clinics.** We will offer training to medical assistants, other support staff, and providers. This training will include how to use data and tools to help improve patient outcomes. Our training will not be delivered as a mandate for clinics, but rather as a collaborative option for process improvement to improve health outcomes and efficiency. We will focus on identifying opportunities for administrative simplification within the practice by leveraging existing tools.

**Education and Training: Community Collaboratives.** PSCS values convening regular meetings to share information and collect input. For example, through our participation and support of COHIE, we began hosting a quarterly HIE Community Stakeholders meeting focused on providing updates on the strategy for the adoption and implementation of HIE and HIT. The collaborations have provided a valuable venue for networking, demonstrations of HIE technologies and updates on strategic plans such as the deployment of OHA’s HIE Onboarding Program. We will expand on this HIT community collaborative strategy. We will also convene topic-specific collaboratives with community providers and provider partners as opportunities or other needs arise.

**Education and Training: State and Local Collaboratives.** We will support providers in taking advantage of state and local collaboratives. These collaboratives promote increased knowledge and awareness as well as specific strategies to improve workflows and coordination. For example, the OHLC has created an EDIE/PreManage Learning Community to enable the spread of best practices and general information sharing in the community of EDIE and PreManage users. The Learning Community provides a central repository of resources and tools and promotes peer networking.
Data: Member Insight/Provider Insight Reports and Gap Lists. When we meet with providers, we will review dashboards and gap lists to ensure that provider partners and their staff understand how to use and “work” the reporting. During this review, we will discuss what these numbers mean, how to drill down into the detail, and what the organization can take away as action items. The data can also help drive workflow changes that improve performance and efficiency. The reporting we developed is updated timely and immediately actionable.

Tools: Collective Medical Platform. We will offer provider training on EDIE/PreManage using several methods. In the initial onboarding stage, we will support dedicated trainers from the Collective Medical Technology staff in providing a complete demonstration to the provider and supporting them in building the knowledge necessary to set up the system and get started. This training can be delivered on-site or remotely. Collective Medical also employs clinic success staff dedicated to the Pacific Northwest that support practices regarding the tool and its operations. PSCS will help facilitate those connections. In addition, we will help providers access bi-weekly webinars, training videos, and an online community as further opportunities for providers to become engaged in all aspects of the platform.

Tools: Reliance eHealth Platform. In regions that have established access to Reliance, we will support provider training using several methods. In the initial onboarding stage, implementation specialists from Reliance will educate and support the provider and staff. Training is available on site and remotely. For continuity, these same implementation specialists support practices after go-live when there are questions and concerns regarding the tool and its operations. PSCS will facilitate these connections and also help providers and staff access training webinars and videos from Reliance. If regions choose a different platform to serve as their Regional Health Information Organization, we will similarly support the success of their providers.

Education: Reliance Insight. The Reliance Insight product is an analytics platform that supports the reporting aspects around health information exchange and various clinically based measures. We piloted this tool, but we have not yet trained provider offices. In 2019 and 2020, we will train providers and expand our training on the Insight product to include the Community Health Record portal if it progresses on schedule.

Attachment 9, Section D.2.e(1): Describe the Applicant’s plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following: (1) Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.

Current Operations
PSCS has long used an advanced HIT infrastructure to process, aggregate, and analyze data in support of population health management and VBP. We know the limitations of retrospective risk stratification using claims and gather and store current clinical data and prospective information about clinical and social factors, some of which is integrated and some of which is still being tested for inclusion. We also moved away from an all-in-one population health
solution to a module-based “best of breed” approach. This change has allowed us to select tools such as analytic models or algorithms to fulfill a specific need while still providing a consistent user interface for each monthly re-stratification via our Member Insight/Provider Insight platform. With this new approach, we now provide a comprehensive view of populations and individuals that includes past health care claims, clinical information, and predictive indicators that can help PSCS and providers to focus our outreach and intervention efforts.

By the Contract Effective Date
PSCS has multiple strategies and processes to use HIT for population health management, including supporting providers with VBP arrangements. All existing processes will remain in place at the start of contract Year 1 in 2020. We will continue to have access to multiple data streams and internal processes that are capable of normalizing and integrating claims, clinical data from HIE such as Reliance and PreManage, consumer data, and results from new member screenings. We use the suite of analytics tools described in section D.2.h.(3), relying most heavily on Truven Health Analytics/IBM Watson, Cotiviti and internally-developed algorithms to generate the information shared through the Member Insight/Provider Insight platform. Providers receive this data via secure transmission methods, and the risk stratification is updated monthly, as are other data.

Future Plans through the Five-Year Contract Period
In the coming years, we will update our stratification processes to incorporate enrollment in care management programs and clinical and social data. In addition, by 2021, we will generate reports weekly and ultimately daily or in real-time where appropriate. This will be coupled with the existing consolidated cockpit approach, removing the need for users to log into different systems to garner different pieces of information. This approach improves efficiency and helps to ensure critical indicators are not missed when PSCS care managers or our provider partners are interacting with patients. We will continue to enhance the distribution mechanisms discussed above to make this information available to providers and support their success.

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<thead>
<tr>
<th>Goal: HIT supports improved population health through risk stratification and sharing of member characteristics.</th>
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<tbody>
<tr>
<td><strong>Strategy 15 (HIT for Population Health)</strong></td>
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<tr>
<td>Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources</td>
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<td><strong>Milestones and Activities</strong></td>
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<td><strong>By 12/31/19</strong></td>
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<td><strong>By 12/31/20</strong></td>
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<td><strong>During 2021-2024</strong></td>
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<td><strong>Activities:</strong></td>
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Attachment 9, Section D.2.f: What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?

**Current Operations**

As described above in **Section D.2.e**, we currently provide risk stratification and member characteristics using the Member Insight report to our contracted providers with VBP arrangements for the entire population that they serve, with indication of which members are in which populations. We deliver the report using secure transmission methods and through providers accessing our secure portal, whichever they prefer.

In addition to standard reporting through the core Member Insight report, various internal PSCS users and teams frequently develop custom population reports or member lists using the self-service tools provided by the Member Insight/Provider Insight platform. Users generate these reports by selecting specific criteria or risk cohorts that are relevant to the specific need or initiative. Once generated, these reports are easily exported to excel or PDF so that they may be shared with providers on an ad-hoc basis. These member reports are made available via the One Health Port integrated PSCS provider portal (InTouch), secure email, and/or SFTP.

**By the Contract Effective Date**

PSCS currently uses multiple reporting mechanisms and delivery methods to provide risk stratification and member characteristics using the Member Insight report to our contracted providers with VBP arrangements. All existing processes will remain in place at the start of contract Year 1 in 2020.

**Future Plans through the Five-Year Contract Period**

During the contract period, we intend to augment our current capability related to risk stratification and member characteristics through decreasing the time required to update scores from monthly to weekly and piloting the integration of SDOH data and clinical data within the current risk stratification process or through a SDOH identification process that is separate from our current clinical risk stratification. In addition, we will investigate and implement, if warranted, ways to deliver risk stratification and member characteristic information more timely via on-demand access through an application programming interface, through delivering a data source to providers that they can query, or contribute these data to regional HIE systems, such as a RHIO or hospital event notification platform.

Attachment 9, Section D.2.g: Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.).

**Current Operations**

PSCS has developed systems to include some information beyond claims in our integrated data warehouse in order to gather information on and measure population health status and outcomes. Current work focuses on identifying and compiling the types of SDOH-HE information currently available, as well as determining respectful and trauma-informed ways to share the information with providers while honoring privacy rules for health care as well as the sector where the information was obtained. We also integrate clinical data to augment the information available.
from claims. Examples are laboratory data to identify diabetes control status, hospital admission data, and vital signs.

By the Contract Effective Date
We will ensure that consultations with stakeholders, including Community Advisory Council members, will be complete by the end of 2019. PSCS staff will also complete staging and modeling of SDOH-HE data sources that are available to determine their viability for integration in the enterprise data warehouse.

During the five year contract
PSCS will continue to identify and evaluate potential sources of non-claims data for integration, will identify or develop definitions for common SDOH-HE elements, and will pursue an annual cycle of work planning to obtain data from providers, members, and other organizations. Early data targeted for evaluation are REAL+D data and childhood health complexity codes from the OHA as well as consumer data.

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<tr>
<th>Goal: HIT supports VBP and population management through collection and sharing of Social Determinants of Health and Health Equity (SDOH&amp;HE) data in a respectful and trauma informed manner.</th>
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<tr>
<td><strong>Strategy 16 (HIT for Population Health)</strong></td>
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<tr>
<td>Augment the existing information provided in the Member Insight/Provider Insight tool with SDOH-HE data in a way that is meaningful and helpful to providers while not stigmatizing members</td>
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<tr>
<th>Milestones and Activities</th>
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<tbody>
<tr>
<td><strong>By 12/31/19</strong> Complete assessment of SDOH-HE information currently available and of viability for inclusion in data warehouse</td>
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<tr>
<td><strong>By 12/31/20</strong> Integrate SDOH-HE data in information used internally and reported to providers</td>
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<tr>
<td><strong>By 12/31/21</strong> Complete two cycles of design and expansion of clinical data warehouse with additional clinical and SDOH-HE data</td>
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<tr>
<td><strong>During 2022-2024</strong> On an annual basis, identify opportunities to expand our storage capabilities for SDOH-HE data reported by providers and members</td>
</tr>
<tr>
<td><strong>Activities:</strong> This strategy includes activities related to Assessment, Governance, and Infrastructure. For details, see attached HIT Roadmap.</td>
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Attachment 9, Section D.2.h: Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

Current Operations:
PSCS has established strong HIT competency for the purposes of supporting VBP arrangements and population management. Our current status is described below in detail in response to Sections D.2.h(1)-(7). Unless otherwise specified, the description of status and activities are items currently in place and fully operational.
By the Contract Effective Date
All existing processes described in Sections D.2.h (1)-(7) will remain in place at the start of contract Year 1 in 2020. We detail our expected additional capacity, below.

Future Plans through the Five-Year Contract Period
PSCS intends to continue to improve capacity, stability, security, and efficiency of our HIT capabilities in the service of VBP arrangements, population management, cost control, and improved support for the providers who serve our members. Our plans related to data storage, strategy around analysis software, and reporting platforms are described in the following table from the attached HIT Roadmap.

<table>
<thead>
<tr>
<th>Goal: PSCS has robust HIT capabilities to support VBP and population management.</th>
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<tr>
<td><strong>Strategy 17 (HIT Capability)</strong></td>
</tr>
<tr>
<td>Continue to build a scalable, stable, and effective array of data storage solutions, modular software for analysis, and reporting platforms</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td><strong>By 12/31/19</strong> Complete multi-year initiative to leverage cloud-based data warehouse technology</td>
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<tr>
<td>Complete 2019 stage of modular analytics transition</td>
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<tr>
<td><strong>By 12/31/20</strong> Implement chosen solution for data warehouse</td>
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<tr>
<td>Assess platform and data model for provider access for reporting</td>
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<tr>
<td><strong>During 2021-2024</strong> Continue annual implementation of modular analytics transition</td>
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<tr>
<td>Convert to standardized reporting</td>
</tr>
<tr>
<td><strong>Activities:</strong> This strategy includes activities related to Infrastructure. For details, see attached HIT Roadmap.</td>
</tr>
</tbody>
</table>

Attachment 9, Section D.2.h(1): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items: (1) Data sources: What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?

Current Operations: Data Sources
We draw on a variety of data sources, as detailed below. Our use of cloud-oriented services, other distributed services, and on-premises software installation allow us to add extended demographic data as well as implement models to create analytics scores and groupers. Direct and feed-oriented connection to provider EHRs and HIE tools allow us earlier and more detailed access to clinical data to assist many operational activities, such as chart review for closing gaps in Quality Incentive Measures. Finally, we support data feeds through a range of integration tools. This capability is one of the more mundane ways we bring in data, but it is critical to be flexible in working with many different providers in many different ways, and we continue to invest in this capability through hiring expert staff.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Source</th>
<th>Updated</th>
<th>Collection Method</th>
<th>Quality Check</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims and Encounter Data (physical, BH, NEMT)</strong></td>
<td>PSCS FACETS claims system</td>
<td>Daily</td>
<td>Processed and loaded from FACETS to PSCS enterprise data warehouse</td>
<td>Automated unit tests and manual monitoring of encounter triangles</td>
</tr>
<tr>
<td><strong>Pharmacy Claims</strong></td>
<td>Caremark PBM Encounter files</td>
<td>Daily</td>
<td>Processed and loaded into FACETS and data warehouse</td>
<td>Automated unit tests and manual monitoring of encounter triangles</td>
</tr>
<tr>
<td><strong>Dental Encounters</strong></td>
<td>DCO encounter files (835 format)</td>
<td>Weekly</td>
<td>Processed and loaded into Data Warehouse</td>
<td>Automated unit tests and manual monitoring of encounter triangles</td>
</tr>
<tr>
<td><strong>Hospital Events</strong></td>
<td>EDIE/PreManage tool</td>
<td>Weekly</td>
<td>Data extract from and integration into a table</td>
<td>Automated unit tests and manual monitoring of encounter triangles</td>
</tr>
<tr>
<td><strong>Member-Reported Health Status</strong></td>
<td>SF-12 risk screening</td>
<td>Once per member</td>
<td>Manual entry, stored in a PacificSource-developed tracker tool</td>
<td>Automated unit tests on monthly data volume</td>
</tr>
<tr>
<td><strong>Immunization Status</strong></td>
<td>Oregon Alert Data Registry</td>
<td>Quarterly</td>
<td>Flat file loaded into data warehouse</td>
<td>Automated unit tests on monthly data volume</td>
</tr>
<tr>
<td><strong>Laboratory Test Results</strong></td>
<td>Laboratory service providers</td>
<td>Monthly</td>
<td>Flat file loaded into data warehouse, then into HEDIS measure engine.</td>
<td>Unit testing and manual review monthly, external audit annually</td>
</tr>
<tr>
<td><strong>Consumer Information</strong></td>
<td>Acxiom including Personix Lifestage Cluster</td>
<td>Semi-annually, monthly for new members</td>
<td>Extract file loaded into Data Warehouse</td>
<td>Automated unit tests</td>
</tr>
<tr>
<td><strong>Clinical Data for eCQM and Hospital Measures</strong></td>
<td>Health care providers (clinics and hospitals)</td>
<td>Monthly</td>
<td>Generated using custom queries or programmed measures, loaded into Data Warehouse</td>
<td>Monthly validation checks for red flags such as anomalies and unexpected change</td>
</tr>
<tr>
<td><strong>Clinical Data for Hybrid Measures</strong></td>
<td>Health care providers (clinics and hospitals)</td>
<td>Monthly or per contract</td>
<td>Data files generated by providers are sent via SFTP or secure email</td>
<td>Manual review and matching of data to claims</td>
</tr>
</tbody>
</table>
Current Operations: Integration of New Data Sources
With respect to how we add new data sources, our approach is to incrementally extend our centralized, managed enterprise data warehouse. Once we identify a new source, we stage the data into the data warehouse environment to make them available to the Analytics staff. Next, depending on the use case, we will often integrate the data into the data warehouse subject models. For example, we add supplemental clinical data for addressing Quality Incentive Measures gaps in care to a centralized supplemental data model designed for that purpose.

Current Operations: Data Quality
To facilitate high-quality data, our developers and Analytics team members are trained on multiple mechanisms for quality assurance. Our standard process is to develop source-to-target validations to ensure completeness of the data after loading. These validations are then run on the final staged data using techniques such as checksum and unit count comparisons. Once these tests are developed they are automated to monitor the data load process once implemented. A comprehensive suite of these data quality tests are run nightly on all data warehouse sources.

Attachment 9, Section D.2.h(2): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

(2) Data storage: Where do you store data (e.g., enterprise data warehouse)?
For over 10 years, PSCS has maintained a robust data warehouse called HPXR, which was originally developed by Trizetto (now Cognizant) as a partner solution to FACETS, our claims processing system. This data warehouse provides a detailed schema for the normalization of administrative claims data. PSCS has taken this base model and extended it significantly since implementation in 2007. We extract, transform, integrate, and store data from enterprise systems such as FACETS, Dynamo, customer relations management system, HEDIS engine, external data feeds, and others primarily in our enterprise data warehouse. We maintain a team of developers dedicated to the modeling, integration, and validation of new data.

Attachment 9, Section D.2.h(3)(a): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

(3) Tools:
(a) What HIT tool(s) do you use to manage the data and assess performance?
PSCS maintains multiple data management and analytics tools to manage data and assess performance, and they are listed below. Through our partnership with Gartner, we reassess our capabilities on an annual basis, and we regularly pilot new technologies via our Innovation Lab. The tools detailed below provide the infrastructure for the delivery of all of our performance assessment applications, like our Member Insight/Provider Insight report suite:

<table>
<thead>
<tr>
<th>Data storage tools</th>
<th>Microsoft SQL Server and Microsoft SQL Server Analysis Services, Microsoft Azure Data Lake, SAS OLAP Cubes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data modeling tools</td>
<td>Informatica, Edifecs Population Dimension, Microsoft SQL Server Integration Services, Alteryx Designer and Scheduler, Tableau Prep</td>
</tr>
<tr>
<td>Analytics models</td>
<td>Cotiviti-certified HEDIS software, SQL-built Quality Incentive Measures (mirroring OHA specifications), PSCS-developed identification algorithm with risk stratification (v1)</td>
</tr>
</tbody>
</table>
### Advanced analytics processes
- SAS, R integration into Tableau, R integration into Microsoft SQL Server Management Studio, Alteryx Designer

### Analytic languages
- SAS, SQL, C#.NET, Python

Attachment 9, Section D.2.h(3)(b): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. (3) Tools: (b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, monthly, quarterly)?

The analytics tools that we use are listed in **Section D.2.h(3)(b)** as analytics models, processes, and languages. We generate tens of thousands of reports on a routine basis to support CCO performance measurement and monitoring. These reports are delivered via processes discussed below in **Section D.2.g(5)**. The following are examples of reports that we publish, produced on a monthly basis unless otherwise specified:

<table>
<thead>
<tr>
<th>Population</th>
<th>Chronic condition summary, Emergency department utilization, Inpatient utilization, Demographic summary, Enrollment, CCO dashboards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Member</td>
<td>Contract reconciliation status, CCO Finance Report, Medicaid experience Member Insight, Member-to-PCP listing (produced daily), Large claimants, Readmission summaries</td>
</tr>
<tr>
<td>Utilization</td>
<td>Line of business experience, Provider population experience, Claims validation</td>
</tr>
</tbody>
</table>

Attachment 9, Section D.2.h(4): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. (4) Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?

Yes, PSCS has staff who can write and run reports and who can help other staff understand the data. Our staff include data scientists, data analytic specialists, business intelligence report developers, Facets business support developers, Data Integration developers, data architects, risk analysts, actuaries, and actuarial analysts. For 2019, PSCS has 24 FTE staff from these groups allocated to Medicaid, with twelve FTE from analytics and business intelligence teams dedicated to CCO work. The majority of staff are in-house employees, although we do engage contracted staff as well. Staff also make reporting capabilities available to providers and staff in the company via self-service methods using tools like SSRS, Tableau, Microsoft Analysis Services, Power BI, and SSRS report builder.

Over the past six years, we significantly increased the resource and budget for our population health analytics capabilities. We added two new Data Scientist positions and developed an Analytics Innovation Lab focused on the development of new ideas and concepts to leverage current or future HIT. Our staffing model is driven by an annual IT strategic planning process that captures and prioritizes all of the projects requested by the business for the coming year, as well as projects that are part of multiyear strategic plans and roadmaps.
By the Contract Effective Date
To date, we have completed scenario planning to augment our staff capacity so that we will be prepared by the contract start date to serve any additional areas awarded in the CCO 2.0 process. In addition, our annual work planning process starts after contract award notifications, to be completed during the fourth quarter of 2019. This process generates a list of necessary resources to complete critical work, which informs annual staffing plans.

Future Plans through the Five-Year Contract Period
In our work today, we dedicate significant IT staff time to regional CCO work and will continue this commitment during the five years of the next CCO contracts. Throughout the contract period, we will continue annual strategic planning and ad hoc evaluation of specific resource needs in support of regional initiatives. Over the next five years we anticipate greater specialization in our staff around the management of clinical data, member engagement, and value based contracting. We will still focus on hiring and training full-time staff to support long term initiatives but have also developed strong partnerships with a number of consulting organizations to augment shorter term projects.

Attachment 9, Section D.2.h(5): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

(5) Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?

Current Operations
After we run reports, we distribute analysis and results to providers and care coordinators in a variety of ways, depending on the report. Some reports are delivered through SFTP or via secure email, some are made available through InTouch for providers, which allows providers to access reports through their portal, and some reports are made available through committees, workgroups, meetings, or presentations. Often the delivery mechanism is custom based on the preferences and requirements of the provider partner. We also recognize that partnering clinics have their own platforms and tools that enable population management activities and methods to support VBP. For this reason, we support delivery of eligibility and claims-based information by supplying automated, regular extracts for machine-level ingestion. We used both EDI-based standards for this type of sharing as well as flat file approaches that can be easily edited when custom ingestion is necessary.

Within our organization, we disseminate analysis in a variety of ways, depending on the reporting and the organizational need. Reports can be automated (with results delivered via secure email), self-service (where a person can use our provider portal to run the report as needed), interactive visualizations (updated with the most recent information), or in-depth analyses that may have written narrative and associated in-person presentations.

By the Contract Effective Date
During 2019, we will complete a number of initiatives focused on providing new information and updates to our contracted provider partners, often through presentations from our Analytics Specialists. These meetings are scheduled for a variety of venues so that both internal and external stakeholders are advised of any changes. We will also give providers updates regarding
our transition to a different our risk model vendor. While the model itself is still the same, the transition will allow us to provide a greater level of transparency about the information making up those risk scores. Finally, we are currently developing a “report of reports” that gives our provider partners an overview of all of the information they are receiving from us, who it is being sent to, and on what frequency. This report allows us to make sure all of the right information is getting to the right people.

**Future Plans through the Five-Year Contract Period**

Through 2024, we plan to continue our evolution from static reporting to more interactive and visual reporting that often generates more insight into the information presented. Throughout the contract period we have plans to deploy more broadly a web-based interactive visualization platform to support CCO providers and other external stakeholders. This deployment plan is similar to our Tableau based interactive analytics platform we have deployed to support large commercial group clients as well as internal customers with visual analytics.

We are also exploring options to support the delivery of reporting via a mechanism that allows for greater control than SFTP and secure email provide. The specific vendor space we are looking at is called Content Collaborative Platforms, and the platforms function similar to Dropbox. These platforms allow for greater collaboration and controls on distributed content. They are also much easier for providers with less technical skill needed to access.

**Attachment 9, Section D.2.h(6): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.**

(6) Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

To monitor progress on our roadmap and the effectiveness of the HIT supports implemented or proposed to be implemented, we will follow our standard company project management approach. This approach includes development and maintenance of the corporate HIT roadmap as well as integrating elements of the roadmap into the corporate strategic plan. Both documents are “living documents” that are tracked and monitored at least quarterly by senior leadership using quarterly and annual targets. Within the department, IT leaders oversee these projects. The management process includes project chartering, monthly status update to sponsors, IT management and other stakeholders, and project retrospectives including lessons learned. If we identify projects that are at risk for not meeting pre-defined milestones in their charters, we execute risk mitigation plans that can include escalation to senior leadership. We are proud to maintain a successful delivery rate of 90% enterprise-wide on hundreds of projects each year.

**By the Contract Effective Date**

During 2019, an updated roadmap will be completed for an existing enterprise strategic initiative addressing multiple HIT objectives. It will outline our plans and specific targets for architecture, systems, and augmented data sources as well as the process and goals to support EHR and HIE adoption by physical, behavioral and oral health providers over the next three to five years. The results of our performance on this initiative are reported on quarterly to the executive team through a summary dashboard that details our performance against stated goals for elements on the quarterly work plan.

Attachment 9-Health Information Technology
Future Plans through the Five-Year Contract Period
Throughout the contract period we will continue to refresh and update our strategic roadmap, set annual targets, and develop work plans through our annual enterprise strategic process. We anticipate that our roadmap beyond 2020 will include significant focus on integration and exchange of SDoH-HE information, population analytics, and improving accessibility and customization of information for providers.

In addition to the oversight set forth above, we will monitor the effectiveness of HIT supports via a variety of means that include process metrics, outcome metrics, and surveying provider partners on how the strategies are impacting shared VBP and health improvement goals. We will also work in partnership with community organizations to monitor progress and effectiveness. One example of the way we do this now is through participation and support of the Central Oregon Health Information Exchange. PSCS began hosting quarterly HIE community stakeholder meetings focused on providing updates on the strategy for the adoption and implementation of HIE in our regions. These collaborations have created neutral venues for networking, demonstrations of HIE technologies, and updates on strategic activities such as the deployment of the OHA’s HIE Onboarding Program.

Attachment 9, Section D.2.h(7): Describe Applicant’s HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines.

(7) Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

Anticipated Challenges
Based on our existing significant experience with HIT and VBP arrangements, we anticipate the following challenges, for both CCOs and providers:

<p>| HIT Challenges to VBP Arrangements - Potential Barriers and Mitigation Plans |
|-----------------------------|------------------------------------------------------------------|
| <strong>Resources and Infrastructure</strong> |
| <strong>Barrier:</strong> | Constrained IT and EHR capacity of providers, unexpected EHR/HIT issues such as upgrades or changes in reporting modules |
| <strong>Mitigation:</strong> | Continue to provide multiple pathways for providers and CCO to share data and information, build timelines to accommodate unpredictable delays |
| <strong>Barrier:</strong> | Limited IT capacity in providers serving culturally and linguistically-specific needs within CCO population |
| <strong>Mitigation:</strong> | Provide incentives, technical assistance, and flexible contracting arrangements to support continued participation of these providers |
| <strong>Quality and Engagement</strong> |
| <strong>Barrier:</strong> | Poor data quality and inconsistency across EHRs and from HIEs, workflows that fail to accurately capture data to represent performance |
| <strong>Mitigation:</strong> | Internal quality checks on submitted data, education and on-site technical assistance with workflows and EHR programming |
| <strong>Barrier:</strong> | Measurement overload for providers, distraction from important aspects of quality and patient safety not included in contract metrics |</p>
<table>
<thead>
<tr>
<th>Mitigation</th>
<th>Contracting Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Align with statewide measure sets to simplify</td>
<td>Provider confusion over specifics of quality measures</td>
</tr>
<tr>
<td>provider experience, continue capacity payments</td>
<td></td>
</tr>
<tr>
<td>to support clinic level quality improvement staff,</td>
<td></td>
</tr>
<tr>
<td>partner with other CCOs or payers to align</td>
<td></td>
</tr>
<tr>
<td>contract quality measures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contracting Barriers</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider confusion</td>
<td>Education, on-site technical assistance, early and frequent feedback on</td>
</tr>
<tr>
<td>over specifics of</td>
<td>performance, publish measure specifications and attribution methods more</td>
</tr>
<tr>
<td>quality measures</td>
<td>widely</td>
</tr>
</tbody>
</table>

| Staffing and         | Mitigation                                                                 |
| Infrastructure       |                                                                            |
| Expense and strain   | Increase automation to support real-time communication with providers,     |
| placed on providers  | continue to partner with RHIOs and other HIEs to share information bi-     |
| and CCOs by increasing| directionally, create consistent points of contact within PSCS for         |
| needs for reporting  | providers that are independent of business line.                           |
| and responding to    |                                                                            |
| information          |                                                                            |

**Adverse Impacts from Planned Projects or Upgrades**

We anticipate no adverse impacts from current or future planned projects or upgrades. We are evaluating a number of HIT solutions specifically aimed at providing better VBP support to our internal and external stakeholders. All of the solutions being evaluated are expansions or modules built on existing platforms that already exist in production. These initiatives are managed under two enterprise strategic initiatives: 1) Enterprise Process Scalability and 2) Provider Partnerships. Many of the platforms that we have evaluated, but not adopted, have proven to be fairly immature in their development. We continue to be cautious and monitor closely to ensure we adopt best of breed solutions.
### Attachment 9, Section B.1.a

**Goal: Increase rate of EHR adoption among contracted physical health providers**

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
<th>Step 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1</td>
<td>Task 2</td>
<td>Task 3</td>
<td>Task 4</td>
<td>Task 5</td>
</tr>
<tr>
<td>Strategy 1</td>
<td>Strategy 2</td>
<td>Strategy 3</td>
<td>Strategy 4</td>
<td>Strategy 5</td>
</tr>
</tbody>
</table>

... (additional steps and strategies)
### Attachment 9, Section B.1.a

**Goal: Increase rate of EHR adoption among contracted physical health providers**

| Provider Type          | Action | Timeframe | Outcome
|------------------------|--------|-----------|---------
| Physical Health        | Increase adoption rates | 2023-2025 | 80%

### Attachment 9, Section B.1.b

**Goal: Increase rate of EHR adoption among contracted Behavioral Health providers**

| Provider Type          | Action | Timeframe | Outcome
|------------------------|--------|-----------|---------
| Behavioral Health      | Increase adoption rates | 2023-2025 | 80%
Goal: Increase rate of EHR adoption among contracted Behavioral Health providers
### Attachment 9, Section B.1.c

**Goal: Increase rate of EHR adoption among contracted oral health providers**
Attachment 9, Section B.1.c

Goal: Increase rate of EHR adoption among contracted oral health providers
Attachment 9, Section C.1.a-c

**Goal:** Providers in all sectors improve their ability to provide coordinated care through use of HIE.
Attachment 9, Section C.1.d-f

Goal: Increase use of HIE for hospital event notification by providers
Attachment 9, Section C.1.g

**Goal: Improve CCO contribution to hospital event notification**

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establish clear communication channels between CCO and hospitals</td>
</tr>
<tr>
<td>2.</td>
<td>Develop standardized hospital event notification criteria</td>
</tr>
<tr>
<td>3.</td>
<td>Enhance CCO's ability to interpret and act upon hospital data</td>
</tr>
<tr>
<td>4.</td>
<td>Implement real-time event notification system</td>
</tr>
<tr>
<td>5.</td>
<td>Conduct regular training sessions for CCO staff on hospital event management</td>
</tr>
<tr>
<td>6.</td>
<td>Establish a feedback mechanism to continually improve service delivery</td>
</tr>
<tr>
<td>7.</td>
<td>Monitor and report on CCO contribution to hospital event resolution</td>
</tr>
<tr>
<td>8.</td>
<td>Collaborate with hospitals to adjust event notification strategies as needed</td>
</tr>
<tr>
<td>9.</td>
<td>Review and update CCO contribution guidelines annually</td>
</tr>
<tr>
<td>10.</td>
<td>Ensure compliance with hospital event notification protocols</td>
</tr>
</tbody>
</table>

Note: The tasks outlined above are indicative of the overall goal and can be customized based on specific CCO and hospital needs.
**Attachment 9, Section D.2.a**

**Goal:** HIT supports Value Based Payment (VBP) arrangements through scale and spread of performance measurement in VBP strategies.

<table>
<thead>
<tr>
<th>Table Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>Spread</td>
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<tr>
<td>Performance</td>
</tr>
<tr>
<td>Measurement</td>
</tr>
<tr>
<td>VBP Arrangements</td>
</tr>
<tr>
<td>Strategies</td>
</tr>
</tbody>
</table>
Attachment 9, Section D.2.b

Goal: Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers on a consistent and timely basis.
**Attachment 9, Section D.2.b**

**Goal:** Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers on a consistent and timely basis.

<table>
<thead>
<tr>
<th>Goal: Actionable data about cost and clinical performance reporting is grounded in accurate attribution and delivered to providers on a consistent and timely basis.</th>
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<tbody>
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Attachment 9, Section D.2.c

Goal: Providers have information to improve care for individuals and populations and control costs
### Attachment 9, Section D.2.e

**Goal:** HIT supports improved population health through risk stratification and sharing of member characteristics.

### Attachment 9, Section D.2.g

**Goal:** HIT supports VBP and population management through collection and sharing of Social Determinants of Health and Health Equity (SDOH&HE) data in a respectful and trauma informed manner.
**Attachment 9, Section D.2.h**

**Goal:** PSCS has robust HIT capabilities to support VBP and population management.

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<td>Integrate existing data sources</td>
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<td>Conduct user acceptance testing</td>
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<td>Deploy online patient portals</td>
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<td>Expand telemedicine services</td>
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<td>Enhance care coordination tools</td>
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<td>Increase population health metrics reporting</td>
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<td>Streamline data migration processes</td>
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<td>Automate clinical decision support mechanisms</td>
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<td>Establish data privacy and security policies</td>
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*Note: Tasks are prioritized based on importance and feasibility.*
# Table of Contents

**ACKNOWLEDGEMENTS**  
4

**SUMMARY**  
5

**INTRODUCTION**  
7

**METHODS AND LIMITATIONS**  
8

**DEMOGRAPHICS OF CENTRAL OREGON**  
9

- POPULATION  
  9
- SOCIOECONOMIC STATUS  
  10
- DISABILITY  
  11
- FOOD INSECURITY  
  11
- SAFETY AND VIOLENCE  
  12
- HOUSING  
  13

**CAUSES OF DEATH**  
14

- YEARS OF POTENTIAL LIFE LOST (YPLL)  
  16

**QUALITY OF LIFE**  
17

**CHRONIC DISEASES**  
18

- ASTHMA  
  18
- CANCER  
  21
- CARDIOVASCULAR DISEASE  
  25
- DIABETES  
  27
- RISK FACTORS AND COMPLICATIONS FOR CHRONIC DISEASE  
  30
- CCO MEASURES  
  34

**COMMUNICABLE DISEASES**  
35

- IMMUNIZATIONS  
  35
- VACCINE PREVENTABLE DISEASES  
  37
- HEPATITIS  
  38
- SEXUALLY TRANSMITTED INFECTIONS  
  39
- VECTOR BORNE DISEASE  
  41
- DIARRHEAL DISEASE  
  41
- HEALTHCARE ASSOCIATED INFECTIONS (HAI)  
  42
- CCO MEASURES  
  42

**MATERNAL HEALTH AND PREGNANCY**  
43

- PRENATAL CARE  
  43
- BIRTHS  
  44
- PREGNANCY RISK FACTORS  
  46
- UNINTENDED PREGNANCY  
  49
- CCO MEASURES  
  49

**INFANT, EARLY CHILDHOOD AND ADOLESCENT HEALTH**  
50

- BREASTFEEDING  
  50
- CHILD AND FAMILY SUPPORT  
  51
- CHILDHOOD HEALTH AND EDUCATION  
  52
- CHILD AND ADOLESCENT HEALTH RISK FACTORS  
  53
- ADVERSE CHILDHOOD EXPERIENCES (ACES)  
  54
- CCO MEASURES  
  55
# Table of Contents

**MENTAL HEALTH**
- YOUTH 56
- ADULTS 56
- SUICIDE 57
- CCO MEASURES 58

**ALCOHOL, TOBACCO AND OTHER DRUG USE**
- ALCOHOL 59
- TOBACCO 59
- PRESCRIPTION OPIOIDS 62
- CCO MEASURES 62

**UNINTENTIONAL INJURIES**
- MOTOR VEHICLE CRASHES 63
- POISONING 66
- FALLS 67
- RISK FACTORS FOR INJURY 68

**ORAL HEALTH**
- CHILDREN 69
- ADULTS 72

**ENVIRONMENTAL HEALTH**
- TRANSPORTATION 73
- AIR QUALITY 75
- WATER QUALITY 76
- LEAD 76

**ACCESS TO HEALTHCARE**
- COMMON REASONS TO ACCESS HEALTHCARE 77
- SPECIFIC ACCESS TOPICS 79
- GAPS IN CARE 80
- CCO MEASURES 83

**GLOSSARY AND ACRONYMS**
- RESOURCES 84

**APPENDIX A**
- 87

**APPENDIX B**
- 88
### Acknowledgements

Thank you to the follow people for their contribution to this document:

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<tr>
<td>Alfredo Sandoval</td>
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<td>Oregon Housing and Community Services</td>
</tr>
<tr>
<td>Kris Williams</td>
<td>Tobacco Prevention and Education Coordinator</td>
<td>Crook County Health Department</td>
</tr>
<tr>
<td>Leslie Neugebauer</td>
<td>Central Oregon CCO Director</td>
<td>PacificSource Community Solutions</td>
</tr>
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<td>Lindsey Hopper</td>
<td>Executive Director</td>
<td>Central Oregon Health Council</td>
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<tr>
<td>Lori Wilson</td>
<td>Virtual Assistant</td>
<td>Central Oregon Health Council</td>
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<tr>
<td>Maggie O’Connor</td>
<td>Community Benefit and Wellness Manager</td>
<td>St. Charles Health System</td>
</tr>
<tr>
<td>Michelle Kajikawa</td>
<td>Community Health Worker</td>
<td>Central Oregon Independent Practice Association</td>
</tr>
<tr>
<td>Muriel DeLaVergne-Brown</td>
<td>Public Health Director</td>
<td>Crook County Health Department</td>
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<tr>
<td>Nancy Tyler</td>
<td>Adult Treatment Program Manager</td>
<td>Deschutes County Health Services</td>
</tr>
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<td>Nikole Zogg</td>
<td>Central Oregon Regional Manager</td>
<td>Advantage Dental</td>
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<td>Pamela Ferguson</td>
<td>Nurse Program Manager</td>
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</tr>
<tr>
<td>Paul Andrews</td>
<td>Deputy Superintendent</td>
<td>High Desert Education Service District</td>
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<td>Penny Pritchard</td>
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<tr>
<td>Rebeckah Berry</td>
<td>Operations and Project Manager</td>
<td>Central Oregon Health Council</td>
</tr>
<tr>
<td>Renee Boyd</td>
<td>BRFSS and OHT Survey Coordinator</td>
<td>Oregon Health Authority</td>
</tr>
<tr>
<td>Rick Treleaven</td>
<td>Executive Director</td>
<td>BestCare Treatment Services</td>
</tr>
<tr>
<td>Sarah Kingston</td>
<td>Senior Data Analytics Specialist</td>
<td>PacificSource Community Solutions</td>
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<tr>
<td>Sarah Worthington</td>
<td>Chronic Disease Program Manager</td>
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<tr>
<td>Scott Montegna</td>
<td>Health Systems Coordinator</td>
<td>Oregon Health Authority</td>
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<td>Scott Willard</td>
<td>Executive Director</td>
<td>Lutheran Social Services</td>
</tr>
<tr>
<td>Steve Strang</td>
<td>Director of Operations</td>
<td>Bridges Health by Mosaic Medical</td>
</tr>
<tr>
<td>Steven Helgerson</td>
<td>Contractor</td>
<td>Deschutes County Health Services</td>
</tr>
<tr>
<td>Thomas Kuhn</td>
<td>Community Health Program Manager</td>
<td>Deschutes County Health Services</td>
</tr>
<tr>
<td>Tom Machala</td>
<td>Director</td>
<td>Jefferson County Health Department</td>
</tr>
<tr>
<td>Tom Schumacher</td>
<td>Director, St Charles Cancer Center</td>
<td>St. Charles Health System</td>
</tr>
</tbody>
</table>
Summary

Access to healthcare and services
- The population is growing in certain areas of Central Oregon, yet housing and transportation services are lacking.
- Healthcare coverage dramatically increased between 2013 and 2014 as measured by enrollment into the Oregon Health Plan (OHP). Customers reported high quality in the care they are receiving.
- Gaps exist in the specialized care that is available, including certain providers, like dentists, mental health specialists, and others.
- Central Oregon has a larger proportion of persons aged 65 years and older than Oregon overall. The prevalence of chronic diseases and disability increases with age. Also, this population is at increased risk for influenza, pneumonia, and other communicable diseases.

Mortality
- All-cause mortality rates are not equal between sexes and among racial categories. American Indian/Alaska Natives have significantly lower life expectancies than other racial groups in Central Oregon.
- In Oregon, people with co-occurring serious mental illnesses and substance use disorders have a particularly young average age at death.

Chronic Disease
- Mortality due to some chronic diseases has significantly decreased since 2000. However, thousands of people in Central Oregon smoke tobacco, a leading cause of death. Adults enrolled in OHP smoke tobacco at even higher rates than those not enrolled in OHP. Resources like the Tobacco Quit Line are available, yet underutilized.
- Chronic diseases or their risk factors are associated with mental health and substance use problems. Approaches for preventing or treating chronic diseases need to address the whole person and their environment, particularly targeting screenings and support for mental health and substance use issues.
- Screening for chronic diseases can detect a condition early and allow for early intervention. More can be done to address screening for diseases like colorectal cancer and cardiovascular disease, especially among the OHP population.
- Four modifiable risk factors cause much of the early death related to chronic diseases. They are tobacco use, physical inactivity, high blood pressure, and alcohol consumption.

Communicable Disease
- While the rate of some vaccine preventable diseases is lower in Central Oregon than in the state overall, too many children in Central Oregon are not up-to-date on age appropriate immunizations, which places them and others at risk.
- Sexually transmitted diseases are preventable. Yet, the incidence rate of chlamydia has increased since 2004.
- Water-borne diseases are common in some Central Oregon counties and were reported at rates higher than the state overall.

Maternal and Infant Health
- Between 2000 and 2013, the percent of mothers who smoked during pregnancy was trending downward, though 1 in 10 pregnant women still reported smoking during their pregnancy. An even higher percent of women enrolled in OHP reported they smoked during their pregnancy.
- Nearly 42% of pregnancies in Central Oregon were considered unintended. Unintended pregnancy and teen pregnancy are associated with high number of adverse childhood events (ACEs).
Summary

Child and Adolescent Health
- The percent of adolescents reporting having participated in a risky behavior like smoking, drinking alcohol, or using drugs increases by as much as two to three times between 8th and 11th grades. Intervening early is important.
- Healthy habits and behaviors are established in childhood. Unhealthy behaviors like tobacco use are primarily initiated during adolescence.

Unintentional Injuries
- Unintentional injuries refer to those injuries where there was no intent to do harm. Unintentional injuries are no longer considered “accidents” because they are preventable. The majority of injury-related deaths in Central Oregon were unintentional.
- The mortality rate due to motor vehicle crashes is decreasing in Central Oregon, but the rate for unintentional poisoning and falls is increasing. The mortality rate due to a fall exponentially increases after the age of 65 years.
- Alcohol-impaired-driving-fatilities accounted for a third of all motor vehicle crash fatalities Oregon.

Mental Health
- About one in five adults in Central Oregon reported they had depression. Poor mental health is associated with other significant health outcomes like tobacco and other substance abuse/misuse, chronic diseases, and injuries, as well as socioeconomic factors like lack of housing, education, and employment.
- The age-adjusted race-specific suicide mortality rate was similar between Central Oregon and Oregon overall, except for American Indians. The suicide mortality rate among American Indians in Central Oregon was about double the rate among American Indians in Oregon overall and about 1.5 times the rate of non-Hispanic whites.
- Experiencing multiple ACEs during childhood has been associated with several poor health outcomes. About one in three adults enrolled in OHP reported a high number of ACEs, while about one in five adults in the general population reported a high number of ACEs.

Substance Abuse
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an underused intervention for addressing unhealthy drinking. About 1 in 5 adults in Crook and Deschutes Counties and 1 in 7 adults in Jefferson County reported binge drinking in the last month.
- People with substance use disorders have a very high incidence of using tobacco, which is often one of the leading causes of early death and disability for this population.
- Substance abuse can place a person who injects drugs at risk for blood borne pathogens like hepatitis C and HIV. Expanding harm reduction approaches can help protect this population.

Oral Health
- Poor oral health can be a costly and painful. At least one in four children and one in three adults in Central Oregon reported they did not see a dental hygienist or other dental practitioner in the last year.
- The Central Oregon region is considered a dental professional shortage area due to its geography, low-income populations, and homeless populations. Among adults in the region, income was directly related to having seen a dentist or hygienist in the last 12 months.
- Income is related to dental health among adults in Oregon. This is especially notable among adults aged 65 years and older. Many are on fixed incomes and may not receive routine dental care because Medicare, the leading insurer for adults 65 years and older, provides little to no coverage.
Introduction

What is a Health Assessment?
A health assessment is a snapshot of the health of a community at a point in time. It describes a variety of health topics, as well as social and economic factors that influence health. These comprehensive reports are intended to guide communities and organizations to strategically address health-related issues with partners working together to maximize the use of resources and target populations most at risk. Assessing the health of a community or region is an ongoing process that involves not only monitoring population health, but measuring progress toward improving it.

Community Input
Central Oregon residents and health organizations care a great deal about working together to improve the health of our communities. From January through August 2015, Central Oregon health system partners created the Central Oregon Regional Health Assessment (RHA), with leadership from the Central Oregon Health Council.

The Operations Council of the Central Oregon Health Council used a planning process called Mobilizing for Action through Planning and Partnership (MAPP) to guide creation of the RHA. The RHA was developed with data, input and information from a wide variety of health and community-based organizations, stakeholders and community members. Input was solicited from the Central Oregon Health Council’s Community Advisory Council, a number of health-related advisory boards and groups, and during community meetings in Crook, Deschutes, and Jefferson Counties. Information from these community meetings not only informed development of this document, but was used to develop priority health issues that will be addressed in the Central Oregon Health Improvement Plan.

How to Use the RHA
Stakeholders gather regularly and deliberate about how to best address issues that have been described in the RHA. The RHA is a resource to ground deliberations in data and information, and to focus resources on important health issues for which there are effective services, programs and interventions that can be brought to bear. The RHA is not an exhaustive compendium of health indicators or analyses. Thus, readers are encouraged to dig deeper and use additional information as Central Oregon health partners continue to construct a more in-depth understanding of the health of the population.
Methods and Limitations

This RHA focuses on the three Central Oregon counties: Crook, Deschutes, and Jefferson. When possible, comparisons were made to the state, the nation, and Healthy People (HP) 2020 goals as well as between relevant demographic and socioeconomic groups.

Data about specific populations or topics were combined to describe the overall health and well-being of the community. These data come from a variety of sources including population level surveys, medical claims, disease registries, birth certificates, death certificates, and program records. Please see the Glossary and Acronym section (page 84) to find more information for most data sources and definitions of major statistical or epidemiological terms used throughout this report.

The Oregon Health Authority (OHA) uses Coordinated Care Organization (CCO) quality health measures to improve care, reduce disparities, and reduce cost of care. In this report, quality health measures are listed in each relevant section. A table of all quality health measures can be found in Appendix A (page 87).

Some charts include 95% Confidence Intervals (CI). A CI is a range of numbers in which the true estimate would be found 95% of the time if the sample were taken an infinite number of times. When two CIs overlap, the estimates are not significantly different from each other. In the example below, estimate 2 is the only significantly different number in the figure. Even though estimate 1 is higher than estimate 3, the CIs overlap. Those estimates would be considered similar.

This RHA is not a complete look at all health indicators, but rather is meant to be an overview of topics addressed by the region's health system. A variety of agencies and organizations maintain detailed data on indicators not shown here. Please see the Resources section at the end of this report (page 86) to learn where to find more information about a specific topic or data source.

Some data are not collected at the county level or may not be appropriate to report at the county level. Data reported in this RHA follow data use guidelines specific to each data set. When appropriate, each data source is marked with limitations. Also, some indicators may have been derived from a sample population that was small and therefore resulted in an unstable statistic. These instances are also marked.
Demographics

Demographic factors like population density, education level, household income, age of the population, and poverty, among others, influence the health of the population.

Population
- In 2013, the estimated total population of the Central Oregon Region was 207,914. Since the 2010 Census, Deschutes County has grown 5.2%, while Crook and Jefferson Counties have decreased in population (Table 1).

<table>
<thead>
<tr>
<th>Table 1. Population of Central Oregon Counties, ACS, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>2013 population</td>
</tr>
<tr>
<td>Population change since 4/1/2010</td>
</tr>
<tr>
<td>Population density, persons per square mile</td>
</tr>
</tbody>
</table>

- Crook County had a higher proportion of residents aged 65 years and older than the other Central Oregon counties (Figure 1).
- There was approximately the same proportion of females and males among the Central Oregon counties (Figure 1).
- A larger proportion of Jefferson County residents identified as American Indian or of Hispanic/Latino ethnicity (any race) than among the other Central Oregon counties (Figure 1).

Figure 1. Demographics of Central Oregon Counties, ACS, Oregon, 2013
Demographics

Socioeconomic Status
Socioeconomic status is a measure of a person's or family's economic and social position compared to others based on their income, education, and occupation. This section presents a few key factors related to socioeconomic status in Oregon and the Central Oregon counties. Other measures are found throughout the report.

- One in five people in Crook and Jefferson counties live in poverty (Table 2).

| Table 2. Socioeconomic status of Central Oregon Counties, ACS, Oregon, 2009-2013 |
|---------------------------------|----------|----------|----------|----------|
|                                   | Oregon   | Crook    | Deschutes | Jefferson |
| Household Income                  |          |          |          |          |
| Median household income           | $50,229  | $38,795  | $50,209  | $43,373  |
| Percent owning their home         | 62.0     | 70.5     | 65.5     | 65.4     |
| Poverty‡                         |          |          |          |          |
| Percent of persons below poverty level | 16.2   | 19.5     | 14.5     | 19.8     |
| Education                        |          |          |          |          |
| Percent Bachelor's degree or higher (Among people 25+ years) | 29.7   | 14.5     | 31.0     | 17.3     |
| Percent high school graduate or higher (Among people 25+ years) | 89.4   | 84.9     | 93.1     | 84.7     |
| Employment§                      |          |          |          |          |
| Unemployment rate                 | 5.2      | 8.3      | 5.6      | 6.7      |
| WIC enrollment‡‡                  |          |          |          |          |
| Number of families served         | N/A      | 479      | 2,593    | 499      |
| Percent working families          | N/A      | 63       | 71       | 72       |

‡ As defined by the Census Bureau: household income compared to appropriate threshold
§ State of Oregon Employment Department, April 2015-seasonally adjusted
‡‡ WIC enrollment
N/A = data not available

- Approximately 60,000 Central Oregon residents were employed in the private sector in 2012 (Table 3). The region's wages in the private sector were nearly 20% lower than the state's private sector wages.

| Table 3. Distribution of private sector employment and income, Oregon Quarterly Census on Employment and Wages, 2012 |
|-------------------------------------------------|----------|----------|----------|----------|
| Employment                                      | Oregon   | Crook    | Deschutes | Jefferson |
| 1,373,607                                       |          |          |          |          |
| Total payroll (in millions)                     | 59,948.70| 172.6    | 1,845.20 | 101.9    |
| Average wage ($)                                | 43,643   | 39,429   | 35,523   | 29,205   |
| % of region employment                         | --       | 7.3      | 86.8     | 5.8      |
| % of statewide average wage                     | 100      | 90.3     | 81.4     | 66.9     | 81.2     |
Disability
Disability refers to anyone with a visual, hearing, cognitive, ambulatory, self-care, or independent living difficulty. Having different abilities may limit a person’s capacity to work and provide for themselves.

- There was a higher proportion of people living with a disability in Crook County than the other Central Oregon counties or Oregon overall (Table 4).

| Table 4. Percent of the population living with a disability, ACS, Oregon, 2009-2013 |
|---------------------------------|-----|------|------|-------|
|                                | Oregon | Crook | Deschutes | Jefferson |
| Total, non-institutionalized population | 14.1   | 20.9  | 11.9  | 16.6 |
| Male                           | 14.2   | 22.5  | 13.2  | 17.4 |
| Female                        | 14.0   | 19.3  | 10.7  | 15.9 |
| White, Non-Hispanic            | 15.3   | 21.7  | 12.6  | 19.6 |
| Hispanic                      | 8.0    | 14.1  | 5.7   | 9.0  |

Food Insecurity
Access to healthy food promotes a healthy diet. However, healthy food must be available and affordable to the population. Food insecurity refers to having limited or uncertain access to adequate food while hunger is the physiologic conditions that may result from food insecurity.

- Nearly 32,000 people in Central Oregon had limited access to a grocery store (i.e. live more than 1 mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area). About 10,300 were both low income and have limited access to grocery stores (USDA Food Environment Atlas).
- Adults enrolled in OHP had a much higher frequency of food insecurity and hunger than did the total adult population of Oregon (Figure 2). Data to compare the prevalence of food insecurity in the general Central Oregon population were not available.

Figure 2. Prevalence of stress and food security among adults enrolled and not enrolled in OHP, MBRFSS, Oregon, 2014

- High-stress based on 4-item scale
- Food insecurity - food insecure
- Food insecurity - hunger

† Estimate not available for general population
H = 95% Confidence Interval
Note: General population percents may not be directly comparable to OHP percents due to survey differences. They are provided for a reference.
Demographics

Safety and Violence
Various types of violence can occur in a community or home as well as at different times during a person's life. Examples of violence include child maltreatment and neglect, intimate partner violence, and elder abuse. Violence can lead to physical, mental, and emotional health problems as well as death. In a community, violence can reduce property value, decrease productivity, and weakening social services (CDC, Violence Prevention).

- One in five (21%, 95% CI 17.1%-25.5%) adults enrolled in OHP in Central Oregon reported that their neighborhood was “not at all” or “slightly” safe (MBRFSS, 2014). Data for comparison to other populations were not available.
- One estimate of the crime index in Bend in 2011 was 224/100,000 population. For comparison, the rate in Redmond was 452/100,000 population, Prineville was 204/100,000 population, and Madras was 350/100,000 population. The US average was 309. (City-Data). The City-data.com crime index counts serious crimes and violent crime more heavily and it adjusts for the number of visitors and daily workers commuting into cities.
- The Oregon Sexual and Domestic Violence Programs offer several services to those experiencing intimate partner violence. In 2014, there were 2,367 calls to the helpline and 131 people sheltered in Central Oregon (Table 5).

<table>
<thead>
<tr>
<th>Table 5. Services provided by Sexual and Domestic Violence Programs, Central Oregon, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of calls to emergency hotline, by primary reason for call</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1,969</td>
</tr>
<tr>
<td><strong>Number of people sheltered, by age</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>74</td>
</tr>
<tr>
<td><strong>Number of shelter nights, by age</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1,790</td>
</tr>
<tr>
<td><strong>Length of shelter stays (percent of total)</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>51.4</td>
</tr>
</tbody>
</table>
Demographics

Housing
Stable, healthy housing is a basic need for people and offers a place of security and an area to rest. However, limited housing stock or low rental vacancy rates can lead to an increase in housing prices. High rent may force a person or family into substandard housing or into a situation where they are rent burdened, meaning more than 30% of their income is spent on housing. Unstable housing is a significant contributor to poor outcomes for people with chronic medical or behavioral health conditions.

- The 2014 one-night homeless count in the Central Oregon region was 2,410 people (Homeless Leadership Coalition, 2014).
- The most common answers for being homeless were that the respondent could not afford rent or that they were unemployed. However, many reasons were given, including being kicked out of the house by family or friends, being evicted, domestic violence, and poor credit. About 200 people reported they were homeless by choice (Homeless Leadership Coalition, 2014).
- The Oregon Department of Education tracks the number of students who are homeless or in an unstable housing situation. Nearly 1 in 5 students in the Culver School District in Jefferson County were homeless or in unstable housing situations at the time of survey (Table 6).

<table>
<thead>
<tr>
<th>School District</th>
<th>Number</th>
<th>Percent of district enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crook County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crook</td>
<td>52</td>
<td>1.6</td>
</tr>
<tr>
<td>Deschutes County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bend-La Pine</td>
<td>650</td>
<td>3.9</td>
</tr>
<tr>
<td>Redmond</td>
<td>545</td>
<td>7.7</td>
</tr>
<tr>
<td>Sisters</td>
<td>30</td>
<td>2.6</td>
</tr>
<tr>
<td>Jefferson County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashwood</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Black Butte</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Culver</td>
<td>126</td>
<td>18.6</td>
</tr>
<tr>
<td>Jefferson Co</td>
<td>114</td>
<td>3.9</td>
</tr>
</tbody>
</table>

- Focus groups conducted in the region demonstrated limited rental housing availability, including low-income housing, in several of the Central Oregon cities and that there is a need for education regarding the link between health and housing (Community Advisory Council (CAC) Panel Report, 2014).
- The housing authority in Central Oregon manages about 1,200 housing vouchers a year. However, the demand for vouchers exceeds the number available and they also manage a wait list of thousands of people (Housing Works).
- Central Oregon is demonstrating best practices by integrating housing and healthcare. In 2014, Housing Works, Mosaic Medical, and EPIC Property Management came together to make improvements to existing affordable housing units, including the inclusion of a medical clinic to serve the residents and the surrounding community (Oregon Housing and Healthcare Best Practices).
Causes of Death

Some diseases and health events are more likely to lead to death than others and are influenced by social determinants of health like those discussed in the previous section. The public health and healthcare systems work to address the health disparities that lead to reduced quality of life and life span.

- The five leading causes of death in Oregon were malignant neoplasms (cancer), heart disease, chronic lower respiratory disease, cerebrovascular events, and unintentional injury (Table 7). The leading causes of death in Central Oregon are the same as in Oregon.
- Specific discussion about leading causes of death in children can be found in the Infant, Early Childhood and Adolescent Health section of this report (page 50).
- Unintentional injury (injuries where there was no intent to do harm) was the leading cause of death for people aged 1-44 years while malignant neoplasms (cancer) were the leading cause of death for people aged 45 years and older (Table 7).

Table 7. Leading Causes of Death in Oregon, CDC WISQARS, Oregon, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>Cause (specific)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital Anomalies</td>
<td>Unintentional Injury</td>
</tr>
<tr>
<td>2</td>
<td>Unintentional Injury*</td>
<td>Malignant Neoplasms*</td>
</tr>
<tr>
<td>3</td>
<td>SIDS</td>
<td>Homicide*</td>
</tr>
<tr>
<td>4</td>
<td>Maternal Pregnancy Complications</td>
<td>Benign Neoplasms*</td>
</tr>
<tr>
<td>5</td>
<td>Placenta Cord Membranes</td>
<td>Homicide*</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional Injury*</td>
<td>Chronic Lower Respiratory Disease*</td>
</tr>
<tr>
<td>7</td>
<td>Necrotizing Enterocolitis*</td>
<td>Septicemia*</td>
</tr>
<tr>
<td>8</td>
<td>Neonatal Hemorrhage*</td>
<td>Influenza &amp; Pneumonia*</td>
</tr>
<tr>
<td>9</td>
<td>Bacterial Sepsis*</td>
<td>Meningococcal Infection*</td>
</tr>
<tr>
<td>10</td>
<td>Two tied*</td>
<td>Five tied*</td>
</tr>
</tbody>
</table>

* Rank based on less than 10 deaths
• The all-cause mortality rate varies by race and Hispanic ethnicity between Oregon and the Central Oregon counties (Figure 3).

Figure 3. Age-adjusted all-cause mortality rate per 10,000 population by race, Oregon, OPHAT, 2009-2013

- Oregon
  - Total: 71.8
  - American Indian/Alaska Native NH: 76.4
  - Hispanic: 51.3
  - White NH: 73.1

- Crook
  - Total: 72.6
  - American Indian/Alaska Native NH: 76.2
  - Hispanic: 32.0
  - White NH: 73.5

- Deschutes
  - Total: 66.6
  - American Indian/Alaska Native NH: 77.3
  - Hispanic: 50.1
  - White NH: 67.1

- Jefferson
  - Total: 85.1
  - American Indian/Alaska Native NH: 152.8
  - Hispanic: 44.8
  - White NH: 76.1

Note: The ability to report other race-specific rates in Central Oregon is limited by the small populations of those races.

• The all-cause mortality rate varies by race and Hispanic ethnicity between Oregon and the Central Oregon counties (Figure 3).

Figure 4. Age-adjusted all cause mortality rate per 10,000 population by sex, Oregon, OPHAT, 2009-2013

- Oregon
  - Female: 62.8
  - Male: 83.8*

- Crook
  - Female: 67.2
  - Male: 78.1

- Deschutes
  - Female: 57.4
  - Male: 77.6*

- Jefferson
  - Female: 73.5
  - Male: 96.4*

* Significantly different
Causes of Death

- American Indians/Alaska Natives in Jefferson County and Oregon overall had a lower life expectancy when compared to the total life expectancy in the area (Table 8).

| Table 8. Life expectancy (in years) at birth by race, Oregon, OPHAT, 2013 |
|---------------------------------|------------|-----------|----------|---------|------------|
|                                | Oregon     | Crook     | Deschutes| Jefferson| Central Oregon |
| American Indian/Alaska Native NH | 78.3       | 80.7†     | 79.0     | 66.2    | 73.6       |
| Hispanic                        | 79.8       | 86.2†     | 83.4     | 82.0    | 83.3       |
| White NH                        | 79.6       | 78.2      | 80.7     | 76.8    | 80.3       |
| Total                           | 79.7       | 78.9      | 81.0     | 79.0    | 80.3       |

†Unstable estimate
Note: the ability to report other race-specific life expectancies in Central Oregon is limited by the small populations of these races
NH: Non-Hispanic

- According to a 2008 study by the Oregon Division of Addiction and Mental Health, people with co-occurring mental health and substance use disorders have an average age at death of 45 years (OHA, 2008).

Years of Potential Life Lost

YPLL measures the number of years of life lost due to a premature death. While it is a good indicator of the burden due to death at an early age, it may not capture the full burden of chronic diseases experienced later in life.
- In Oregon, 633.8 years of life were lost before age 75 for every 10,000 people under the age of 75 years (Figure 5).
- Deschutes County had a lower YPLL rate than Oregon, while Jefferson and Crook Counties had a higher rate.

Figure 5. Years of potential life lost before the age 75 per 10,000 population, Oregon, OPHAT, 2009-2013
Health-related quality of life includes the physical, mental, and emotional well-being of an individual. This can include socioeconomic status, health risks and diseases, and social support. In a community this refers to the policies, resources, and conditions that influence a person’s health. Health-related quality of life is considered an important outcome of a program or service needs of a population. Health-related quality of life is associated with chronic disease prevalence and risk factors. The following sections of this document address specific topics pertaining to health-related quality of life.

- 85%-89% of adults in Central Oregon reported their general health was excellent, very good, or good (Figure 6). Only about 3 of 4 adults enrolled in OHP in Central Oregon reported good or better general health (72.2%, 95% CI 62.7%-76.4%) (MBRFSS, 2014).

  ![Figure 6. Age-adjusted prevalence of self-reporting excellent, very good, or good general health, Oregon, BRFSS, 2008-2011](image)

  Note: Due to a BRFSS method change in 2011, data from prior years are not comparable to current years.

- One quarter to one third of adults reported limitations due to physical, mental, or emotional problems (Figure 7). However, there were no statistical differences between the counties and Oregon overall.

  ![Figure 7. Age-adjusted prevalence of having any limitations due to physical, mental, or emotional problems, Oregon, BRFSS, 2008-2011](image)

  Note: Due to a BRFSS method change in 2011, data from prior years are not comparable to current years.
Chronic Diseases

Chronic diseases are those conditions that a person may live with for many years or a lifetime. In 2012, about one in four adults in the US had two or more chronic diseases (CDC, 2014). Chronic diseases can lead to early death, decreased quality of life, and added personal expense in healthcare spending. Chronic diseases account for a large proportion of healthcare expenditures in the US.

- Adults enrolled in OHP in Central Oregon had similar prevalence of chronic diseases as adults enrolled in OHP in Oregon, except for stroke, for which the self-reported prevalence was lower (data not shown).
- Though not directly comparable due to some measurement differences, the OHP population appears to have a higher prevalence of some diseases than does the general population (Figure 8). Data to compare the prevalence of chronic diseases in the general Central Oregon population are available throughout this section.

![Figure 8. Prevalence of chronic diseases among adults enrolled and not enrolled in OHP, Oregon, MBRFSS, 2014](chart)

**Asthma**

Asthma is a chronic condition of the respiratory system characterized by inflammation and narrowing of the airways. While asthma affects people of all ages, asthma is one of the most common chronic diseases among children. Approximately 320,000 people in Oregon in 2011 reported that they currently had asthma (Asthma Burden Report, 2013). When monitored and treated with proper medication, asthma should not limit a person's activities or affect their quality of life. Yet thousands of adults and children miss work and school and limit their activities due to their asthma each year.

- Nationally and in Oregon, the prevalence of asthma is higher in female adults than in male adults (data not shown).
Chronic Diseases

Asthma Continued

- Nationally and in Oregon, the prevalence of asthma is higher in female adults than in male adults (data not shown).
- The prevalence of asthma in Oregon and Central Oregon is similar, except in Jefferson County where the prevalence of current asthma is about 24% (Figure 9).

![Figure 9. Percent of adults with current asthma, Oregon, BRFSS, 2010-2013](image)

It is important for people with asthma to have the disease well-controlled. This includes rarely using rescue medications (other than before exercising), waking up due to asthma, experiencing daytime symptoms, and limiting activities due to asthma. Emergency department (ED) visits and hospitalizations are a sign that a person's asthma is not in control.

- Crook and Jefferson Counties had asthma-related ED discharge rates significantly higher than did the state overall (Figure 10). Jefferson County had an asthma hospitalization rate significantly higher than the state.
- The US asthma ED rate was 69.7/10,000 population and the hospitalization rate was 14.1/10,000 population in 2009 and 2010, respectively.
- The median cost for an asthma-related ED visit among OHP members in Central Oregon facilities was $301 and for an asthma-related hospital stay the cost was $3,690 (Central Oregon CCO, 2012-2014).

![Figure 10. Age-adjusted rate per 10,000 population of one or more asthma-related ED visits and hospitalizations by county, Oregon, Oregon Hospital Discharge Data, 2011](image)
Asthma Continued

- Oregon has met all of the age-specific HP 2020 goals related to asthma hospital discharge rates (Table 9). ED discharge rates were not available for Central Oregon.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Central Oregon</th>
<th>Oregon</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–4</td>
<td>10.5</td>
<td>10.7</td>
<td>18.2</td>
</tr>
<tr>
<td>5–64</td>
<td>4.1</td>
<td>4.0</td>
<td>8.7</td>
</tr>
<tr>
<td>65+</td>
<td>4.5</td>
<td>8.6</td>
<td>20.1</td>
</tr>
</tbody>
</table>

- A larger percent of OHP members aged 5–64 years from Jefferson County (33.7%) with asthma went to the ED for asthma than in the other Central Oregon counties (Crook=16.9%, Deschutes=18.3%) and the state overall (17.1%) (OHP, 2011).

Asthma self-management education is integral for achieving asthma control. Self-management education includes being taught how to respond to an attack, knowing the signs, symptoms, and triggers of an asthma attack, using medication and devices properly, using a peak flow meter to track lung function, having an asthma action plan (AAP), and having taken a class on asthma management.

- Adults and children in Oregon have met the HP 2020 goal for learning how to respond to an asthma attack. However, more can be done to address a wide range of asthma control issues in the state (Figure 11).

![Figure 11. Percent of adults and children with asthma who reported having received key asthma self-management education, Oregon, BRFSS-ACBS, 2011](image)
Chronic Diseases

Asthma Continued

- Tobacco is a significant asthma trigger. Adults with current asthma reported smoking at a rate similar to those without asthma (Figure 12).

![Figure 12. Prevalence of smoking among adults with and without current asthma, Oregon, BRFSS, 2010-2013](image)

Cancer

Cancer refers to a group of cells that grow out of control and no longer function as intended and may spread to other areas in the body. Cancer is the leading cause of death for adults aged 45 years and older in Oregon. Significant advances have been made recently to extend the life of persons with cancer or even eliminate the cancer completely. Early detection can help increase the chances of surviving cancer.

Overall Cancer Mortality

Cancer can occur at most sites in the body. Some cancers are far more common than others. The overall cancer mortality rate refers to deaths related to all types of cancer in the state.

- The cancer mortality rate has been decreasing in Oregon since 2000 (Figure 13).
- All of the Central Oregon Counties are nearing or have passed the HP 2020 goal (161.4/100,000) for cancer mortality (Figure 13).

![Figure 13. Age-adjusted cancer mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013](image)
Cancer Continued

- Deschutes and Crook Counties had significantly lower cancer mortality rates than Oregon overall (Figure 14). The US cancer mortality rate was 173.1/100,000 population.
- Males in Oregon and Deschutes County had significantly higher cancer mortality rates than females in those areas (Figure 14).

Figure 14. Age-adjusted cancer mortality rate per 100,000 population by sex, Oregon, OPHAT, 2009-2013

* Significantly higher than females
** Significantly lower than the state overall

- Central Oregon counties have met the HP 2020 goal for breast and prostate cancer mortality, but these rates could be lower still and more could be done to address mortality rates from other cancers (Table 10).

<table>
<thead>
<tr>
<th>Cancer site</th>
<th>US§</th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>22.2</td>
<td>20.4</td>
<td>6.8</td>
<td>15.1</td>
<td>12.6</td>
<td>20.7</td>
</tr>
<tr>
<td>Colorectal</td>
<td>15.7</td>
<td>14.8</td>
<td>11.8</td>
<td>13.1</td>
<td>17.2</td>
<td>14.5</td>
</tr>
<tr>
<td>Lung</td>
<td>48.5</td>
<td>45.4</td>
<td>42.7</td>
<td>37.6</td>
<td>43.6</td>
<td>45.5</td>
</tr>
<tr>
<td>Melanoma</td>
<td>2.8</td>
<td>3.3</td>
<td>7.0</td>
<td>4.1</td>
<td>3.9</td>
<td>2.4</td>
</tr>
<tr>
<td>Prostate</td>
<td>22.0</td>
<td>22.0</td>
<td>20.2</td>
<td>21.0</td>
<td>20.3</td>
<td>21.8</td>
</tr>
</tbody>
</table>

§ Data from 2009

Overall Cancer Incidence

Incidence refers to newly diagnosed cases. The overall cancer incidence rate measures the number of new cancer cases in a certain population within a specific time frame.
- The cancer incidence rate in the US was 459.8/100,000 population (statecancerprofiles.cancer.gov, 2007-2011).
Chronic Diseases

Cancer Continued

- Jefferson County had a lower cancer incidence rate than did Oregon or the US (Figure 15). Deschutes County had a higher cancer incidence rate than did the US and Oregon overall. The incidence rate in the US was 459.8/100,000 population.
- Males in Deschutes County and Oregon overall had a higher incidence of cancer than did females in those regions (Figure 15).

![Figure 15. Age-adjusted cancer incidence rates per 100,000 population by sex, Oregon, State Cancer Profiles, 2007-2011]

Specific Cancer Sites

Lung cancer is the most commonly diagnosed reportable cancer. Most risk factors for lung cancer are avoidable. Tobacco use or exposure to secondhand tobacco smoke is the leading cause of lung cancer. However, even people who have never smoked are diagnosed with lung cancer. Environmental factors like exposure to asbestos or radon also can cause lung cancer.

Breast cancer most commonly occurs in women, but can occur in men. It is one of the leading cancer sites. The risk for breast cancer is associated with older age and white race, obesity, physical inactivity, genetic predisposition, and reproductive history.

Colorectal cancer occurs in the colon or rectum. Factors related to colorectal cancer are older age, being male, black/African American race, poor diet, smoking, a history of polyps, and genetics.

Melanoma, a type of skin cancer, is one of the most common cancers in the US and is the most deadly of the skin cancers. Risk for melanoma can be reduced by limiting exposure to the sun, avoiding sunburns, especially early in life, and not using indoor tanning beds. Other risk factors for melanoma are having lighter skin or skin that burns, reddens, or freckles easily.

The prostate is a gland found only in males. Prostate cancer is one of the most common cancers among men and when detected early can usually be treated successfully. Risk factors for prostate cancer include older age (65 years and older), African-American race, and family history or genetic changes.
Cancer Continued

- Incidence rates of specific cancers are shown in Figure 16.
- The lung cancer incidence rate did not differ between the Central Oregon counties and Oregon overall.
- The breast cancer incidence rate was significantly lower in Jefferson County than in Oregon, but no different than the US rate.
- The colorectal cancer incidence rate did not differ between the Central Oregon counties and Oregon.
- Deschutes County had a melanoma incidence rate that was significantly higher than the Oregon rate.
- Deschutes County had a significantly higher prostate cancer incidence rate than did Oregon.

Figure 16. Age-adjusted cancer incidence rate per 100,000 population by cancer site, Oregon, State Cancer Profiles, 2007-2011

* Significantly different from Oregon
H = 95% Confidence Interval

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>US</th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast (Female)</td>
<td>122.7</td>
<td>129.4</td>
<td>104.9</td>
<td>128.1</td>
<td>95.3*</td>
</tr>
<tr>
<td>Colorectal</td>
<td>43.3</td>
<td>39.6</td>
<td>31.1</td>
<td>36.2</td>
<td>35.5</td>
</tr>
<tr>
<td>Lung</td>
<td>64.9</td>
<td>62.6</td>
<td>57.0</td>
<td>57.3</td>
<td>50.4</td>
</tr>
<tr>
<td>Melanoma</td>
<td>19.7</td>
<td>25.1</td>
<td>26.2</td>
<td>35.7*</td>
<td>23.0</td>
</tr>
<tr>
<td>Prostate</td>
<td>147.3</td>
<td>134.4</td>
<td>133.5</td>
<td>164.4*</td>
<td>92.4*</td>
</tr>
</tbody>
</table>

Rate per 100,000 population

* Significantly different from Oregon
H = 95% Confidence Interval

US = Oregon = Crook = Deschutes = Jefferson
Cardiovascular Disease
Cardiovascular disease is a classification of diseases of the heart and blood vessels. It is one of the leading causes of death in Oregon and the US. Cardiovascular disease is preventable with good nutrition, exercise, and by not smoking.

- Among males and females admitted to St. Charles facilities in Central Oregon, 21% and 14% respectively, were for cardiovascular disease events (St. Charles Health System, 2014).

Heart Disease and Heart Attack
- Heart disease includes several conditions, including angina (chest pain), myocardial infarction (heart attack), and other conditions that affect the heart muscle, rhythm, or valves.
- The mortality rate due to ischemic heart disease (disease of the heart's major blood vessels) has decreased significantly in Oregon and Deschutes County since 2000 (Figure 17). The rate has also been decreasing in the US and was 116.1/100,000 population in 2009 (CDC MMWR).

Figure 17. Age-adjusted ischemic heart disease mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013

- The prevalence of heart disease or having had a heart attack (and survived) is similar in the three Central Oregon counties (Figure 18). In 2013, the prevalence in the U.S. was 4.1% for heart disease and 4.3% for heart attack (BRFSS, 2013).

Figure 18. Age-adjusted prevalence of heart disease or a history of heart attack, Oregon, BRFSS, 2010-2013

† Statistically unreliable
Chronic Diseases

Cardiovascular Disease Continued

- There were no differences in the mortality rate due to ischemic heart disease among the Central Oregon counties when compared to each other or the state (Figure 19).
- Males in Crook County, Deschutes County, and Oregon had a higher ischemic heart disease mortality rate than females (Figure 19).

![Figure 19. Age-adjusted mortality rate per 100,000 population of ischemic heart disease by sex, Oregon, OPHAT, 2009-2013](image)

Cerebrovascular Disease and Stroke

Cerebrovascular disease is a group of diseases dealing with blood flow in the brain. Stroke is one of the cerebrovascular diseases and is a leading cause of death and disability. A stroke is caused by a blood vessel breaking or an artery becoming clogged in the brain that leads to reduced blood flow and brain damage. Knowing the signs and symptoms of stroke can save lives. A healthy lifestyle and medication can help reduce the risk of a stroke.

- The mortality rate due to cerebrovascular disease has significantly decreased in Oregon and Deschutes County since 2000 (Figure 20).

![Figure 20. Age-adjusted cerebrovascular disease mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013](image)
Chronic Diseases

Cardiovascular Disease Continued

- The age-adjusted prevalence of stroke (and survived) was similar in Central Oregon (Figure 21). The prevalence in the U.S was 2.8% in 2013 (BRFSS, 2013).

![Figure 21. Age-adjusted prevalence of stroke, Oregon, 2010-2013](image)

† Statistically unreliable

Diabetes

Diabetes is characterized by having high blood glucose levels and can lead to serious adverse outcomes if left untreated. There are several types of diabetes, including type 1, type 2, and gestational diabetes. Type 1 diabetes is an autoimmune disorder usually diagnosed at an early age. Type 2 diabetes is often diagnosed in adulthood. Many people are at risk for developing type 2 diabetes, a condition known as pre-diabetes. Pre-diabetes is characterized by high blood glucose levels, but not high enough to be considered diabetes. Pre-diabetes places a person not only at risk for developing diabetes, but also heart disease and stroke, however this risk can be lowered by losing weight and exercising. Gestational diabetes is a condition only pregnant women acquire during pregnancy and often resolves once the baby is born. If left untreated, gestational diabetes may cause problems for the mother and baby. In addition, gestational diabetes puts women at increased risk for later developing type 2 diabetes.

- Diabetes prevalence has been increasing in the US and Oregon. In 2013, diabetes affected an estimated 287,000 adults in Oregon (Oregon Diabetes Report, 2015).
- CDC estimates that about 37% of adults with pre-diabetes are not aware they have it. That translates to about 1.1 million adults in Oregon living with pre-diabetes (Oregon Diabetes Report, 2015).
- There were no statistical differences in diabetes prevalence among adults in the three Central Oregon Counties (Figure 22).

![Figure 22. Prevalence of diabetes, Oregon, BRFSS, 2010-2013](image)

† Statistically unreliable
Diabetes Continued
A key part of diabetes control is self-management education. Diabetes self-management education includes taking classes to learn how to self-monitor blood glucose and maintain a healthy lifestyle, as well as monitoring key clinical outcomes like blood A1C levels, as well as eye and foot health.

- Two of the three HP 2020 goals for diabetes self-management education have been met in Oregon (Figure 23).

**Figure 23.** Percent of adults with diabetes who reported having received key diabetes self-management education, Oregon, BRFSS, 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percent</th>
<th>HP 2020 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C checked 2+ times by HCP in the last year</td>
<td>72.6</td>
<td>*</td>
</tr>
<tr>
<td>Ever taken a class on managing diabetes</td>
<td>67.8</td>
<td>*</td>
</tr>
<tr>
<td>Eye exam within the past year</td>
<td>63.0</td>
<td>*</td>
</tr>
<tr>
<td>Self blood glucose monitoring 1+ times per day</td>
<td>62.3</td>
<td>**</td>
</tr>
<tr>
<td>Foot monitoring 1+ times per day</td>
<td>62.6</td>
<td>**</td>
</tr>
</tbody>
</table>

*Note: not all measures match HP goals*

- The age-adjusted mortality rate for diabetes in the US was 21.2/100,000 population (CDC, 2013).
- Jefferson County had a higher diabetes mortality rate than did Oregon or the US (Figure 24).
- Males in Oregon and Deschutes County had higher mortality rates due to diabetes than females in those regions (Figure 24).

**Figure 24.** Age-adjusted diabetes mortality rate per 100,000 population by sex, Oregon, OPHAT, 2009-2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate per 100,000 population</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>24.1</td>
<td>19.4</td>
<td>29.8</td>
<td></td>
</tr>
<tr>
<td>Crook</td>
<td>22.4</td>
<td>16.8</td>
<td>28.8</td>
<td></td>
</tr>
<tr>
<td>Deschutes</td>
<td>21.1</td>
<td>16.0</td>
<td>27.2</td>
<td></td>
</tr>
<tr>
<td>Jefferson</td>
<td>39.2</td>
<td>26.8</td>
<td>53.5</td>
<td></td>
</tr>
</tbody>
</table>

* Significantly higher than females
** Significantly higher than the state overall
Chronic Diseases

Diabetes Continued

- The rate of hospitalizations where diabetes was the primary reason for admission did not differ from the rate in Oregon (11.3 vs. 11.9/10,000 population, respectively) (Figure 25).
- There were no statistical differences in age-specific diabetes hospitalization rates between Central Oregon and Oregon overall (Figure 25).

Figure 25. Hospitalization rate per 10,000 population due to diabetes by age group, Central Oregon and Oregon, HCUP, 2013

- The rate of non-traumatic lower-extremity amputation among people with diabetes was similar in Central Oregon (2.1/10,000 population 95% CI 1.5-2.8) as Oregon (2.8/10,000 population 95% CI 2.5-2.9) (Oregon HDD, 2013). There were 43 non-traumatic lower-extremity amputations among people with diabetes in Central Oregon in 2013.
- About one-third of end-stage renal disease (ESRD) was attributed to diabetes in Oregon and the US. In Jefferson County, nearly two-thirds of ESRD was attributed to diabetes (Table 11).


<table>
<thead>
<tr>
<th></th>
<th>US</th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number</td>
<td>605,055</td>
<td>5,527</td>
<td>27</td>
<td>176</td>
<td>39</td>
</tr>
<tr>
<td>Number due to diabetes</td>
<td>228,896</td>
<td>1,885</td>
<td>†</td>
<td>53</td>
<td>25</td>
</tr>
<tr>
<td>Percent due to diabetes</td>
<td>37.8</td>
<td>34.1</td>
<td>†</td>
<td>30.1</td>
<td>64.1</td>
</tr>
<tr>
<td>Percent ESRD due to diabetes by reported race</td>
<td>White</td>
<td>60.7</td>
<td>84.2</td>
<td>†</td>
<td>96.2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>39.3</td>
<td>15.8</td>
<td>†</td>
<td>3.8</td>
</tr>
</tbody>
</table>

†Too few cases to report
‡Unable to calculate

Chronic Diseases

Risk Factors and Complications of Disease
Several factors increase a person’s risk of developing a chronic disease. While some people are genetically predisposed to developing a chronic disease, many other factors are modifiable. These include tobacco use, high body mass index (BMI), physical inactivity, multiple adverse childhood experiences (ACEs), and not receiving specific disease screenings. People with significant and chronic mental health and substance use problems are particularly prone to develop one or more chronic diseases.

- There were no statistical differences between adults enrolled in OHP in Central Oregon versus those throughout the state regarding risks for chronic disease (data not shown). Though not directly comparable due to survey differences, adults enrolled in OHP in Central Oregon experienced some risk factors for chronic diseases at higher frequencies than the general population in Oregon (Figure 26). Data to compare the prevalence of chronic disease risk factors in the general Central Oregon population are available throughout this section.

Tobacco
Cigarette smoke is associated with many chronic diseases and is a leading cause of preventable death in the US. Smoking tobacco is linked to about 20% of deaths (CDC OSH, 2014). Cigarette smoking and even exposure to cigarette smoke can lead to a higher risk for heart disease, many cancers, stroke, asthma, and other diseases. See the Alcohol, Tobacco, and Other Drug Use section (page 59) for more information about tobacco.

- The prevalence of smoking tobacco among adults had been declining in the US, but one in five adults (21%) in the US still smoke tobacco (CDC Vital Signs, 2010).
- About 1 in 3 adults (36%) with a mental illness in the US smoked cigarettes (CDC Vital Signs, 2013).
Chronic Diseases

- Nearly one in three adults in Crook County report smoking tobacco (Figure 27). See the Child and Adolescent Health section (page 54) of this report for more information on youth tobacco use.

**Figure 27. Age-adjusted prevalence of adult current smokers, Oregon, BRFSS 2010-2013**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>US², 18.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>19.0</td>
<td>18.9</td>
</tr>
<tr>
<td>Crook</td>
<td>31.0</td>
<td>18.9</td>
</tr>
<tr>
<td>Deschutes</td>
<td>16.3</td>
<td>18.9</td>
</tr>
<tr>
<td>Jefferson</td>
<td>24.1</td>
<td>18.9</td>
</tr>
</tbody>
</table>

National Health Interview Survey, 2011

**Body Mass Index (BMI)**

Many chronic diseases are associated with being overweight (BMI between 25 and 29) or obese (BMI 30 or greater), including heart disease, cancer, diabetes, and stroke. BMI can particularly be high for people with a serious mental illness as a mental illness may lead to sedentary lifestyle and physical inactivity. The medications used to manage mental health illnesses may also lead to a rapid weight gain (US DHHS, 2010).

- 40% of adults were obese in Jefferson County (Figure 28).

**Figure 28. Age-adjusted prevalence obesity among adults, Oregon, BRFSS 2010-2013**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>HP 2020 30.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>25.1</td>
<td></td>
</tr>
<tr>
<td>Crook</td>
<td>25.1</td>
<td></td>
</tr>
<tr>
<td>Deschutes</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>Jefferson</td>
<td>40.1</td>
<td></td>
</tr>
</tbody>
</table>
Chronic Diseases

Mental Illness and Substance Use Disorders
Mental illness is associated with many chronic diseases, including cardiovascular disease, diabetes, asthma, and arthritis, among others. Furthermore, several risky behaviors are common to mental illnesses and chronic disease including tobacco and alcohol use, physical inactivity, and poor nutrition (CDC, 2012).

- Data from several studies show an association between asthma and other respiratory symptoms and anxiety disorders among youth. Clinical data has also shown that anxiety is associated with increased severity of asthma symptoms, healthcare use, functional impairment and poorer asthma control, compared to youth without anxiety (Goodwin et al, 2012).
- The American Heart Association recommends that all cardiac patients be screened for depression (AHA, 2008).
- People with mental illness, substance use disorders, or both are at increased risk for developing diabetes. Untreated behavioral health disorders can exacerbate diabetes symptoms and complications (SAMHSA Advisory, 2013). An estimated 28.5% of people with diabetes meet criteria for clinical depression (Mauer & Jarvis, 2010).
- In the US, co-occurring mental illness and drug and alcohol disorders for Medicaid enrollees with common chronic diseases like asthma, cardiovascular disease, and diabetes led to a two to three fold increase in healthcare costs (Boyd, et al., 2010).

Disease Monitoring and Health Screenings
Several chronic diseases can be monitored regularly to ensure that they are under control. Other diseases have methods for regular screening. Screening may help detect disease earlier and allow for early intervention or may help avoid the disease altogether. Examples are monitoring blood cholesterol or blood pressure to help decrease risk of heart disease and stroke, and screening using the PAP test for cervical cancer, mammogram for breast cancer, fecal occult blood test or colonoscopy for colorectal cancer, and total body skin check for melanoma, among others. Screening can also be done for chronic disease risk factors like mental health status, alcohol use, and other substance use.

- There were no differences in the prevalence of high blood pressure among adults in the Central Oregon Counties (Figure 29).

![Figure 29. Age-adjusted prevalence of high blood pressure or high blood cholesterol, Oregon, BRFSS, 2010-2013](image)
Chronic Diseases

- The percent of adults who are current with a cholesterol check is nearing the HP 2020 goal of 82.1% (Figure 30).

![Figure 30. Age-adjusted prevalence of having had a cholesterol check in the last 5 years, Oregon, BRFSS, 2010-2013](image)

- Though the estimates are not directly comparable, adults enrolled in OHP tended to have a lower frequency of having received key screenings for chronic diseases than the general population (Figure 31).

![Figure 31. Percent of adults enrolled and not enrolled in OHP who have received key chronic disease screenings, Oregon, MBRFSS, 2014](image)

H=95% Confidence Interval
\( \pm \) No estimate available

Note: General population percents may not be directly comparable to OHP percents due to survey differences. They are provided for a reference.
Chronic Diseases

- Only one third of adults in Crook County reported being current for colorectal cancer screening (Figure 32).
- Deschutes County was nearing the HP 2020 goals for cancer screening (Figure 32).

**Figure 32. Age-adjusted prevalence of having received cancer screening, Oregon, BRFSS, 2010-2013**

**CCO Measures**

Several chronic diseases can be monitored regularly to ensure that they are under control. Other diseases have methods for regular screening. Screening may help detect disease earlier and allow for early intervention or may help avoid the disease all together. Examples are monitoring blood cholesterol or blood pressure to help decrease risk of heart disease and stroke, and screening using the PAP test for cervical cancer, mammogram for breast cancer, fecal occult blood test or colonoscopy for colorectal cancer, and total body skin check for melanoma, among others. Screening can also be done for chronic disease risk factors like mental health status, alcohol use, and other substance use.

- There were no differences in the prevalence of high blood pressure among adults in the Central Oregon Counties (Figure 29).

**Percentage of adult patients (ages 18-75 years) with diabetes who received at least one A1c blood sugar test.**

**Percentage of adult patients (aged 18-75 years) with diabetes who received an LDL-C (cholesterol) test.**

**Percentage of patients (18-75 years of age) with diabetes who had hemoglobin A1c>9.0% during the measurement period.**

**Percentage of adult members (ages 50-75 years) who had appropriate screening for colorectal cancer.**

**Percentage of women (aged 21 to 64 years) who got one or more Pap tests for cervical cancer in the past three years.**

**Percentage of patients 18-85 years of age who had a diagnosis of hypertension (high blood pressure) and whose blood pressure was adequately controlled.**

**Rate of adult patients (18 years and older) with diabetes who had a hospital stay because of a short-term problem from their disease (per 100,000 member years). (PQI 01)**

**Rate of adult patients (aged 18 years and older) who had a hospital stay because of congestive heart failure (per 100,000 member years). (PQI 08)**

**Rate of adult patients (age 40 years and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease (per 100,000 member years). (PQI 05)**

**Rate of adult members (ages 18-39 years) who had a hospital stay because of asthma (per 100,000 member years).**

34

Attachment 10-Community Health Assessment
Communicable Diseases

Communicable disease refers to infectious diseases that can be transmitted among people either directly or indirectly. Public health officials track infections that are of most importance to the health of the population in order to help stop their spread. Public health surveillance is conducted to monitor outbreaks and disease burden, describe burden of new or emerging disease, and locate and inform people exposed to a communicable disease.

Immunizations

Immunizations are a key public health measure for preventing the spread of disease (CDC). Immunizations have successfully reduced the number of some diseases to historic lows. However, some people are unable to receive immunizations due to a medical condition or they decline immunizations for other reasons.

- Non-medical exemptions for kindergarteners were more common in Deschutes County (8.3%) than Jefferson County (1.0%) and Crook County (2.7%). The non-medical exemption rate for kindergartners in Oregon was 5.8% (OHA, 2014-2015). There were 159 non-medical exemptions in Deschutes County during the 2014-2015 school year.
- All three counties and the state overall reported a drop in non-medical exemption rate for the 2014-2015 school year. A new law went into effect on March 1, 2014 requiring parents seeking non-medical exemption to receive education about the risks and benefits of vaccines.

Childhood

A series of immunizations are delivered to children to ensure their immunity to many diseases. Some immunizations require several doses to establish immunity. To be up-to-date, children should receive 4 doses of Diphtheria, Tetanus, and acellular Pertussis (DTaP), 3 doses of Polio vaccine, 1 dose of Measles, Mumps and Rubella (MMR), 3 doses of Haemophilus Influenzae Type b (HiB), 3 doses of Hepatitis B, 1 dose of Varicella, and 4 doses of pneumococcal conjugate vaccine (PCV) by their second birthday.

- Two-year-olds in Jefferson County were more frequently up to date with immunizations than were two-year-olds in the other Central Oregon Counties and the state overall (Figure 34).

Figure 34. Two-year old up-to-date* immunization rates, ALERT, Oregon, 2013

* 4 doses DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses HepB, 1 dose Varicella, 4 doses PCV
1=95% confidence interval
† National Immunization Survey, 2013
**Immunizations Continued**

- Jefferson County two-year-olds enrolled in the Women, Infants, and Children (WIC) Program and OHP were more frequently up-to-date with immunizations than were those enrolled in those programs in Oregon (Figure 35).
- Deschutes County two-year-olds not enrolled in WIC and OHP were less frequently up-to-date with immunizations than were those enrolled in those programs in Oregon (Figure 35).

**Figure 35.** Two-year old up-to-date\(^\dagger\) immunization rates by program, ALERT, Oregon, 2013

\[\text{\(4\) doses DTaP, 3 doses IPV, 1 dose MMR, 3 doses Hib, 3 doses HepB, 1 dose Varicella}\]  
\[\text{I=95\% confidence interval}\]

**Adolescents**

Other vaccines are available to reduce the risk of some diseases among adolescents. Adolescents are eligible for vaccine coverage from human papilloma virus (HPV) and meningococcal disease. It is also important to maintain immunity for diseases covered in the Tetanus, Diptheria, and acellular Pertussis vaccine (TDaP) and influenza vaccine.

- Adolescent immunization rates are shown in Figure 36.

**Figure 36.** Adolescent (aged 13-17 years) immunization rates by type of vaccine, ALERT, Oregon, 2013

\(\text{\(\dagger\)Healthy People 2020 goal is for adolescents 13-15 years}\)
Communicable Diseases

Adults

As people age, there is still a need to receive new immunizations or update past immunizations. Some factors such as age, lifestyle, travel, history of having received a vaccine, and existing health conditions may also determine the need for adult immunizations. Some vaccines may be new and were not available during childhood, like the herpes zoster vaccine for shingles.

- Deschutes County adults aged 65 years and older had a significantly higher frequency of receiving an annual influenza vaccine than did those in Oregon overall. There were no differences in having ever received a pneumococcal vaccine (Figure 37).

![Figure 37. Age-adjusted percent of adults aged 65 years and older who received key immunizations, Oregon, BRFSS, 2008-2011](image)

**Vaccine Preventable Diseases**

Despite having a vaccine available for prevention, the diseases below still occur in Oregon and the Central Oregon Counties.

- Influenza (flu) is a vaccine preventable disease that causes mild to severe respiratory illness. In the US, thousands of influenza-associated deaths occur each year. The severity of influenza varies year-to-year depending on what versions of the virus are spreading, timing of flu season, and how well the vaccine matches the viruses that are causing illness. Another key factor is how many people get vaccinated. During the 2013-2014 influenza season, an estimated 7.2 million influenza-associated illnesses were prevented by influenza vaccination in the US (CDC, 2015).

- Between 2004 and 2013, the incidence rates of Haemophilus influenzae (a bacterial infection) and meningococcal disease in Central Oregon were similar to the Oregon rate (Table 12).

- Between 2004 and 2013, the incidence rate of pertussis was lower in Central Oregon than in Oregon overall (Table 12). However, in 2014, 60 cases of pertussis were identified in Deschutes County, more than identified in the previous 10 years. Pertussis is now considered widespread in Deschutes County.

- Other vaccine preventable diseases are not shown here because they occur infrequently.

<table>
<thead>
<tr>
<th>Table 12. Age-adjusted rate per 100,000 population of vaccine preventable diseases, Oregon, OPHAT, 2004-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em></td>
</tr>
<tr>
<td><em>Meningococcal disease</em></td>
</tr>
<tr>
<td><em>Pertussis (whooping cough)</em></td>
</tr>
</tbody>
</table>

(#): Number of cases

Significantly lower than the state overall
Communicable Diseases

Hepatitis
There are several hepatitis viruses present in the world. The most common in the US are hepatitis A, B, and C. Some hepatitis viruses are spread through sexual activity, others via contact with blood or items contaminated with blood, and some are spread through contaminated food and water. While hepatitis A, B, and C can be acute infections, hepatitis B and C can progress into a serious lifelong, chronic disease. Hepatitis A and B are preventable with a vaccine. Currently, there is no vaccine for hepatitis C. However, treatment options are available for hepatitis C and it may be cured.

- Chronic hepatitis B occurred less frequently in the Central Oregon Counties than in the state overall (Table 13).
- The age-adjusted rate of past or present hepatitis C in Central Oregon was similar to the Oregon rate (Table 13). However, the age-adjusted rate in Jefferson County for past or present hepatitis C was higher than in the state overall (272.9/100,000).
- Nationally, there was a 151.5% increase in acute hepatitis C cases from 2010 to 2013. This increase is thought to be due to both true increases in incidence and improved case reporting and detection (CDC, 2013).

| Table 13. Age-adjusted rate per 100,000 population of hepatitis, Oregon, OPHAT, 2004-2013 |
|---------------------------------|------------------|------------------|
|                                | Oregon           | Central Oregon   |
| Hepatitis A                    | 0.4 (86)         | 0.5 (5)          |
| Hepatitis B (acute)            | 1.0 (189)        | 0.9 (9)          |
| Hepatitis B (chronic)          | 11.0 (2,137)     | 3.8 (39)         |
| Hepatitis C (acute)            | 0.7 (122)        | 0.7 (6)          |
| Hepatitis C (past or present)  | 122.0 (25,448)   | 114.3 (1,276)    |

[†] Number of cases
(§) Significantly lower than the state overall
Communicable Diseases

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are preventable with proper precautions, testing, and treatment. Clinicians and public health staff work diligently to stop the spread of STIs by breaking transmission via screening and helping patients with partner notification. In Oregon, the use of expedited partner therapy allows a patient to provide medication to their sexual partners without a healthcare provider first examining the partner.

- **Chlamydia** is the most commonly reported STI in the US and in Central Oregon. If left untreated, chlamydia can lead to infertility and tubal pregnancy. Gonorrhea is another common STI that is readily treatable, yet has serious long-term effects if left untreated. Gonorrhea is less common than is chlamydia. Chlamydia and gonorrhea can be present without symptoms, so women and men with specific risks should be tested annually. Syphilis is a rarer STI, but can have serious implications if left untreated.

- There were 13 cases of early syphilis in Central Oregon between 2009 and 2013 (OPHAT, 2009-2013), an average of 2-3 cases a year. There were 4 cases reported in 2014 (Provisional data, OHA).

- Chlamydia rates have been increasing in Oregon since 2004 (Figure 38). There were 721 cases of chlamydia reported in Central Oregon in 2014 (Provisional data, OHA).

- The chlamydia rate is higher in Jefferson County, though the difference has not reached statistical significance (Figure 38).

  **Figure 38. Age-adjusted chlamydia incidence rate per 100,000 population, Oregon, OPHAT, 2004-2013**

- Ages 18-24 years had the highest rates of chlamydia (Figure 39).
- Deschutes and Jefferson Counties had higher rates than did Oregon overall for several age groups (Figure 39). Other age groups are not presented due to very low case numbers.

  **Figure 39. Chlamydia incidence rate per 100,000 population by age group, Oregon, OPHAT, 2009-2013**

* Significantly higher than the state overall
† Too few cases to report
Sexually Transmitted Infections Continued

- The incidence rate of gonorrhea was lower in Deschutes County than in Oregon overall (Figure 40).
- Between 2009 and 2013, there were 79 cases of gonorrhea reported in Central Oregon (data not shown), an average of about 16 cases a year. In 2014 alone, there were 49 cases of gonorrhea reported in Central Oregon (Provisional data, OHA).

![Figure 40. Age-adjusted gonorrhea incidence rate per 100,000 population, Oregon, OPHAT, 2009-2013](image)

- *Significantly lower than the state overall

- Human Immunodeficiency Virus (HIV) is transmitted via infected bodily fluids, such as blood, semen, vaginal secretions, and breast milk. HIV leads to the development of Acquired Immune Deficiency Syndrome (AIDS) and is a serious, chronic disease that makes a person susceptible to many other infections and diseases. There is no vaccine or cure for HIV.
- Between 2003 and 2012, an average of 5-6 people were diagnosed with HIV each year in Central Oregon (HIV/AIDS Epidemiologic Profile, 2012)
Vector Born Diseases
- Vector borne diseases are rare in Central Oregon (Table 14).
- Malaria and dengue fever cannot be contracted in Central Oregon, as the vector that transmits the disease is not present. The cases presented in this report represent residents of Central Oregon who traveled to malaria or dengue fever endemic areas and contracted the disease. These data suggest more could be done to inform travelers about their risks when leaving the area.

Diarrheal Diseases
Diarrheal diseases are often associated with contaminated water or food. Many efforts are made by public health officials to ensure clean drinking water and food safety guidelines are followed. See the Environmental Health (page 63) and Water Quality (page 76) sections for more information.
- Water-borne diseases are common in the Central Oregon counties and were reported at higher rates than in Oregon overall (Table 15). However, note that many water-borne diseases go unreported. Higher rates may be related to capacity to detect disease.
- There were too few cases of legionellosis and listeriosis in Central Oregon to report (Table 15).

| Table 14. Number of vector borne diseases reported in Oregon and Central Oregon, OPHAT, 2004-2013 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                  | Oregon          |            | Central         | Oregon          |
| Colorado tick fever | 7               | <5           | 16.4 (125)      | 1.4 (26)        |
| Dengue fever      | 43              | <5           | 1.1 (16)        | 9.3 (12)        |
| Hantavirus        | 14              | 6            | 4.2 (1,568)     | 1.0 (105)       |
| Lyme disease      | 380             | 10           | 4.3 (1,568)     | 1.1 (16)        |
| Malaria           | 145             | 7            | 16             | 1.4 (26)        |
| Rocky mountain spotted fever | 16 | <5 | 6.8 (105) | 1.1 (16) |
| West Nile virus   | 172             | <5           | 29.0 (451)      | 26.4 (56)       |

§ May not be region of acquisition
† While the vector for Lyme disease exists in Oregon, it has not been found in Central Oregon
‡ Acquired elsewhere

| Table 15. Age-adjusted incidence rate per 100,000 population of water-borne diseases, Oregon, OPHAT, 2004-2013 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                  | Oregon          | Crook           | Deschutes       | Jefferson       |
| Campylobacteriosis | 20.4 (7,727) | 26.8 (52) | 29.0 (451) | 26.4 (56) |
| Cryptosporidiosis | 4.2 (1,568)   | † (9)          | 1.1 (16)        | † (<5)         |
| E. coli (STEC)    | 3.3 (1,207)    | 5.7 (12)       | 6.8 (105)       | † (8)           |
| Giardiasis        | 11.7 (4,296)   | 5.7 (12)       | 18.4 (274)      | 10.2 (22)       |
| Legionellosis     | 0.5 (197)      | † (<5)         | † (<5)          | † (<5)         |
| Listeriosis       | 0.3 (113)      | † (<5)         | † (<5)          | † (<5)         |
| Salmonellosis (non-typhoidal) | 11.1 (4,098) | 13.0 (26) | 9.9 (149) | 9.3 (19) |
| Shigellosis       | 2.3 (823)      | † (<5)         | 1.0 (15)        | 9.5 (20)        |
| Vibriosis (non cholera) | 0.4 (158) | † (<5) | 0.8 (13) | 0.7 (15) |
| Yersinosis        | 0.5 (191)      | † (<5)         | ** (5)          | † (<5)         |

† Too few cases to calculate a rate
‡ Number of cases
§ Significantly higher than the state overall
| Presumed non- endemic diseases are not included in the age-adjusted incidence rates.

While the vector for Lyme disease exists in Oregon, it has not been found in Central Oregon.

Acquired elsewhere

† Acquired elsewhere
Communicable Diseases

Healthcare Associated Infections
Significant effort has focused recently on the prevention of HAIs. These include central line associated bloodstream infections (CLABSI), infections related to coronary artery bypass grafts (CABG), and Clostridium difficile infections. Hospitals and healthcare providers have instituted processes and protocols to help reduce the incidence of HAIs in their facilities.

- The Standardized Infection Ratio (SIR) is a measure used to track HAI prevention progress. According to CDC, the SIR compares the number of infections in a facility or state to the number of infections that were “predicted”, or would be expected, to have occurred based on previous years of reported data (national baseline). Lower SIRs are better. The SIR is low for most HAIs in Central Oregon facilities. (Table 16)

- The SIR is higher than the national baseline for C. difficile in the St. Charles Health System in Redmond and Bend (Table 16).

<table>
<thead>
<tr>
<th>Table 16. Standard Infection Ratios of selected HAI among Central Oregon healthcare facilities, Oregon Health Authority, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>CLABSI-adult</td>
</tr>
<tr>
<td>CLABSI-neonatal</td>
</tr>
<tr>
<td>CABG</td>
</tr>
<tr>
<td>Knee replacement</td>
</tr>
<tr>
<td>Colon surgery</td>
</tr>
<tr>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Hip replacement</td>
</tr>
<tr>
<td>Laminectomy</td>
</tr>
<tr>
<td>C. difficile</td>
</tr>
<tr>
<td>--</td>
</tr>
</tbody>
</table>

Data from: Oregon Health Authority

Vaccination of healthcare staff from influenza is an effective way to reduce spread to vulnerable patients and to reduce staff illness.

- St. Charles-Madras staff had a higher healthcare worker influenza vaccination rate than other Central Oregon healthcare facilities (OHA, 2013-2014). The HP 2020 goal is a 90% vaccination rate.

  - Bend: 73%, Madras: 78%, Redmond: 75%, Prineville: 77%

CCO Measures

- Central Oregon CCO has met the quality measure goal for testing children with a sore throat for strep before getting an antibiotic (Figure 41).

Figure 41. Central Oregon CCO quality measures related to communicable disease, June 2014

Percentage of adolescents who received recommended vaccines before their 13th birthday.

Percentage of children who received recommended vaccines before their second birthday.

Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.

Percentage of sexually active women (ages 16-24 years) who had a test for chlamydia infection.
Maternal Health and Pregnancy

Introduction
The health of a child begins with a healthy mother and a healthy pregnancy. Factors like not using tobacco, alcohol, or other drugs, maintaining a healthy weight, receiving prenatal care, maintaining good oral health, breastfeeding, and preventing injuries and adverse childhood experiences (ACEs) are key for starting an infant’s life in a healthy manner. See the Adverse Childhood Experiences section (pages 54-55) for more information on this topic.

Several programs exist to support mothers and infants. One program is the Women, Infants, and Children (WIC) Program, a special supplemental nutrition program that “provides supplemental foods, healthcare referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to five years of age who are found to be at nutritional risk” (USDA). Another program is the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. Home visiting is a proven strategy for strengthening families and improving the health status of women and children. There are a variety of home visiting programs available in Central Oregon, including: Maternity Case Management, Nurse Family Partnership, Babies First!, CaCoon, and Healthy Families Oregon.

- In 2013, there were 770,514 women of childbearing age (15-44 years) in Oregon and 36,801 in Central Oregon representing 19.6% and 17.7% of the total population, respectively.
  - 3,177 in Crook County
  - 30,069 in Deschutes County
  - 3,555 in Jefferson County

Prenatal Care
Prenatal care is the healthcare a woman receives during pregnancy. Beginning early in pregnancy, visits to a healthcare provider are recommended based on a specific schedule. A dental visit is also recommended after the first trimester. Prenatal care helps healthcare providers detect problems early to improve the health of the mother and baby and may even prevent or cure some conditions.

- One method to measure adequate prenatal care is the Kotelchuck index. Adequate prenatal care is defined as having received at least 80% of expected prenatal visits. Jefferson County had a lower frequency of mothers receiving adequate prenatal care than Oregon overall (Table 17).

<table>
<thead>
<tr>
<th>Table 17. Timeliness of prenatal care, Oregon, OPHAT, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of births</td>
</tr>
<tr>
<td>Oregon</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Adequate Prenatal Care-Kotelchuck Index</td>
</tr>
<tr>
<td>Prenatal care started in 1st trimester</td>
</tr>
<tr>
<td>Prenatal care started in 2nd trimester</td>
</tr>
<tr>
<td>Prenatal care started in 3rd trimester</td>
</tr>
<tr>
<td>No prenatal care</td>
</tr>
</tbody>
</table>

† Significantly different than the state overall
† Too few births to report
§ Percent of births in Central Oregon paid by the Oregon Health Plan
Maternal Health and Pregnancy

Prenatal Care Continued

- About 3 of 4 (77%, 95% CI 68.2%-85.2%) of Central Oregon mothers said that they received an HIV test sometime during their most recent pregnancy or delivery. The proportion for the rest of the state was 68.8% (95% CI 66.6%-71.0%) (PRAMS, 2009-2011).
- 60.9% (95% CI 51.4%-70.4%) of mothers in Central Oregon reported they were offered an influenza vaccine or were told to get one during their last pregnancy. This was significantly lower than in the rest of the state (77.8% 95% CI 76.0%-79.6%).

Births

Healthcare is important during and immediately after birth. At this point, breastfeeding can be implemented and safety topics can be addressed. Reviewing the birth rates in an area can help identify a specific population’s fertility patterns and identify the need for reproductive health services.

- The fertility rate (the number of pregnancies per 1,000 women of childbearing age) has not significantly changed since 2000 among the three Central Oregon Counties. However, there has been a significant decrease in the fertility rate in Oregon overall (Figure 42).
- In 2013, Jefferson County had the highest fertility rate among women aged 15-44 years among the Central Oregon Counties and as compared to Oregon overall (Figure 42).

Figure 42. Fertility rate per 1,000 women aged 15-44 years, Oregon, OPHAT, 2000-2013

- American Indians and whites in Jefferson County had a higher fertility rate than the state overall (Figure 43).
Maternal Health and Pregnancy

Births Continued

- Teen parents and their children experience several long-term impacts that lead to significant socioeconomic costs (CDC, Teen Pregnancy). The fertility rate among teens was higher in Jefferson County than in Oregon overall (Figure 44). However, the total number of births to teens aged 15-19 years in Central Oregon has decreased from 215 in 2004 to 128 in 2013 (data not shown).
- The fertility rate among women aged 20-24 years old was higher among all the Central Oregon counties than those aged 20-24 years in Oregon (Figure 44).

Figure 44. Fertility rate per 1,000 women aged 15-44 years by age group, Oregon, OPHAT, 2009-2013

There are approximately 45,000 births each year in Oregon and 2,200 in Central Oregon (Table 18).

<table>
<thead>
<tr>
<th>Table 18. Total number of births by county and payer, Oregon, OHA Birth Certificate Data, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of births</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Percent of births paid by OHP</strong></td>
</tr>
</tbody>
</table>

- The percent of births paid for by OHP varies by age group and race (Figure 45).
Maternal Health and Pregnancy

**Pregnancy Risk Factors**

There are several risk factors related to poor pregnancy outcomes, such as use of tobacco, alcohol, certain medications, controlled substances, and poor nutrition during pregnancy. Other factors like maternal age and existing health conditions may also complicate a pregnancy.

- 4.7% of Central Oregon mothers reported that they drank alcohol in the last 3 months of their pregnancy (95% CI 0.9%-8.6%). The prevalence was 8.2% for the rest of the state (95% CI 7.0%-9.5%) (PRAMS, 2009-2011).
- 60.3% (95% CI 51.3%-69.3%) of Central Oregon mothers reported that they drank alcohol in the 3 months before their pregnancy. The prevalence for the rest of the state was 55.8% (95% CI 53.8%-57.8%).
- The National Institute on Drug Abuse states that, “THC exposure very early in life may negatively affect brain development.… However, more research is needed to separate marijuana’s specific effects from other environmental factors, including maternal nutrition, exposure to nurturing/neglect, and use of other substances by mothers.… Breastfeeding mothers are cautioned that some research suggests that THC is excreted into breast milk in moderate amounts. Researchers do not yet know what this means for the baby’s developing brain.”
- Though not statistically significant, Crook County had a higher rate of smoking during pregnancy than the other Central Oregon Counties (Figure 46). The percent of mothers who smoked during pregnancy in Crook County peaked in 2008 and has been declining since. However, the rate is still much higher than the HP 2020 goal of 1.4%.

**Figure 46. Percent of mothers who smoked during pregnancy, Oregon, OPHAT, 2000-2013**

![Graph showing smoking rates over time.](image)
Maternal Health and Pregnancy

Pregnancy Risk Factors Continued

- The frequency of smoking during pregnancy was six times higher among women enrolled in OHP in Central Oregon than those with private insurance (Figure 47).

Figure 47. Prevalence of smoking during pregnancy by type of insurance, Central Oregon, OHA, 2010-2012

- Pregnancy risk factors occurred at similar frequencies among mothers enrolled in OHP and the general population (Table 19).

Table 19. Percent of births with specific pregnancy risk factor, Oregon, OPHAT, 2013

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Oregon</th>
<th>Oregon-OHP</th>
<th>Central Oregon</th>
<th>Central Oregon-OHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational diabetes</td>
<td>7.6</td>
<td>8.0</td>
<td>6.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Pre-pregnancy diabetes</td>
<td>0.9</td>
<td>1.2</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>0.8</td>
<td>0.9</td>
<td>0.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td>6.1</td>
<td>5.8</td>
<td>6.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Pre-pregnancy hypertension</td>
<td>1.6</td>
<td>1.6</td>
<td>1.2</td>
<td>1.2</td>
</tr>
</tbody>
</table>

- The prevalence of gestational diabetes nearly doubled between 2004 and 2013 (Figure 48).
Pregnancy Risk Factors Continued

- The prevalence of preterm birth is higher among women enrolled in OHP in Central Oregon than the state overall (Table 20).

| Table 20. Percent of births by gestational age at birth and birth weight, Oregon, OPHAT, 2013 |
|-----------------------------------------------|-------------|-----------------|-----------------|-----------------|-----------------|
|                                  | Oregon     | Oregon-OHP     | Central Oregon  | Central Oregon-OHP | HP 2020         |
| Preterm birth                   |            |                |                 |                  |                 |
| <36 weeks                       | 7.8        | 8.0            | 7.6             | 10.1             | 11.4            |
| 32-36 weeks                     | 6.4        | 6.7            | 7.1             | 9.2              |                 |
| <32 weeks                       | 1.2        | 1.3            | 0.7             | 0.9              | 1.2             |
| Birth Weight                    |            |                |                 |                  |                 |
| < 2500 grams (low birth weight) | 6.3        | 6.9            | 6.4             | 8.1              | 7.8             |
| >=4000 grams (high birth weight)| 10.6       | 9.1            | 8.0             | 6.2              |                 |

- Healthcare providers discuss several topics during prenatal visits to ensure a mother and her baby are kept safe (Figure 49). The percent of mothers reporting their healthcare provider discussed these topics with them was not significantly different in Central Oregon than in the remainder of the state (data not shown).

Figure 49. Percent of mothers who state their health care professional discussed topics with them about most recent pregnancy, Central Oregon, PRAMS, 2009-2011

<table>
<thead>
<tr>
<th>Medications that are safe to use during pregnancy</th>
<th>90.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>What to do if labor starts early</td>
<td>89.0</td>
</tr>
<tr>
<td>Screening test for birth defects</td>
<td>84.9</td>
</tr>
<tr>
<td>Breastfeeding their baby</td>
<td>82.0</td>
</tr>
<tr>
<td>Signs of preterm labor</td>
<td>81.8</td>
</tr>
<tr>
<td>Getting tested for HIV</td>
<td>74.6</td>
</tr>
<tr>
<td>Eating fish high in mercury</td>
<td>72.5</td>
</tr>
<tr>
<td>What to do if feel depressed during pregnancy</td>
<td>70.9</td>
</tr>
<tr>
<td>How drinking alcohol could affect baby</td>
<td>69.1</td>
</tr>
<tr>
<td>How smoking tobacco could affect baby</td>
<td>64.7</td>
</tr>
<tr>
<td>How using illegal drugs could affect baby</td>
<td>59.0</td>
</tr>
<tr>
<td>Physical abuse by their partners</td>
<td>55.4</td>
</tr>
<tr>
<td>Using a seatbelt</td>
<td>48.0</td>
</tr>
</tbody>
</table>
Maternal Health and Pregnancy

Unintended Pregnancy
Unintended pregnancy refers to pregnancies that are mistimed, unplanned, or unwanted. About 51% of pregnancies in the US are unintended (Guttmacher Institute, 2015). Measuring rates of unintended pregnancy helps gauge a population’s needs of contraception and family planning. Unintended pregnancy is associated with increased risk of health problems for the baby as the mother may not be in good health or delay prenatal care upon learning of the pregnancy.

- 41.7% (95% CI 32.4%-51.0%) of pregnancies in Central Oregon were considered unintended. The proportion for the rest of the state was 37.9% (95% CI 35.9%-40.0%) (PRAMS, 2009-2011).
- The abortion rate (induced abortions) decreased to 10.6 per 1,000 women aged 15-44 years in 2013. During the past 20 years, Oregon’s abortion rate for women aged 15 to 44 years has generally declined from a high of 21.4 in 1991 to a low in 2013 of 10.6. (Oregon Vital Statistics Annual Report, 2013).
- Contraceptive failure is not the reason for the majority of abortions in Central Oregon. For about 3 of 4 abortions, no contraceptive was used (Figure 50).

Figure 50. Percent of abortions with contraceptive use, Oregon†, Vital Statistics, 2011-2013

CCO Measures
- Figure 51 contains the maternal and infant-related CCO measures. The Central Oregon CCO has met the goal of providing postpartum care visits to women within a specific time frame.

Figure 51. Central Oregon CCO quality measures related to maternal and infant health, June 2014

- Percentage of pregnant women who received within the first trimester or within 42 days of enrolling in Medicaid.
- Percentage of women who had an elective delivery between 37 and 39 weeks of gestation.
- Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.
- Percentage of children up to 15 months old who had at least 6 well child visits with a HCP.
Child and Adolescent Health

Infant, Early Childhood and Adolescent Health

Children are exposed to and react to environmental and physical exposures differently than adults. Adolescents are entering a time in their life when they are exploring and establishing health patterns and behaviors. Ensuring their safety and knowledge of health behaviors is vital to their overall health. For information on childhood immunization see the Immunizations Section (page 35-36).

- From 2004 to 2013, the average number of infant deaths each year in Central Oregon was 11. The leading causes of death for infants were conditions originating in the perinatal period, congenital malformations, and unintentional injuries (OPHAT, 2004-2013).
- Between 2004 and 2013, there was an average of 10 deaths per year among children and adolescents (1-17 years) in Central Oregon. The three leading causes of death for children and adolescents were unintentional injuries, suicide, and malignant neoplasms (cancer) (OPHAT, 2004-2013).
- The leading causes of unintentional injury-related death for children and adolescents (1-17 years) were motor vehicle crash and drowning in Central Oregon and Oregon overall (OPHAT, 2004-2013).
- The most common childhood cancers in the United States are leukemia and brain or central nervous system tumors (American Cancer Society).

Breastfeeding

Breastfeeding is an important source of nutrition for a baby with several health benefits for the mother and the baby. A mother’s milk can deliver important antibodies to an infant to help fight infections and has been shown to decrease incidence of allergies and asthma. Breastfeeding is also a low cost method for feeding infants that promotes bonding between a mother and baby. Breastfeeding for longer periods and exclusively can increase the health benefits for both the mother and the baby. Recommendations suggest exclusively breastfeeding a baby for at least six months and then supplementing solid food with breast milk. Many mothers initiate breastfeeding, but several barriers lead to discontinuation or decreased breastfeeding as the infant grows.

- The Maternity Practices and Infant Nutrition and Care (mPING) survey ranked Oregon 5th among state and territory respondents (2013). This survey focuses closely on breastfeeding practices.
- Breastfeeding as reported on the birth certificate was similar in Crook and Deschutes Counties (90.5%, 90.3%, respectively) as it was in Oregon (89.2%). Jefferson County’s breastfeeding rate at birth was slightly lower (85.0%) (Birth Certificates, 2011-2013). The HP 2020 goal is 81.9%.
- The WIC Program supports families with supplemental nutrition and promotes healthy behaviors, like breastfeeding. In 2014, WIC served over 8,500 individuals in Central Oregon in 2014 (Table 21).

<table>
<thead>
<tr>
<th>Table 21. Percent of mothers enrolled in WIC who breastfeed and number of WIC clients served in Central Oregon, WIC County Data Reports, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals served</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td>Percent initiated breastfeeding</td>
</tr>
<tr>
<td>Percent still breastfeeding at six months</td>
</tr>
</tbody>
</table>

N/A = data not available
§ Data from 2013 Annual Report
Child and Adolescent Health

Child and Family Support
Some children and families need extra support in order to ensure they receive the healthiest start in life. The child welfare system includes various services to support children, promote safety, and strengthen families in an effort to prevent abuse and neglect. The Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) programs work to provide support for low-income families and individuals and help them become self-sufficient. Other state services also are available to help families provide best for themselves including free or reduced lunch and foster care.

- Free and reduced cost lunch programs ensure that access to healthy food at school is available to all students, regardless of family income. Between 26% and 31% of children live in food insecure houses in Central Oregon (Table 22).
- The foster care system links children with temporary living arrangements during times when their biological parents cannot care for them. Children are often in foster care due to abuse and neglect. About 1% of children in Central Oregon were in foster care for at least 1 day in 2012 (Table 22). That equates to about 350 children.

<table>
<thead>
<tr>
<th>Table 22. Information related to child and family support, Oregon</th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in SNAP† (Food stamps)</td>
<td>297,162</td>
<td>1,797</td>
<td>12,148</td>
<td>3,071</td>
</tr>
<tr>
<td>Number in TANF† (Cash assistance)</td>
<td>63,016</td>
<td>388</td>
<td>2,222</td>
<td>838</td>
</tr>
<tr>
<td>Average monthly number of children in employment related day care program</td>
<td>16,289</td>
<td>37</td>
<td>570</td>
<td>119</td>
</tr>
<tr>
<td>Percent of children in food insecure house‡</td>
<td>27.3</td>
<td>30.4</td>
<td>26.1</td>
<td>31.2</td>
</tr>
<tr>
<td>Percent of students eligible for free or reduced lunch§</td>
<td>52.0</td>
<td>56.5</td>
<td>46.8</td>
<td>81.0</td>
</tr>
<tr>
<td>Rate of available childcare providers per 100 children under 13 years†</td>
<td>17</td>
<td>10</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Rate of child victims of abuse or neglect per 1,000 children under age 18‡‡</td>
<td>11.6</td>
<td>19.9</td>
<td>9.2</td>
<td>9.7</td>
</tr>
<tr>
<td>Rate of children in foster care per 1,000 children (point in time) ‡‡</td>
<td>1.5</td>
<td>1.2</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Rate of referrals to juvenile justice per 1,000 children aged 0-17 years‡‡‡</td>
<td>17.5</td>
<td>41.2</td>
<td>24.4</td>
<td>31.8</td>
</tr>
</tbody>
</table>

† Data from 2013
‡ Data from 2012
§ Data from 2013-2014
‡‡ Data from 2010
‡‡‡ Data from Oregon DHS: Children, Adults, and Families Division
http://datacenter.kidscount.org
Child and Adolescent Health

Childhood Health and Education
Good nutrition, access to physical activity, abstinence from alcohol and other drugs of abuse, and emotional support have been linked to better academic performance. Academic performance is measured regularly throughout a child's primary and secondary school years and ends in an on-time graduation from high school.

Early care and education centers play an important role in a young child's dietary and physical activity behaviors. In 2012, an estimated 37.3%, 39.4%, 25.7% of 3 and 4-year-olds were enrolled in early education in Crook, Deschutes, and Jefferson Counties, respectively. The frequency was 42.0% in Oregon (Children First For Oregon 2014 Report).

- In an assessment of Kindergarteners, children from underserved races and ethnicities in Central Oregon scored lower than those of other races and ethnicities with regards to number recognition, letter names, and letter sounds (ODE, 2014).
- The percent of students meeting or exceeding standards for writing skills were 39%, 64%, and 41% among Crook, Bend-La Pine, and Jefferson students, respectively (ODE, 2014).
- 68% of 8th graders in Central Oregon are math proficient (ODE, 2013-2014).
- Bend-La Pine schools has consistently had a higher percent of students meeting or exceeding standards than the other Central Oregon school districts (Figure 52).
- Despite the percent of students meeting or exceeding standards being lower in early grades, by the time students reached 11th grade, the percent meeting or exceeding standards for reading and science were approximately the same among all schools (Figure 52). Crook County schools had lower percent of students meeting or exceeding math standards in 11th grade than did Bend-La Pine and Jefferson students.

Figure 52. Percent of students that meet or exceed standards for math, reading, science by grade, Central Oregon, ODE, 2014

- Students who are economically disadvantaged or are of an underserved race or ethnicity have a lower four-year graduation rate than the rate for the region (economically disadvantaged=59.2%, underserved race/ethnicity=55.3%, respectively) (Better Together Baseline Report, 2015).
Child and Adolescent Health

- The four-year graduation rate (excluding GED) in Crook County was 30.5%, 75.6% in Deschutes County, and 62.5% in Jefferson County (Oregon Department of Education, 2015) (Table 23).

<table>
<thead>
<tr>
<th>School District</th>
<th>4 year percent</th>
<th>5 year percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>72.0</td>
<td>75.9</td>
</tr>
<tr>
<td>Central Oregon</td>
<td>67.6</td>
<td>76.9</td>
</tr>
<tr>
<td>Crook County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deschutes County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bend-La Pine</td>
<td>77.2</td>
<td>82.0</td>
</tr>
<tr>
<td>Redmond</td>
<td>70.5</td>
<td>75.2</td>
</tr>
<tr>
<td>Sisters</td>
<td>82.8</td>
<td>90.9</td>
</tr>
<tr>
<td>Jefferson County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashwood</td>
<td>100.0</td>
<td>--</td>
</tr>
<tr>
<td>Culver</td>
<td>76.6</td>
<td>88.9</td>
</tr>
<tr>
<td>Jefferson Co</td>
<td>57.5</td>
<td>75.9</td>
</tr>
</tbody>
</table>

§ May be artificially low due to an error when the data were reported

Child and Adolescent Health Risk Factors
Many of the risk factors for child and adolescent health are the same as adults. However, addressing the specific risks may require different approaches. Avoiding these risks early in life is important for leading a long and healthy life.

- Risky sexual activity places an adolescent at risk for STIs and unplanned pregnancy. About half of Central Oregon 11th graders reported having ever had sexual intercourse (Figure 53). This was a large increase from the percentages reported among 8th graders. Among 8th grade student the prevalence of having ever had sexual intercourse was 12.5%, 11.5% and 10.3% in Crook, Deschutes, and Jefferson Counties, respectively (OHTS, 2013).

Figure 53. Percent of 11th graders who reported sexual activity, Oregon, OHTS, 2013
Child and Adolescent Health

Child and Adolescent Health Risk Factors Continued

- 11th graders in Deschutes County reported using marijuana and drinking alcohol at least once in the last 30 days more frequently than the other Central Oregon counties and Oregon overall (Table 24).
- One in five 11th graders in Crook County reported smoking cigarettes in the last month (Table 24). While use of other substances like tobacco, marijuana, and alcohol increases with age, use of inhalants to get high decreases with age in Central Oregon (Table 24).

<table>
<thead>
<tr>
<th>Table 24. Percent of personal health risks among 6th, 8th, and 11th graders, Oregon, OSWS, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 30 days, rode in a vehicle driven by a teenager who had been drinking alcohol</td>
</tr>
<tr>
<td>Oregon</td>
</tr>
<tr>
<td>n/a</td>
</tr>
<tr>
<td>Drove a vehicle at least 1 time while drinking alcohol in the last 30 days</td>
</tr>
<tr>
<td>Drank alcohol on at least 1 day in last 30 days</td>
</tr>
<tr>
<td>Use inhalant to get high in the last 30 days</td>
</tr>
<tr>
<td>Used illicit drug (other than marijuana) in the last 30 days</td>
</tr>
<tr>
<td>Used prescription drugs at least 1 time in last 30 days</td>
</tr>
<tr>
<td>Used other tobacco products during the last 30 days</td>
</tr>
<tr>
<td>Smoked at least 1 day in last 30 days</td>
</tr>
</tbody>
</table>

Minimum vertical axis value is zero and maximum vertical axis value is 50 for each chart. Bars are in order of table columns (Oregon, Crook, Deschutes, Jefferson).

- Cigarette use among high school students in Oregon declined from 11.5% to 9.4% from 2011 to 2013 (OHTS). However, electronic cigarette (e-cigarette) use among 11th grade students in Oregon rose from 1.8% to 5.2% from 2011 to 2013 (OHTS 2011, 2013). E-cigarette use among high school students tripled from 4.5% in 2013 to 13.4% across the US (CDC, 2015). A similar increase was seen among middle school students, though the prevalence was not as high (1.1% in 2013 to 3.9% in 2014).
- Hookah smoking roughly doubled among middle and high school students across the U.S. Hookah use rose from 5.2% in 2013 to 9.4% in 2014 among high school students and from 1.1% to 2.5% among middle school students (CDC, 2015). In 2013, hookah use among 11th graders in Crook, Deschutes, and Jefferson Counties was 6.8%, 12.7%, and 5.6%, respectively. The state average was 8.9% (OHTS, 2013).

Adverse Childhood Experiences

ACEs refer to physical, emotional, and sexual abuse, parental substance abuse, adult mental illness, a missing parent at home due to separation, divorce or incarceration, and intimate partner violence experienced before the age of 18 years. Research has shown that experiencing several ACEs, especially early in life, is associated with increased risk for chronic disease, substance abuse, poor mental health, and other risky health behaviors. Children in non-parental care, such as living with grandparents or in foster care, are particularly likely to have experienced a high number of ACEs compared to children living with two biological parents. These experiences may have contributed to their current living situation (CDC Data Brief, 2014). In order to prevent ACEs, families should be encouraged and supported in order to provide nurturing and supportive environments for children.
Adverse Childhood Experiences Continued

- Similar to the original ACEs study published in 1998, the most common ACEs during childhood in Oregon were (Oregon ACEs Report, 2012):
  - Living with someone who was a problem drinker or alcoholic, or using illegal drugs or abusing prescription medications
  - Having a parent or adult swear at, insult, or put them down more than once
  - Experiencing physical abuse
  - Living with a family member who has a mental illness
- 16% of Oregon adults reported 4 or more ACEs. In the original study, 12.5% of adults in the US reported 4 or more ACEs.
- Over a third (35.6% CI 30.7%-40.9%) of adults enrolled in OHP in Central Oregon reported a high ACEs score (based on 11 point scale). For reference, one fifth of the total Oregon population reported a high ACEs score (MBRFSS, 2014).
- About half of 11th graders in Central Oregon reported that their parents were divorced or separated sometime since they were born (Figure 54). About a quarter have ever lived with someone who uses or used illegal drugs.

Figure 54. Percent of 11th graders who reported adverse childhood experiences, Oregon, OSWS, 2014

COO Measures

- The Central Oregon CCO has met the goal for screening children for developmental, behavioral and social delays. (Figure 55).
Mental Health

Introduction
Mental health is defined as “our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood” (mentalhealth.gov). Mental illness refers to diagnosable mental disorders. Mental disorders are one of the top five most costly conditions according to most current data (AHRQ, 2014), with depression being the most common (Mental Health Basics, CDC). While good mental health is associated with positive health outcomes, mental illness is associated with poor health outcomes like chronic diseases, injury, and a history of ACEs. As with good physical health, the social determinants of health need to be present to support good mental health. These include appropriate housing, safe neighborhoods, equitable employment, education opportunities, and equity in access to quality healthcare.

- Central Oregon Counties have a residential capacity of about 280 people in their approximately 100 addiction or mental health programs (Behavioral Health MAP data, 2014).

Youth
Good mental health in children allows them to grow, learn, and interact socially at home, in the community, and at school. Several mental illnesses affect children and need to be addressed promptly to ensure proper development. Parents can be informed in order to monitor any mental health changes in their children, healthcare providers can diagnose issues early and, if necessary, provide treatment, and other professionals like teachers can communicate concerns to parents.

- A large proportion of 6th and 8th graders in Central Oregon report being harassed at school (Table 25).
- One in four 8th graders in Crook County reported they had seriously considered attempting suicide in the last year (Table 25).
- The frequency of reporting fair or poor emotional and mental health increased with age (Table 25).

Table 25. Percent of mental health risks among 6th, 8th, and 11th graders, Oregon, OSWS, 2014

<table>
<thead>
<tr>
<th></th>
<th>6th</th>
<th>8th</th>
<th>11th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>6.5</td>
<td>8.9</td>
<td>13.3</td>
</tr>
<tr>
<td>Crook</td>
<td>5.2</td>
<td>7.4</td>
<td>11.0</td>
</tr>
<tr>
<td>Deschutes</td>
<td>6.4</td>
<td>8.8</td>
<td>11.1</td>
</tr>
<tr>
<td>Jefferson</td>
<td>6.6</td>
<td>10.1</td>
<td>13.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>6th</th>
<th>8th</th>
<th>11th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>7.1</td>
<td>14.2</td>
<td>18.5</td>
</tr>
<tr>
<td>Crook</td>
<td>7.1</td>
<td>15.5</td>
<td>18.0</td>
</tr>
<tr>
<td>Deschutes</td>
<td>6.5</td>
<td>12.7</td>
<td>14.7</td>
</tr>
<tr>
<td>Jefferson</td>
<td>7.4</td>
<td>9.9</td>
<td>13.9</td>
</tr>
</tbody>
</table>

- See the Child and Adolescent Health section (page 54) for more information on substance abuse and misuse among children and adolescents and see the Access to Healthcare section (page 77) for more information about available services related to mental health.
Mental Health

Adults
Nearly one in five adults in the United States had a mental illness (SAMHSA, 2012). Serious mental illness (SMI) among people ages 18 years and older is defined as “having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment, that substantially interferes with or limits one or more major life activities.” Intervening early, soon after the first SMI, has been shown to be effective. People with mental health issues can identify a support group, join recovery groups, and work collaboratively with a healthcare provider on a treatment and recovery plans (Mental and Substance Use Disorders, SAMHSA).

- In Oregon, people with co-occurring mental health and substance use disorders had an average age at death of 45 years (OHA, 2008).
- Depression among adults in Central Oregon is common. When surveyed, about 25%, 21%, and 24% of adults in Crook, Deschutes, and Jefferson Counties, respectively, reported that they had depression (BRFSS, 2010-2013). About 4.8% of adults in Oregon reported SMI. That translates to about 7,800 adults in Central Oregon (SAMHSA Behavioral Health Barometer, 2014).
- Mental health disorders like depression and anxiety are common among pregnant women. One in four women in Oregon reported prenatal or postpartum depression after pregnancy (OHA, 2010).
- In Oregon, postpartum depression was more common among women who lived below the federal poverty line, who smoked, were of racial/ethnic minority, or were teen mothers (OHA, 2010).

Suicide
Suicide is directed violence towards oneself with the intent to end their life. Suicide is a complex public health issue involving several risk factors like history of depression or other mental illness, alcohol or drug abuse, family history of suicide or violence, physical illness, feeling alone, or previous suicide attempt(s). Many more people survive suicide than die and may live with serious physical injuries (CDC Factsheet).

- Since 2000, the highest suicide mortality rate occurred in 2010 in Central Oregon at a high of 26.8 per 100,000 population (Figure 56). The Central Oregon suicide mortality rate in 2013 was not significantly different from what it was in 2000.
- Between 2004 and 2013, there was an average of 38 suicides per year in Central Oregon and 78% occurred among Deschutes County residents (OPHAT, 2004-2013).

The age-adjusted race-specific suicide mortality rate was similar between Central Oregon and Oregon overall, except for American Indians (Figure 57). On average, there were about two suicides deaths a year among American Indians in Central Oregon between 2004 and 2013. While this translates to a relatively small number, Central Oregon American Indians accounted for about 22% of all suicides among American Indians in the state in the last decade, but accounted for only 10% of the state’s American Indian population. The overall age-adjusted suicide mortality rate was also significantly higher than the Oregon rate.
Mental Health

The majority (58%) of suicides in Central Oregon occur among people aged 30-59 years. One in five (21%) occur among people aged 60 years and older (OPHAT, 2009-2014).

When compared to the same age group in Oregon, people aged 15-24 years in Central Oregon had a higher suicide rate (Figure 58).

In the Central Oregon counties, the three leading mechanisms related to suicide were firearm (55%), suffocation (22%), and poisoning (15%) (OPHAT, 2009-2013). These were also the leading mechanisms for suicide in Oregon.

CCO Measures
- The Central Oregon CCO has met the benchmark for three of four mental health-related CCO measures (Figure 59).

Figure 59. Central Oregon CCO quality measures related to mental health, June 2014

<table>
<thead>
<tr>
<th>Measure</th>
<th>State</th>
<th>Central Oregon CCO</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of children aged 4+ years that receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOs that the children.</td>
<td>70.8</td>
<td>62.4</td>
<td>50.0</td>
</tr>
<tr>
<td>Percentage of patients (aged 6+) who received a follow up with a HCP within 7 days of being discharged from the hospital for mental illness.</td>
<td>66.7</td>
<td>71.2</td>
<td></td>
</tr>
<tr>
<td>Percentage of children (aged 6-12 years) who had one follow up visit with a provider during the 30 days after receiving a new prescription for ADHD medication.</td>
<td>51.0</td>
<td>57.7</td>
<td>55.0</td>
</tr>
<tr>
<td>Percentage of patients ages 12 years and older who were screened for clinical depression using an age-appropriate standardized depression screening tool and if positive, have a documented follow-up plan.</td>
<td>25.0</td>
<td>24.1</td>
<td></td>
</tr>
</tbody>
</table>
Alcohol Tobacco and Drug Use

Introduction
Substance abuse is the ongoing use of drugs or alcohol that leads to impairments in health, work and family life. Poor mental health and substance abuse often occur together. About 9% of adults in the US have a substance abuse disorder and more than one in four adults with mental health issues also has a substance abuse problem (mentalhealth.gov) (SAMHSA, 2012).

Although taking drugs at any age can lead to addiction, research shows that the earlier a person begins to use drugs, the more likely he or she is to develop serious problems. Addiction may stem from the harmful effects that drugs can have on the brain and may also result from a mix of factors like unstable family relationships, exposure to physical or sexual abuse, genetics, or mental illness (NIDA, Science of Addiction).

Heavy drinking, tobacco use, and drug use are associated with higher rates of all-cause mortality, chronic disease, violence and abuse. Excessive alcohol and drug use is also a risk factor for motor vehicle fatalities, fetal alcohol syndrome, interpersonal violence, overdose and STIs. This has impact on families, schools, workplaces and the community. Treatment programs for substance abuse have been shown to have a positive return on investment and can improve the quality of life for people with substance use disorders (Robert Wood Johnson Foundation, 2007).

Alcohol
The majority of people who use alcohol at levels that impact their health and mental health do not meet dependency criteria and are inappropriate for specialty treatment programs. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice that targets patients in primary care with nondependent substance use. It is a strategy for intervention prior to the need for more extensive or specialized treatment. For more information on alcohol use see the Child and Adolescent Health Risk Factor Section (page 53 and 54) and Unintentional Injuries Section (page 63).

- In Oregon, an estimated 1,302 deaths and 33,933 years of potential life lost are attributed to excessive alcohol use each year (Prevention Status Report, CDC, 2013).
- About 1 in 5 adults in Crook and Deschutes Counties and 1 in 7 adults in Jefferson County reported binge drinking in the last month (BRFSS, 2010-2013).
- Eleventh graders frequently said that drinking more than five drinks in one sitting once or twice a week (65.3%, 74.6%, 72.0%, respectively) and smoking at least a pack of cigarettes every day (77.8%, 89.2%, 82.9%, respectively) was a moderate or great risk to one’s health (OSWS, 2014). Only about 40% of 11th graders in Crook, Deschutes, and Jefferson Counties said that smoking marijuana once or twice a week places someone at moderate to great risk for harming their health (43.7%, 42.6%, 41.0%, respectively) (OSWS, 2014).

Tobacco
Smoking cigarettes and smokeless tobacco use are initiated and established primarily during adolescence. Nearly nine of 10 cigarette smokers first tried smoking before the age of 18 (CDC OSH, 2015). Tobacco use causes multiple diseases such as cancer, respiratory disease and other adverse health outcomes.

- During 2009-2011, the prevalence of cigarette smoking was higher among adults with any mental illness than those without mental illness (36.1% vs. 21.4%) and was highest among males, those aged less than 45 years, and those living below the poverty level. Adults with mental illness smoked 30.9% of all cigarettes smoked by adults during this time frame (CDC, 2013).
Tobacco Continued

- Over a third of OHP members in Central Oregon smoke tobacco (Figure 60). This is comparable to the overall OHP adult population's smoking rate (34%) (CAHPS, 2014).
- Three out of four adults enrolled in OHP want to quit smoking tobacco (Figure 60).
- Males (48%) and adults aged 45-54 years (49%) had the highest rates of using tobacco compared to females (26%) and other age groups (17%-36%) among OHP members (CAHPS, 2014).

Figure 60. Percent of adults enrolled and not enrolled in OHP who use tobacco and e-cigarettes, Oregon, MBRFSS, 2014

<table>
<thead>
<tr>
<th>Tobacco Use</th>
<th>Enrolled in OHP</th>
<th>Not Enrolled in OHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smokes tobacco and wants to quit</td>
<td>77.3</td>
<td>78.1</td>
</tr>
<tr>
<td>Attempted to quit smoking last year</td>
<td>53.2</td>
<td>68.4</td>
</tr>
<tr>
<td>Current tobacco user</td>
<td>19.8</td>
<td>32.3</td>
</tr>
<tr>
<td>Ever use e-cigarette</td>
<td>51.8</td>
<td>39.1</td>
</tr>
<tr>
<td>Current cigarette smoker</td>
<td>77.0</td>
<td>32.6</td>
</tr>
<tr>
<td>Current e-cigarette use</td>
<td>44.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Current tobacco chewer</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Note: General population percents may not be directly comparable to OHP percents due to survey differences. They are provided as a reference.

- Indoor air quality is greatly affected by second-hand smoke. Most adults in Oregon and the Central Oregon counties reported having rules to limit exposure to second-hand tobacco smoke in their homes and cars (Figure 61).

Figure 61. Percent of adults who reported having rules against tobacco use in the home and car, Oregon, BRFSS, 2011

- An estimated 26,200 people in Central Oregon smoke tobacco leading to serious illness, death, and significant healthcare costs (Table 26). The Tobacco Quit Line (1-800-QUIT-NOW) serves the Central Oregon counties to support tobacco cessation for its residents. However, during 2014 only 325 tobacco users in the region used this service (Health Promotion and Chronic Disease Prevention, OHA).
Alcohol Tobacco and Drug Use

Tobacco Continued

<table>
<thead>
<tr>
<th>Table 26. Tobacco Use in Central Oregon Counties, County Tobacco Fact Sheets, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crook</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>In one year:</td>
</tr>
<tr>
<td>Number that regularly smoke cigarettes</td>
</tr>
<tr>
<td>Number that suffer from a serious illness caused by tobacco</td>
</tr>
<tr>
<td>Number that died from tobacco</td>
</tr>
<tr>
<td>Amount spent on medical care</td>
</tr>
<tr>
<td>Productivity lost due to tobacco-related deaths</td>
</tr>
</tbody>
</table>

- In 2012, four focus groups held in La Pine, Bend, Redmond, and Sisters assessed 39 residents’ feelings about tobacco smoke in their respective downtown areas. Perceived need for a smoke free downtown area policy varied depending on location of the focus group. Regardless of support for the policy, a common concern was whether a smoke free downtown policy could be enforced. However, several other suggestions were made to address tobacco in the downtown areas including enforcing a smoke free area in front of libraries, in multi-unit housing, and at events. Of note was that no focus group participants were current tobacco smokers (Deschutes County Smoke Free Report, 2012).
- In 2014, the Oregon Health Authority Tobacco Prevention Education Program conducted a Community Readiness Assessment (CRA) in all counties across Oregon. The purpose of the assessment was to determine the willingness and preparedness of each county in Oregon to take action related to local tobacco prevention and education. Key local government, business and school district sector stakeholders were interviewed. The CRA results from each county are not intended to represent the opinions of the whole community, but rather what community stakeholders think about the opinions of the community. The key respondents are not only proxies for representing the community in general, but they are also key decision makers who have an impact on and deeper understanding of the community. The findings from the CRA in Deschutes, Crook, and Jefferson County suggest that stakeholders perceive tobacco use is of concern to community members, however general knowledge of the tobacco burden and its causes are not understood in depth and stereotyped. Therefore, the political will to support tobacco prevention policies seem low.

Oregon is one of few states that does not have a tobacco retail-licensing program. Licensing tobacco retailers is considered an effective tool to enforce point of sale and tax laws (Public Health Law Center). However, implementing a tobacco retail licensing alone will not reduce the prevalence of tobacco use among youth. A comprehensive approach that eliminates price discounts, coupon redemption, and candy, fruit, and dessert flavored tobacco products should also be considered.
- Oregon has had the highest number of retailers who sell tobacco products illegally to minors for the last 5 years (Synar, 2009-2013). In 2013-2014, Deschutes County had a higher (26.7%) non-compliance rate among tobacco retailers compared to the state average (21.3%) (Synar Report, 2013-2014).
- In 2013, nearly one in five tobacco retailers in Deschutes County were within 1,000 feet of school property. In Crook County, half of retailers were within 1,000 feet of a school. Research shows that areas with a higher concentration of tobacco retailers near schools have a higher youth smoking prevalence (Deschutes County Retail Assessment, 2013; Crook County Retail Assessment, 2013).
Alcohol Tobacco and Drug Use

**Prescription Opioids**
Recent concern related to substance abuse has been related to the misuse of prescription drugs. The mortality rate due to prescription drugs has dramatically risen in the US since 1999. This rise has been linked with the increased availability of opioid pain medications (Paulozzi, 2006). The misuse of prescription opioids has been associated with injection drug use, which places a person at risk for diseases like hepatitis C and HIV and at risk for other drug use like heroin (CDC, 2015). There are several recommendations for preventing the misuse of prescription medications, including medication “Take Back” days, providing provider education on pain management and prescribing guidelines, and using tools like prescription drug monitoring programs and clinical decision support tools to manage prescriptions (US DHHS).

- The opioid-related unintentional prescription drug mortality rate has tripled in Oregon since 2000 (Figure 62).
- The 5-year average age-adjusted opioid-related unintentional prescription drug mortality in Central Oregon was 3.6/100,000 population (95% CI 2.5-5.1) (CDC Wonder, 2009-2013). The 5-year average rate in Oregon during this time period was 4.1/100,000 population (95% CI 3.8-4.4).
- The opioid prescription drug hydrocodone, was the leading drug prescribed among Central Oregon OHP members. Over 24,200 prescriptions were written for hydrocodone between November 2012 and October 2014 (CCO Annual Report, December, 2014).

**CCO Measures**
- The Central Oregon CCO has not met goals related to tobacco (Figure 63). The measure related to screening and intervention for alcohol or other substance abuse among adults remains low.

**Figure 62.** Age-adjusted opioid-related unintentional poisoning mortality rate per 100,000 population, Oregon, CDC WONDER, 2000-2013

**Figure 63.** Central Oregon CCO quality measures related to alcohol, tobacco, and other drugs, June 2014

- Percentage of adults members (ages 18 years and older) who had appropriate screening and intervention for alcohol or other substance abuse (SBIRT measure)
- Percentage of patients (aged 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis
- Percentage of patients (aged 13 and older) who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment
- Percentage of adult tobacco users advised to quit by their doctor
- Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking
- Percentage of adult tobacco users whose doctor discussed or recommended strategies to quit smoking
- Percentage of adult Medicaid members (ages 18 years and older) who currently smoke cigarettes or use other tobacco products.

*State  Central Oregon CCO  Benchmark*
Introduction
Injuries are classified by intent and mechanism. Some injuries are considered unintentional, meaning there was no intent to do harm, while others are intentional (suicide and homicide). Unintentional injuries are preventable events and are no longer considered “accidents.” In the case of some injuries, the intent is unknown. Many measures have been put in place in the last several decades to reduce the number of unintentional injuries including increased seatbelt use in cars, increased helmet use during many activities, promotion of life jackets while in or near water, and safe sleeping habits for babies, among many others. Injuries are caused by a variety of mechanisms and these mechanisms vary with age.

- The leading causes of unintentional injury-related death in Oregon were falls, poisoning, and motor vehicle crashes (MVC) (Table 27). The leading causes of unintentional injury-related death were the same in Central Oregon.
- Drowning and MVC were a leading cause of injury-related death for children.

| Table 27 Leading causes of unintentional injury in Oregon, CDC WISQARS, 2013 |
|---|---|---|---|---|---|---|---|---|---|---|
| Rank | Age Groups | | | | | | | | | |
| 1 | <1 | Suffocation* | Drowning* | MV-traffic* | MV-traffic* | MV-traffic | Poisoning | Poisoning | Poisoning | Poisoning | Fall | Fall |
| 2 | 1-4 | Drowning* | Fire/Burn* | Drowning* | Pedestrian, other* | Poisoning | MV-traffic | MV-traffic | MV-traffic | MV-traffic | Poisoning |
| 3 | 5-9 | Fall* | Suffocation* | Fire/Burn* | Drowning* | Fall* | Suffocation* | Fall | Fall | Suffocation | MV-traffic |
| 4 | 10-14 | Fire/Burn* | Fall* | Natural/ Environment* | Fire/Burn* | Pedestrian, other* | Drowning* | Drowning | Suffocation | Poisoning | Suffocation |
| 5 | 15-24 | Firearm* | Pedestrian, other* | Other land transport* | Firearm* | Other land transport* | Other, specified* | Fire/Burn* | Drowning | Unspecified | Drowning |
| 6 | 25-34 | MV-traffic* | Other, not classifiable* | Eight tied* | Suffocation* | Fall* | Suffocation* | Fire/Burn* | Other, not classifiable | Unspecified |
| 7 | 35-44 | | | Eight tied* | Five tied* | Other land transport* | Other, not classifiable* | Fire/Burn | Fire/Burn |
| 8 | 45-54 | | | Eight tied* | Five tied* | Four tied* | Other land transport* | Struck by/against* | Natural/ Environment | Other, not classifiable |
| 9 | 55-64 | Eight tied* | Five tied* | Four tied* | Other, specified* | Other | Specified | Other | Specified | Other, specified |
| 10 | 65+ | Eight tied* | Five tied* | Four tied* | Other, unspecified* | Two tied* | Drowning* | Natural/ Environment |

- Most injuries are unintentional. Two-thirds of all injuries in Oregon and Deschutes County were unintentional. In Crook County 57% of injuries were unintentional and in Jefferson County the proportion is 83% (OPHAT, 2013).
Unintentional Injuries

- The unintentional injury mortality rate has not changed significantly in Oregon since 2000 (Figure 64) and the 2013 rate was similar to the US age-adjusted rate (38.8/100,000) (CDC WONDER, 2013)
- The unintentional injury mortality rate in Jefferson County was significantly higher than the state overall in 2013 (Figure 64).

![Figure 64. Age-adjusted unintentional injury mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013](chart)

- The primary mechanism involved in unintentional injuries varies with age (Figure 65). Falls are more common in younger and older ages while MVC are more common between the ages of 15-64 years.

![Figure 65. Percent of unintentional injury hospitalizations by age group and mechanism, Central Oregon and Oregon, HCUP, 2013](chart)
Unintentional Injuries

Motor Vehicle Crashes
MVC refer to any injury occurring in traffic. The person injured may be a driver or occupant of a vehicle, a pedestrian or cyclist struck by a vehicle, or a motorcyclist.

- The mortality rate due to MVC has significantly decreased since 2000 in Oregon and Central Oregon (Figure 66).

![Figure 66. Age-adjusted unintentional motor vehicle crash (traffic) mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013]

- Residents of Jefferson County had a significantly higher mortality rate due to MVC than Oregon overall (Figure 67).
- Males had a significantly higher mortality rate due to MVC than did females in Oregon, Deschutes County, and Jefferson County (Figure 67).
- Between 2004 and 2013, there were 280 motor vehicle fatalities in Central Oregon. Seventy of those fatalities were in Jefferson County (OPHAT, 2004-2013).

![Figure 67. Age-adjusted mortality rate per 100,000 population for unintentional motor vehicle crash (traffic), Oregon, OPHAT, 2004-2013]

* Significantly higher than the state overall
**Significantly higher than females overall
Unintentional Injuries

Poisoning
Poisoning is the ingestion or inhalation of a toxic substance or a substance that if consumed in high enough quantities becomes toxic. Recently, focus has been placed on unintentional poisoning due to the increased number of toxic exposure deaths related to prescription medications.

- In Oregon, the unintentional poisoning mortality rate has more than doubled since 2000 (Figure 68).
- Though not statistically different, the rate in Central Oregon has also increased (Figure 68).
- On average, there were 14 unintentional poisoning deaths in Central Oregon each year between 2004 and 2013 (OPHAT, 2004-2013).

Figure 68. Age-adjusted mortality rate per 100,000 population for unintentional poisoning, Oregon, OPHAT, 2000-2013

![Graph showing mortality rate per 100,000 population for unintentional poisoning in Oregon and Central Oregon from 2000 to 2013.]

- Men in Oregon had a higher unintentional poisoning mortality rate than did females (Figure 69).

Figure 69. Age-adjusted mortality rate per 100,000 population for unintentional poisoning by sex, Oregon, OPHAT, 2004-2013

![Bar chart showing mortality rates for Oregon, Crook, Deschutes, and Jefferson counties from 2004 to 2013.]

*Significantly higher than females overall
Unintentional Injuries

Falls

Falls can occur at any age, but are a serious risk for young children and older adults. The highest risk for death due to a fall, however, is among older adults. The mortality rate due to a fall exponentially increases after the age of 65 years (OPHAT, 2009-2013). Maintaining a hazard free home, performing strength and balance exercises, and reviewing medications regularly can help older adults avoid falls.

- In Oregon, the unintentional fall mortality rate has significantly increased since 2000 in Oregon. Though not statistically significant, the unintentional fall mortality rate has increased in Central Oregon (Figure 70).

![Figure 70. Age-adjusted unintentional fall mortality rate per 100,000 population, Oregon, OPHAT, 2000-2013](image)

- The age-adjusted fall mortality rate was higher in Jefferson County than in the state overall (Figure 71).

![Figure 71. Age-adjusted mortality rate per 100,000 population for unintentional fall by sex, Oregon, OPHAT, 2004-2013](image)

67

- The fall mortality rate among adults aged 65 years and older was significantly lower in Deschutes County than in Oregon overall (69.2/100,000 vs. 90.3/100,000). The rate in Jefferson County was 121.1/100,000 and in Crook County it was 62.9 (OPHAT, 2009-2013). None of these rates met the HP 2020 goal of 47.0 deaths/100,000 population or less.
Unintentional Injuries

Risk Factors for Injury
Risk factors for injury vary dramatically by age. However, reducing drug and alcohol use and increasing appropriate use of safety equipment are important behaviors to prevent injuries at any age.
- 11th graders in Deschutes County reported using marijuana and drinking alcohol at least once in the last 30 days more frequently than 11th graders in the other Central Oregon Counties and Oregon overall (see the Child and Adolescent Health Risk Factors section).
- In 2013, alcohol was listed as a contributing factor for a MVC at about the same rate among all of the Central Oregon Counties (Crook 5.1%, Deschutes 6.1%, Jefferson 6.5%) (ODOT Crash Data, 2013).
- One in three MVC fatalities was considered alcohol-impaired (blood alcohol concentration over 0.08) in Oregon in 2013 (NHTSA, 2013).
- The top three causes for a MVC in the Central Oregon Counties were driving too fast, failing to yield, and following too close (ODOT Crash Data, 2013).
- Oregon adult females more frequently reported that they always or nearly always wear a seatbelt than did adult males (99.3% vs. 96.7%) (BRFSS, 2013).
Oral Health

Dental caries (cavities) are largely preventable. However, tooth decay is one of the most common chronic diseases among children. Untreated tooth decay causes problems with eating and speaking, and causes pain, which can disrupt learning and personal growth. Some community water systems treat their water with fluoride, which has been shown to strengthen teeth and reduce tooth decay (CDC Oral Health Program). However, Central Oregon does not fluoridate the public water systems. Reducing dental caries rates is possible without water fluoridation and with limited resources through effective use of the existing healthcare workforce. The focus should be on identifying high-risk children and pregnant women to receive proven community-based preventive care. Several oral health services in Central Oregon exist to provide the best care possible.

- Advantage Dental: Community Outreach: Partners with community organizations in the tri-county region to deliver preventive oral health services using expanded practice permit dental hygienists. This service also promotes coordinated and seamless care between providers.
- Kemple Memorial Children's Dental Clinic: Provides critical preventative, educational and dental treatment services for children whose families cannot access basic dental care.
- Central Oregon Community College Dental Assistant School: Partners with Deschutes County Health Services to provide dental care to low-income individuals.
- Volunteers in Medicine: Identifies uninsured/underinsured patients with unmet oral health needs and refers them into their dental hygienist or refers them to local services.
- Mosaic Medical: Offers primary care clinics and dental care services.
- La Pine Community Health Center: Partners with Advantage Dental to provide low cost dental services to uninsured individuals.
- Sisters School-based Health Center: Operates under an integrated care model with primary care, mental health, and dental services available for students aged 0-21 years regardless of ability to pay.
- Deschutes Family Drug Court: Partners with Advantage Dental to coordinate dental care for families enrolled in the Deschutes Family Drug Court.

- Using the hospital and ED for dental care is an indication of poorly managed oral health. People enrolled in OHP accessed dental care in hospitals and EDs at similar rates in the Central Oregon Counties (Figure 72).
Oral Health

- Jefferson County residents enrolled in OHP accessed dental care less frequently than residents of Crook and Deschutes Counties (Figure 73).

![Bar chart showing percent of those enrolled in OHP who accessed dental care, Central Oregon, PacificSource, 2015](chart.png)

**Figure 73. Percent of those enrolled in OHP who accessed dental care, Central Oregon, PacificSource, 2015**

**Note:** There are many ways that members can be identified as having diabetes. The method for identification used is based on claims and may underrepresent the true number of members living with diabetes in the population.

**Children**
Good oral health starts in childhood. This includes regular visits to a dentist, regular brushing, and a healthy diet.

- The Kemple Memorial Children's Dental Clinic assesses the oral health of thousands of children in the region. During the 2013-2014 school year:
  - Over a quarter (26.3%) of screened students were determined to need improved home oral health hygiene.
  - About half (49.9%) of screened children needed sealants, which are thin, plastic coatings painted on the chewing surfaces of the back teeth that help prevent tooth decay.
  - 4.5% of those screened had serious immediate oral health needs.
- Only 59% of Jefferson County 8th graders reported having gone to a dentist or dental hygienist in the last 12 months (Table 28).
- About three of four 8th and 11th graders reported having ever had a cavity (Table 28).

<table>
<thead>
<tr>
<th></th>
<th>8th</th>
<th>11th</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Oregon</td>
<td>Crook</td>
</tr>
<tr>
<td>Went to a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dentist or</td>
<td>72.8</td>
<td>75.3</td>
</tr>
<tr>
<td>dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hygienist for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a check-up,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exam, teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had a</td>
<td>70.1</td>
<td>76.3</td>
</tr>
<tr>
<td>cavity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brushed your</td>
<td></td>
<td></td>
</tr>
<tr>
<td>teeth in the</td>
<td>95.5</td>
<td>91.4</td>
</tr>
<tr>
<td>past 24 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Minimum vertical axis value is zero and maximum vertical axis value is 100 for each chart. Bars are in order of table columns (Oregon, Crook, Deschutes, Jefferson).
Oral Health

Children Continued
Good oral health starts in childhood. This includes regular visits to a dentist, regular brushing, and a healthy diet.

- 8th and 11th graders in Jefferson County more frequently reported missing school due to a toothache or painful tooth than in Oregon (Table 29).

| Table 29. Percent of 8th and 11th graders who reported specific oral health indicators, Oregon, OHTS, 2013 |
|---|---|---|---|---|---|---|---|
| Missed one or more hours of school due to toothache or painful tooth | Oregon | Crook | Deschutes | Jefferson | Oregon | Crook | Deschutes | Jefferson |
| 8th | 2.6 | 1.8 | 2.8 | 8.2 | 2.7 | 3.6 | 4.7 | 5.5 |
| 11th | 2.2 | 1.8 | 3.0 | 3.2 | 1.8 | 2.7 | 4.0 | 5.3 |

- One quarter to one half of first and second graders that were screened in selected Central Oregon schools had untreated tooth decay (Figure 74).

Figure 74. Percent of screened first and second graders with untreated dental decay, Central Oregon, School Dental Sealant Program, 2013-2014

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71
Oral Health

Adults

Good oral health as an adult helps maintain adult teeth. Poor oral health can be a costly and painful condition. Some health conditions and behaviors like diabetes, HIV, cancer, and tobacco use increase the chance of having oral health problems (CDC, 2006).

- About half of adult OHP members in Central Oregon (52.3%, 95% CI 47.3%-57.2%) reported having had a dental visit in the last year. For reference, nearly two-thirds of the general adult population in Oregon (66.9%) said they had had a dental visit in the last year (MBRFSS, 2014).
- Half (52.4%) of adults in Jefferson County have lost one or more permanent teeth (Table 30). This was significantly higher than the rest of the state’s population.

| Table 30. Age-adjusted tooth loss and edentulous rates in Central Oregon, Oregon, BRFSS, 2010-2013 |
|-------------------------------------------------|---------|--------|--------|--------|--------|---------|
|                                                  | Crook   | Deschutes | Jefferson | All other counties |
| Percent                                         | 95% CI  | Percent | 95% CI  | Percent | 95% CI  | Percent | 95% CI  |
| Adults aged ≥18 years with one or more tooth loss | 42.3    | 32.2-53.1 | 35.5    | 31.4-39.7 | 52.4    | 39.9-64.6 | 38.5    | 37.6-39.3 |
| Adults aged ≥18 years who are edentulous (have no teeth) | 6.3     | 3.1-12.2 | 2.4     | 1.7-3.4  | 4.0     | 2.0-7.7  | 4.2     | 3.9-4.6  |

- Income is related to dental health among adults in Oregon (Table 31). This is especially notable among adults aged 65 years and older. Many are on fixed incomes and may not receive routine dental care because Medicare, the leading insurer for adults 65 years and older, provides little to no coverage. Older adults with dental insurance are 2.5 times more likely to visit the dentist routinely (Oral Health America).

| Table 31. Prevalence of dental health factors by income, Oregon, BRFSS, 2012 |
|-------------------------------------------------|---------|--------|---------|---------|---------|---------|
| Had permanent teeth extracted                    | 95% CI  | Aged 65+ years and had all teeth extracted | 95% CI  | Visited dentist or dental clinic for any reason in last year | 95% CI  |
| Percent                                         | Percent | Percent | 95% CI  | Percent | 95% CI  | Percent | 95% CI  |
| Total                                           | 41.1    | 39.3-42.9 | 14.0    | 12.9-17.1 | 65.3    | 63.5-67.0 |
| Less than $15,000                               | 58.0    | 52.0-64.0 | 31.5    | 21.5-41.5 | 47.0    | 41.2-52.9 |
| $15,000-24,999                                  | 48.1    | 43.2-53.1 | 28.1    | 21.9-34.3 | 43.5    | 38.6-48.4 |
| $25,000-34,999                                  | 49.3    | 43.3-55.2 | 12.9    | 7.4-18.5  | 59.3    | 53.5-65  |
| $35,000-49,999                                  | 46.4    | 41.6-51.2 | 10.6    | 5.9-15.3  | 68.9    | 64.3-73.5 |
| $50,000+                                        | 27.4    | 24.9-29.8 | 5.4     | 3.1-7.8   | 80.4    | 78-82.9  |
Environmental Health

Introduction
Where people work, live and play can dramatically affect their health. Environmental health “addresses the physical, chemical, and biological factors external to a person, and all the related factors impacting behaviors” (WHO). These topics include air and water quality, the built environment, and consumer product exposures. Environmental Health Specialists in Central Oregon inspect and license several types of public facilities to ensure the public remains safe and healthy. This includes issuing over a thousand licenses in 2014 alone for restaurants, mobile food units, temporary restaurants, commissaries, food warehouses, and bed and breakfasts. In 2014, over 300 licenses were also issued for pools, spas, hotels, motels, and recreational vehicle parks. Inspections are also conducted regularly for all of these facilities as well as school lunch programs, childcare centers, residential institutions.

In Central Oregon, a recreation needs assessment that included a community interest and opinion survey and focus groups was summarized in the 2012 Parks, Recreation, and Green Spaces Comprehensive Plan. This needs assessment found that:

- Respondents felt the most needed facilities were small neighborhood and large community parks, swimming pools, natural areas, and trails.
- Respondents were most supportive of the region improving multi-purpose trails, connecting existing trails, preserving open space and repairing older parks. Respondents were willing to spend tax dollars on these initiatives.
- Drinking fountains, trash and recycling containers, and permanent restrooms were listed as needed features.
- Reasons for not using facilities or programs were “no interest,” hours were not conducive to use, and fees were too high.
- From the 2012 report, a strategic plan has been written and will be implemented through 2017.

Transportation
Transportation is a vital part of a community by increasing access to services, moving goods in and out of the area, and engaging the community socially. Recently, more focus has been placed on active transportation to help reduced chronic disease and obesity by encouraging walking, biking, or other physical activities to move about the community. Policy has focused on ensuring low-income, the aged, and rural populations have transportation options available to access goods and services that will help them maintain or improve their health.

- Surveys were implemented at eight community events in Central Oregon in 2011 to gauge resident interest in public transportation. Summary results indicated that 65% of Central Oregon residents spend $100 dollars or more a month on gas and 64% would ride the bus if it were more convenient (Health Impacts of Transportation in Central Oregon, 2012).
- About two of three people in the Central Oregon counties commuted less than 20 minutes to work (ACS 3-year Estimates, 2011-2013). About half (50.3%) of commuters in Oregon had a commute that was less than 20 minutes to work.
- The 2012 Health Impacts of Transportation in Central Oregon report summarized data from community surveys, local experts, and an advisory council to identify four key recommendations:
  -Invest in strategies that increase use of active and public transportation.
  -Increase access to healthcare services for rural and transportation disadvantaged populations.
  -Increase access to employment opportunities for rural and transportation disadvantaged populations.
  -Consider the safety and needs of all road users (including vulnerable populations) in planning and design standards.
Transportation Continued

- Less than 6.3% of the population in all of the Central Oregon counties uses active transportation (walk, bike, etc.) to work (Figure 75).

Figure 75. Percent of working population that uses active transportation, Oregon, EPHT, 2011

- As previously referenced in the Socioeconomic Status section (page 10), food insecurity and access to healthy food is an issue in Central Oregon. Of the Central Oregon Counties, the shortest walking distance to food retailers and restaurants is in Deschutes County (Figure 76).

Figure 76. Average walk distance in miles to food retailers and restaurants, Oregon, EPHT, 2012
Environmental Health

Air Quality

Air quality refers to the amount of pollutants in the air and can refer to air indoors or outdoors. Research has identified six pollutants most linked with harmful effects to health. They are ozone, particulate matter, nitrogen oxides, sulfur oxides, carbon monoxide, and lead. The amount of these pollutants (except lead) in the air can be classified using the Air Quality Index. The higher the index score is, the worse the air quality. Poor air quality has been linked to respiratory disease, including asthma and lung cancer, as well as heart disease, stroke, and other health conditions (World Health Organization).

- Since 2010, Crook County has experienced a lower frequency of good air quality days than the other Central Oregon Counties (Figure 77).

- In 2013, poor air quality days occurred during certain parts of the year in Central Oregon (Figure 78). Air quality varies year to year as factors influencing it change depending on a variety of factors, like weather.

Figure 77. Percent of days that had good air quality (when air quality was recorded), Central Oregon, airnow.gov, 2010-2013

Figure 78. Air Quality Index values by day and month, Central Oregon, airnow.gov, 2013

Crook County

Deschutes County

Jefferson County

Good (<=50 AQI)
Moderate (51-100 AQI)
Unhealthy for Sensitive Groups (101-150 AQI)
Unhealthy (151-200 AQI)
Very Unhealthy (>=201 AQI)

Data source: airnow.gov
Environmental Health

Water Quality
Water contains varying levels of inorganic and organic compounds, like minerals, microorganisms, lead, nitrates, sulfates, radon, and other chemicals. Water quality refers to the levels of these compounds in the water. Water quality can be classified into several categories based on its use. For example, there are water quality standards for human consumption, use for agriculture and irrigation, domestic use, and environmental water quality (lakes and rivers). For more information about water-borne diseases see the Diarrheal Disease section (page 41) of this document.

- Water quality (Oregon Drinking Water Quality Database, 2014)
  - Crook: 8 systems with alerts in 2014
  - Deschutes: 20 systems with alerts in 2014
  - Jefferson: 0 systems with alerts in 2014

Lead
Lead poisoning is an environmental exposure that can cause irreversible health effects. No level of lead in the blood is safe and lead poisoning can occur among people of any age. Over the last few decades the prevalence of lead poisoning has significantly decreased. However, it is still a risk, especially for children. Lead can be found in old paint (before 1978), dust (some related to occupations like working in a gun range), and toys or fake jewelry, among other items. Prevention steps can include renovating your home safely by a certified renovator, staying current on recalled toys and items with lead, and considering lead testing for your home if it was built before 1978.

- Among those people tested in Oregon, there were no differences in detectable blood lead levels by race (Table 32).

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>1718</td>
<td>1.07</td>
<td>1.73</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>White</td>
<td>19702</td>
<td>1.43</td>
<td>2.05</td>
<td>0</td>
<td>72</td>
</tr>
<tr>
<td>Black</td>
<td>3159</td>
<td>2.02</td>
<td>2.12</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1718</td>
<td>2.11</td>
<td>3.14</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19</td>
<td>2.74</td>
<td>3.03</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>14</td>
<td>1.79</td>
<td>2.15</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>1.73</td>
<td>2.43</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Unknown/Missing</td>
<td>52362</td>
<td>1.23</td>
<td>2.05</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>78729</td>
<td>1.33</td>
<td>2.09</td>
<td>0</td>
<td>72</td>
</tr>
</tbody>
</table>

Data from: Northwest Tribal Epidemiology Center, 2012

Table 32. Average blood lead level (μg/dL) among screened children by race, Oregon, Northwest Tribal Epidemiology Center, 2012, 2005-2010
Access to Care

Ensuring equal access to healthcare is important. The topics previously discussed in this document highlight the factors that can lead to varying access to healthcare, like socioeconomic status, language or cultural barriers, or environmental factors like availability of services and transportation.

- OHP provides healthcare access to lower income populations in the state. Recently, Oregon expanded OHP to allow for the inclusion of more people. Younger age groups make up a large portion of the Central Oregon OHP membership. However in 2014 the expansion of OHP allowed membership to increase dramatically for those aged 20-64 years (Figure 79).

![Figure 79. Central Oregon CCO total OHP membership by age group and year, PacificSource, 2013-2014](image)

- The 2012 Small Area Health Insurance Estimates are based on modeled estimates from the American Community Survey (ACS). These estimates calculated the percent of the population that was uninsured in Central Oregon (Crook: <1, Deschutes: 2.6, Jefferson 4.6, Oregon 5.6) (Health Insurance Coverage in Oregon Report, 2015).
- According to the CAHPS Survey in 2013, OHP members in Central Oregon reported they usually got care in a timely fashion. They also reported receiving support when needed from customer service (Figure 80). Most of these rates were no different than the state overall.
- There were no significant differences by Hispanic ethnicity (data not shown).

![Figure 80. Quality Measures for Oregon and Central Oregon OHP members, CAHPS Survey, 2013](image)

*Significantly higher than Oregon OHP
Access to Care

- The Central Oregon CCO strives to meet specific quality measures. Not all measures apply to all populations. Figure 81 demonstrates progress towards meeting incentive measures for specific population groups. Five out of seven incentive measures for Hispanics, males, and whites were being met at the end of 2014.

Figure 81. Number of incentive measures meeting or exceeding benchmark or target by specific population, Central Oregon CCO, OHA CCO Dashboard, 2014

Common Reasons to Access Healthcare

The population's health can also be described by quantifying the leading reasons for accessing healthcare or the most common pharmaceuticals prescribed. The All Payers All Claims (APAC) is comprised of medical and pharmacy claims, and information about a member’s eligibility and provider files, as collected from health insurance payers for residents of Oregon. The data include fully-insured and self-insured persons. The APAC database allows for a detailed understanding of the Oregon healthcare delivery system by providing access to timely and accurate data about healthcare utilization.

- Opioid analgesics are the most numerous prescriptions (RX) among those with commercial insurance and Medicaid in Central Oregon. They are the third most common prescription among those enrolled in Medicare (Table 33).
- In terms of total cost (number of prescriptions multiplied by cost), anti-inflammatory analgesics are the most expensive prescriptions for those enrolled in commercial insurance, while antipsychotics are the most expensive for those enrolled in Medicaid. Antineoplastics (anticancer drugs) are the most expensive for those enrolled in Medicare (Table 33).

| Table 33. Pharmacy claims from all payors in Central Oregon and Oregon by total number and total amount paid, APAC Database, 2013 |
|---|---|---|---|---|---|---|---|---|
| | Commercial | 1 | 2 | 3 | Medicare | 1 | 2 | 3 | Medicaid |
| | | Analgesics - Opioid | Thyroid Agents | Antihypertensives | Thyroid Agents | Antihypertensives | Analgesics - Opioid | Analgesics - Opioid | Antiepileptic Agents | Antidepressants | Ulcer Drugs | Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexics | Antidepressants | Antidiabetics |
| Oregon | RX, number | Analgesics - Opioid | Thyroid Agents | Antihypertensives | Thyroid Agents | Analgesics - Opioid | Analgesics - Opioid | Antiepileptic Agents | Antidepressants | Ulcer Drugs | Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexics | Antidepressants | Antidiabetics |
Access to Care

- The most common claim for people enrolled in commercial insurance in Central Oregon is for routine gynecological exams, while the number one claim for those enrolled in Medicare is for diabetes (Table 34). The most common claim for those enrolled in Medicaid was for a reason that could not be specified with available codes.
- By total amount paid (number claims multiplied by cost), rehabilitation for a specific procedure was the most expensive among members of Medicare and Medicaid. Osteoarthritis in the lower leg was the most expensive claim for members of commercial insurance (Table 34).

| Table 34. Medical claims from all payors in Central Oregon and Oregon by total number and total amount paid. APAC Database, 2013 |
|--------------------------------------------------|--------------------|---------------------|
| **Commercial**                                   | **Medicare**       | **Medicaid**        |
| **1**                                            | **2**              | **3**               |
| **1**                                            | **2**              | **3**               |
| **1**                                            | **2**              | **3**               |
| **Central Oregon**                               |                    |                     |
| Claims, number                                   | Routine Gynecological Examination | Lumbago Nonallopactic Lesions, Cervical Region | Diabetes Mellitus Without Mention Of Complication, Type II Or Unspecified Type, Not Stated As Uncontrolled |
| Claims, paid                                     | Osteoarthritis, Localized, Not Specified Whether Primary Or Secondary, Lower Leg | End Stage Renal Disease Special Screening for Malignant Neoplasms Of Colon | Care Involving Other Specified Rehabilitation Procedure |
| **Oregon**                                       |                     |                     |
| Claims, number                                   | End Stage Renal Disease | Encounter For Antineoplastic Chemotherapy Routine Infant Child Health Check | Care Involving Other Specified Rehabilitation Procedure |
| Claims, paid                                     | Routine Gynecological Examination | Routine General Medical Examination At A Health Care Facility Routine Infant Child Health Check | Diabetes Mellitus Without Mention Of Complication, Type II Or Unspecified Type, Not Stated As Uncontrolled |

**Specific Access Topics**
Recent data collected focused on topics related to access to healthcare. Focus group participants reported a variety of barriers and concerns related to their care or the care of others. Other services have focused on addressing gaps in healthcare like healthcare provider shortages or areas with higher need than others.

**OHP Expansion**
With changes to healthcare and insurance availability, the Central Oregon Health Council Community Advisory Council (CAC) gathered information on residents’ thoughts about the expansion (CAC reports, 2014). Some themes included:
- Need for ongoing assistance about using health insurance and what primary care means.
- Need for more support for Hispanics, especially to address language barriers.
- Need to address misinformation and community perceptions about who is eligible and data security related to OHP enrollment.

**Adolescents**
Another area of concern related to access to care was for adolescents. Specific focus groups were centered on gathering information about this population (CAC reports, 2014). Findings suggested:
- Children receive sports physicals, but these visits are missed opportunities for well-child visits for adolescents.
- Benefits could come from more reminders or scheduling well-child visits ahead of time, emphasizing the importance of well-child visits for adolescents, and potentially expanding health screenings past 3rd grade.
- Adolescents fear they will find out something bad about their health during a healthcare visit.
Access to Care

Emergency Medical Services
Health emergencies need a timely response. Distance from a healthcare facility or preparedness to handle a serious trauma can delay care and affect long-term health outcomes.

- In Central Oregon there are 4 trauma-designated hospitals. There is one level II hospital in Bend, one level III hospital in Redmond and two level IV hospitals, one in Madras and one in Prineville (Trauma Registry Reports, 2010-2011).
- The average travel time to a hospital in Oregon is 24 minutes. Most of Central Oregon had a travel time less than the state average. The Sisters area, however, was 29 minutes (Areas of Unmet Healthcare Need in Rural Oregon Report, 2015).

Gaps in Care
A key factor in accessing care is that the services are available nearby in the community. Health professional shortages can limit access to specialized care and may delay care. Services need to be culturally considerate and provide convenient locations and hours. Areas with limited healthcare workforce are often classified into Healthcare Provider Shortage Areas (HPSA) and Medically Underserved Areas or Populations (MUA/P). Areas qualify as a HPSA because of a high population-to-provider ratio. This includes having specialized care that is either not available or is at or over capacity in the surrounding areas. Additionally, certain types of facilities and population groups within a geographic area are eligible for designation. HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers.

MUA/Ps are identified by measuring population to provider ratios, infant mortality rates, poverty rates, and other key data points. There are federally defined rules that identify which data to use to define a HPSA and MUA/P (HRSA). Five distinct types of designations are available:

- Geographic: the entire population in the designated area is identified as underserved and resources are considered over-utilized.
- Population: an underserved population identified within a specific area. Eligible populations include:
  - Low-income: there must be at least 30% of the population at or below 200% of the Federal Poverty Level.
  - Migrant farmworkers: migrant farmworkers and their non-farm working family members.
  - American Indians: American Indians or Alaska Natives that are not part of a group that is already automatically designated.
  - Other populations that face access barriers due to language, cultural or disability barriers.
- Facility: a facility that may or may not be in a designated area, but that serves residents located from a shortage area.
- Federal and state correctional facilities that are considered either a maximum- or medium- security facility.
- Federally recognized tribes.

Healthcare Provider Workforce
Having an adequate number of healthcare providers and facilities in an area is important for accessing healthcare. Specific medical associations track the number of healthcare providers that hold a specific license. For example, the American Medical Association maintains a master file of physicians and surgeons and the American Dental Association, the dentists. These lists can be used to describe the number of healthcare providers practicing in a specific area.
Access to Care

Healthcare Provider Workforce Continued

- Some of the highest provider to population ratios in Central Oregon were for certified nurse anesthetists, psychologists, general surgeons, and licensed counselors and therapists (Table 35). There are no obstetrician/gynecologists in Crook County and no psychologists or general surgeons in Jefferson County.

<table>
<thead>
<tr>
<th>Table 35. Licensed health professional ratios by profession, Oregon, Office of Oregon Health Policy and Research, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>20,978</td>
</tr>
<tr>
<td>Obstetrician/Gynecologist</td>
</tr>
<tr>
<td>Psychologists</td>
</tr>
<tr>
<td>General surgeon</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>Licensed counselors and therapists</td>
</tr>
<tr>
<td>Dentist</td>
</tr>
<tr>
<td>Social Workers</td>
</tr>
<tr>
<td>Physician Assistant</td>
</tr>
<tr>
<td>Dental hygienists</td>
</tr>
<tr>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Physicians, total</td>
</tr>
<tr>
<td>Nurses</td>
</tr>
</tbody>
</table>

‡ No professional practicing in the county
Data from: Office of Oregon Health Policy Research

Healthcare Safety Net Clinics

The Oregon Primary Care Office defines the term “healthcare safety net” as “the array of clinical sites around the state that provide healthcare opportunities for those who otherwise would have barriers to accessing quality health services. These barriers include lack of coverage, geographic isolation, language and culture, mental illness and homelessness.” There are several safety net clinics in Central Oregon including hospitals, clinics, and school based clinics (Oregon Primary Care Office). Central Oregon contains:

- 1 Urban hospital
- 2 Critical access hospitals
- 1 Rural hospital
- 1 Federally qualified health center-School based health center
- 3 Rural health clinics
- 4 Federally qualified health centers
- 5 School based health centers
- 1 Indian Health Service facility
Access to Care

Health Professional Shortage Areas in Central Oregon
- Jefferson County is considered a HPSA due to its geography. Crook County also falls in this category due to its population's low-income status. (Oregon Primary Care Office, 2015).

Dental
- All Central Oregon counties are classified as dental professional shortage areas. Jefferson County for its geography, Crook County for low income populations, and Deschutes County for low income populations, homeless populations, and migrant farmworker populations (Oregon Primary Care Office, 2015).

Mental Health
- Crook and Jefferson Counties are mental health HPSA due to geography and Deschutes County is a mental health HPSA due to low-income populations (Oregon Primary Care Office, 2014).
- There are shortages of more advanced mental health treatment options for children and adolescents beyond what is currently available (Central Oregon Behavioral Health Needs Assessment, 2015).
- There are shortages of specialized prescribers of psychiatric medications in Central Oregon. Also, there is limited access to psychiatric prescribers for OHP and Medicare members (Central Oregon Behavioral Health Needs Assessment, 2015).
- There are shortages of private mental health professionals in Central Oregon (Central Oregon Behavioral Health Needs Assessment, 2015).
- Individuals with depression average twice as many visits to their primary care doctor than do non-depressed patients and have nearly twice the annual healthcare costs. (Mauer & Jarvis, 2010).

Medically Underserved and Populations in Central Oregon
- There are several medically underserved areas and populations in Central Oregon (Figure 82).

Figure 82. Medically underserved areas or populations, Oregon, Oregon Primary Care Office, 2011
### Public Health Workforce

Public health systems are often defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.” (CDC) Employees of public health organizations work to provide the 10 essential public health services. Having a well-staffed and funded public health workforce is key for providing these services.

- Directors of the three Central Oregon health departments were asked to quantify the number of staff by position and programmatic area in the spring of 2015. Estimates suggest:
- The most common positions in Crook, Deschutes, and Jefferson County Health Departments are administrative and fiscal, health educators, and public health nurses. The least common are epidemiologists, biostatisticians, and mental health specialists.
- The most commonly staffed areas were in reproductive health and maternal and child health, followed by communicable disease control and environmental health. The areas with some of the fewest staff were chronic disease control, substance abuse prevention, and performance management.
- Self-reported public health service needs of the Central Oregon region were in emergency preparedness, chronic disease prevention and control, and grant writing/management.
- Deschutes County and Crook County participated in a workforce needs assessment conducted by the University of Washington's Northwest Center for Public Health Practice to identify specific areas for staff development. Results for Jefferson County were not available. In Deschutes County, communications and cultural competency were high priority areas for training, while supervisors wanted extra training in performance management and conducting health impact assessments. In Crook County, leadership, communication, management and systems thinking were high priority areas for training. Training in emergency preparedness and health impact assessments was also mentioned as an interest.

### CCO Measures

- The Central Oregon CCO performance on healthcare utilization metrics are similar to the state performance overall (Figure 87). There is no benchmark for the percent of CCO members enrolled in a patient-centered primary care home or avoidable ED utilization.

<table>
<thead>
<tr>
<th>Measure</th>
<th>State</th>
<th>Central Oregon CCO</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of members (adults and children) who thought they received appointments and care when they needed them.</td>
<td>83.8</td>
<td>84.0</td>
<td>88.0</td>
</tr>
<tr>
<td>Percentage of Medicaid members (adults) who report their overall health as excellent or very good.</td>
<td>67.2</td>
<td>68.0</td>
<td>70.0</td>
</tr>
<tr>
<td>Percentage of Medicaid members (children) who report their overall health as excellent or very good.</td>
<td>72.2</td>
<td>72.0</td>
<td>74.0</td>
</tr>
<tr>
<td>Percentage of members (adults and children) who received needed information or help, and thought they were treated with courtesy and respect by customer service staff.</td>
<td>72.0</td>
<td>72.0</td>
<td>74.0</td>
</tr>
<tr>
<td>Percentage of adult members (ages 18 years and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge.</td>
<td>10.5</td>
<td>11.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Percentage of eligible providers within a CCO’s network and service area who qualified for a “meaningful use” incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.</td>
<td>67.3</td>
<td>67.3</td>
<td>70.4</td>
</tr>
<tr>
<td>Percentage of CCO members who were enrolled in a recognized patient-centered primary care home.</td>
<td>82.3</td>
<td>82.3</td>
<td>84.6</td>
</tr>
<tr>
<td>Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.</td>
<td>6.4</td>
<td>7.4</td>
<td>7.4</td>
</tr>
<tr>
<td>Rate of patient visits to an emergency department per 1000 member months.</td>
<td>41.5</td>
<td>47.3</td>
<td>47.8</td>
</tr>
<tr>
<td>Rate of outpatient services per 1000 member months.</td>
<td>288.7</td>
<td>297.5</td>
<td>473.1</td>
</tr>
</tbody>
</table>
Glossary and Acronyms

**Age-adjusted:** A method for standardizing and comparing rates when the populations differ significantly by age. In this report, populations were weighted using the 2000 census.

**American Community Survey (ACS):** A survey conducted annually between census years by the US Census Bureau.

**Asthma Call-back Survey (ACBS):** A follow-up survey conducted after the Behavioral Risk Factor Surveillance System Survey with people who indicated they had or currently have asthma.

**Behavioral Risk Factor Surveillance System (BRFSS):** A phone survey conducted among randomly selected, non-institutionalized adults that asks about a variety of health risks and behaviors.

**Body Mass Index (BMI):** Use both weight and height to determine the size of an individual. BMI is divided into four categories: underweight (<18.5), normal (18.5-24.9), overweight (25.0-29.9), obese (30.0 or greater).

**Centers for Disease Control and Prevention (CDC):** The federal organization that protects the health of the nation's residents and helps local communities do the same.

**Community Advisory Council (CAC):** A group of individuals that guides the Central Oregon Health Council on the organization's direction and makes recommendations that support the community.

**Central Line Associated Bloodstream Infection (CLABSI):** Infection of the blood related to an intravascular catheter.

**Chronically homeless:** A person who is 18 years or older, has a disability, and has been homeless for the past 12 or more months or has had 4 episodes of homelessness in the past 3 years.

**Confidence Interval (CI):** A range of numbers in which the true estimate would be found 95% of the time if the sample were taken an infinite number of times.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS):** A survey that asks consumers and patients to report on and evaluate their experiences with healthcare.

**Coronary Artery Bypass Graft (CABG):** Procedure used to treat coronary artery disease.

**Crude rate:** A method for reporting disease counts. They are calculated by dividing the number of people (cases) by the number of people at risk (or in the population). Rates are often standardized to per 100,000 people.

**Emergency Department (ED):** Part of a hospital that serves people in need of immediate care.

**Environmental Public Health Tracking (EPHT):** Public health surveillance, data analysis, and reporting on environmental exposures that can affect health. Twenty-six sites are funded from CDC to perform EPHT.

**Fecal Occult Blood Test (FOBT):** A screening test for colorectal cancer.

**Health Resource and Services Administration (HRSA):** An agency of the US Department of Health and Human Services that focuses on improving access to healthcare.

**Healthcare Associated Infection (HAI):** Infection associated with the use of a medical device like a catheter or ventilator or infections at a surgical site.

**Healthcare Provider (HCP):** A licensed individual that delivers health services.

**Healthcare Providers Shortage Area (HPSA):** Geographic areas with limited healthcare professional workforce.
Glossary and Acronyms

**Healthy People 2020 (HP 2020):** National goals to meet by the year 2020.

**Healthcare Cost and Utilization Project (HCUP):** A collection of longitudinal hospital care data for the United States.

**Incidence:** The number of new cases that occurred in a population. Often used for communicable disease reporting.

**Long-acting Reversible Contraception (LARC):** Birth control methods that provide effective, reversible contraception for extended periods of time without requiring user action.

**Medicaid Behavioral Risk Factor Surveillance Survey (MBRFSS):** The BRFSS conducted among adults enrolled in Medicaid (OHP).

**Medically Underserved Area or Population (MUA/P):** Geographic areas with high population to provider ratios, infant mortality rates, and poverty rates.

**Oregon Health Plan (OHP):** Healthcare coverage program for low-income Oregonians.

**Oregon Healthy Teens Survey (OHT):** School-based, anonymous and voluntary survey conducted among 8th and 11th graders that informs schools, communities, and the state about strengths or areas for improvement related to student health and health behaviors.

**Oregon Public Health Analysis Tool (OPHAT):** A data warehouse containing datasets with vital records and reportable condition counts. This is a tool for authorized personnel to use when performing.

**Oregon School Wellness Survey (OSWS):** A survey conducted in even numbered years to assess mental health and substance use of 6th, 8th, and 11th graders.

**Pregnancy Risk and Monitoring Survey (PRAMS):** A survey of mothers who recently gave birth that addresses prenatal care, health behaviors and risks, and post-partum topics.

**Prevalence:** The number of cases that exist in a population. Often used for chronic disease reporting.

**Prevention Quality Indicator (PQI):** Quality measures used to identify areas for performance improvement. Measures are focused on conditions where good outpatient care could prevent the need for a hospitalization.

**Severe and Persistent Mental Illness (SPMI):** Mental illnesses that lead to significant disability, including need for medications, rehabilitation, and other support.

**Supplemental Nutritional Assistance Program (SNAP):** Nutrition assistance program for low-income families.

**Standard Infection Ratio (SIR):** A summary measure that is adjusted for various risk factors and is used to track the prevention of healthcare acquired infections. A lower number is better.

**Temporary Assistance for Needy Families (TANF):** A program to help families reach self-sufficiency. The four goals of the program are 1) support families so that children can be cared for in their own homes, 2) promote job preparation, work and marriage, 3) promote planned pregnancies, and 4) encourage two-parent families.

**Women, Infants, and Children (WIC):** A Federal program for low income and nutritionally at risk women, infants and children. Participants receive education, screening, and support in purchasing nutritious foods.

**Wide-ranging Online Data for Epidemiologic Research (CDC WONDER):** Menu-driven web-based system that makes public health data available to the public.

**Years of Potential Life Lost (YPLL):** A measure of premature mortality. Calculated by subtracting the age at death from a predetermined life expectancy age, usually 75 years.
Resources

1. Adverse Childhood Experiences (ACEs) CDC: http://www.cdc.gov/violenceprevention/acestudy/
3. Centers for Disease Control and Prevention: www.cdc.gov
4. BRFSS (Behavioral Risk Factor Surveillance System), Data Analysis Tools: http://www.cdc.gov/brfss/data_tools.htm
   a. WONDER (Wide-ranging Online Data for Epidemiologic Research): http://wonder.cdc.gov
6. Central Oregon Housing Works: http://housing-works.org
7. Crook County Health Department: http://co.crook.or.us/Departments/HealthDepartment/HealthHome/tabid/2169/Default.aspx
8. Deschutes County Health Services: http://www.deschutes.org/services?category=47
14. Oregon Department of Education: http://www.ode.state.or.us/home/
16. Substance Abuse and Mental Health Services Administration: samhsa.gov
17. United States Census Bureau: http://www.census.gov
Appendix A

CCO Quality Health Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Infant Health</td>
<td>Percentage of members (adults and children) who thought they received appointments and care when they needed them.</td>
</tr>
<tr>
<td></td>
<td>Percentage of Medicaid members (adults) who report their overall health as excellent or very good.</td>
</tr>
<tr>
<td></td>
<td>Percentage of Medicaid members (children) who report their overall health as excellent or very good.</td>
</tr>
<tr>
<td></td>
<td>Percentage of members (adults and children) who received needed information or help, and thought they were treated with courtesy and respect by customer service staff.</td>
</tr>
<tr>
<td></td>
<td>Percentage of adult members (ages 18 years and older) who had a hospital stay and were readmitted for any reason within 30 days of discharge.</td>
</tr>
<tr>
<td></td>
<td>Percentage of eligible providers within a CCO’s network and service area who qualified for a “meaningful use” incentive payment during the measurement year through the Medicaid, Medicare, or Medicare Advantage EHR Incentive Programs.</td>
</tr>
<tr>
<td></td>
<td>Percentage of CCO members who were enrolled in a recognized patient-centered primary care home.</td>
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<td>Rate of patient visits to an emergency department for conditions that could have been more appropriately managed by or referred to a primary care provider in an office or clinic setting.</td>
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<td>Rate of patient visits to an emergency department per 1000 member months.</td>
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<td>Rate of outpatient services per 1000 member months.</td>
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<td>Percentage of adults (ages 18 years and older) who had appropriate screening and intervention for alcohol or other substance abuse (SBIRT measure)</td>
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<td>Percentage of patients (aged 13 and older) newly diagnosed with alcohol or other drug dependence and who began treatment within 14 days of the initial diagnosis</td>
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<td>Percentage of patients (aged 13 and older) who had two or more additional services for alcohol or other drug dependence within 30 days of their initial treatment</td>
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<td>Percentage of adult tobacco users advised to quit by their doctor.</td>
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<td>Percentage of adult tobacco users whose doctor discussed or recommended medication to quit smoking.</td>
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<td>Percentage of adult Medicaid members (ages 18 years and older) who currently smoke cigarettes or use other tobacco products.</td>
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<td>Percentage of adolescents and young adults (ages 12-21 years) who had at least on well-care visit during the year.</td>
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<td>Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second, or third birthday.</td>
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<td>Percentage of adult patients (ages 18-75 years) with diabetes who received at least one A1c blood sugar test</td>
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<td>Percentage of adult patients (aged 18-75 years) with diabetes who received an LDL-C (cholesterol) test.</td>
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<td>Percentage of patients (18-75 years of age) with diabetes who had hemoglobin A1C&gt;9.0% during the measurement period.</td>
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<td>Rate of adult patients (18 years and older) with diabetes who had a hospital stay because of a short-term problem from their disease (per 100,000 member years) (PQI 01)</td>
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<td>Rate of adult patients (aged 18 years and older) who had a hospital stay because of congestive heart failure (per 100,000 member years) (PQI 08)</td>
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<td>Rate of adult patients (age 40 and older) who had a hospital stay because of asthma or chronic obstructive pulmonary disease (per 100,000 member years) (PQI 05)</td>
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<td>Rate of adult members (ages 18-39 years) who had a hospital stay because of asthma (per 100,000 member years).</td>
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<td>Percentage of adolescents who received recommended vaccines before their 13th birthday.</td>
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<td>Percentage of children who received recommended vaccines before their second birthday.</td>
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<td>Percentage of children with a sore throat (pharyngitis) who were given a strep test before getting an antibiotic.</td>
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<td>Percentage of sexually active women (ages 16-24 years) who had a test for chlamydia infection.</td>
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<td>Percentage of pregnant women who received within the first trimester or within 42 days of enrolling in Medicaid.</td>
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<td>Percentage of women who had an elective delivery between 37 and 39 weeks of gestation.</td>
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<td>Percentage of women who had a postpartum care visit on or between 21 and 56 days after delivery.</td>
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<td>Percentage of children up to 15 months old who had at least 6 well child visits with a HCP.</td>
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<td>Percentage of children aged 4+ years that receive a mental health assessment and physical health assessment within 60 days of the state notifying CCOS that the children were placed into custody with the DHS.</td>
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<td>Percentage of patients (aged 6+) who received a follow up with a HCP within 7 days of being discharged from the hospital for mental illness.</td>
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<td>Percentage of children (aged 6-12 years) who had one follow up visit with a provider during the 30 days after receiving a new prescription for ADHD medication</td>
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<td>Percentage of patients ages 12 years and older who were screened for clinical depression using an age-appropriate standardized depression screening tool and if positive, have a documented follow-up plan.</td>
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# Appendix B

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2016-2019
CENTRAL OREGON
REGIONAL HEALTH IMPROVEMENT PLAN
A Message from the Central Oregon Health Council Board of Directors

Central Oregon health system partners are making important strides to improve the health of residents. These strides will continue to be facilitated by partnerships among healthcare providers, local governments, educators, community-based and non-profit organizations, citizen groups and other entities in the region. To further our vision of a healthier Central Oregon, regional partners have collaborated to create the Central Oregon Regional Health Improvement Plan (RHIP).

The nature of Central Oregon’s economy varies among and within communities and the region is sensitive to fluctuations in the state and national economic conditions. In Central Oregon, many people enjoy an elevated quality of life, experience the natural beauty of the great outdoors, and pursue their dreams. Creating a healthier Central Oregon is critical to our region’s continued success. This plan offers a roadmap through which this can be achieved.

As the Central Oregon Health Council (COHC) Board of Directors, we are committed to the following:

• Pursuing the priorities, goals and strategies described in this plan.
• Continuing to build a health system that supports these priorities and meets the needs of our region.
• Aligning plans of our respective organizations with the priorities and goals of the RHIP.
• Facilitating partnerships to achieve these goals.

To the extent these goals are achieved, there will be a healthier Central Oregon and healthier citizens to enjoy the special place in which we live, work, and play!

Tammy Baney, Chair
Commissioner, Deschutes County

Mike Shirtcliff, DMD, Vice Chair
President, Advantage Dental

Mike Ahern
Commissioner, Jefferson County

Ken Fahlgren
Commissioner, Crook County

Megan Haase, FNP
CEO, Mosaic Medical

Greg Hagfors
Chair Finance Committee
CEO, Bend Memorial Clinic

Stephen Mann, DO
Chair, Provider Engagement Panel
Central Oregon IPA Representative

Linda McCoy
Chair, Community Advisory Council

Joseph Sluka
CEO, St. Charles Health System

Dan Stevens
Executive VP, PacificSource Health Plans
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td> What is a Health Improvement Plan?</td>
<td>6</td>
</tr>
<tr>
<td> Factors that Affect Health</td>
<td>6</td>
</tr>
<tr>
<td> Clinical-Community Linkages</td>
<td>7</td>
</tr>
<tr>
<td> Community Input</td>
<td>8</td>
</tr>
<tr>
<td> How This Plan Is Organized</td>
<td>8</td>
</tr>
<tr>
<td> Implementation and Accountability</td>
<td>9</td>
</tr>
<tr>
<td>Behavioral Health: Identification and Awareness</td>
<td>10</td>
</tr>
<tr>
<td>Behavioral Health: Substance Use and Chronic Pain</td>
<td>14</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>18</td>
</tr>
<tr>
<td>Diabetes</td>
<td>21</td>
</tr>
<tr>
<td>Oral Health</td>
<td>25</td>
</tr>
<tr>
<td>Reproductive and Maternal Child Health</td>
<td>29</td>
</tr>
<tr>
<td>Social Determinants of Health Part One: Education &amp; Health</td>
<td>33</td>
</tr>
<tr>
<td>Social Determinants of Health Part Two: Housing</td>
<td>38</td>
</tr>
<tr>
<td>Appendix A: Acronyms</td>
<td>44</td>
</tr>
<tr>
<td>Appendix B: References</td>
<td>44</td>
</tr>
<tr>
<td> Behavioral Health</td>
<td>44</td>
</tr>
<tr>
<td> Cardiovascular Disease</td>
<td>44</td>
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<td>44</td>
</tr>
<tr>
<td> Oral Health</td>
<td>45</td>
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<tr>
<td> Reproductive and Maternal Child Health</td>
<td>45</td>
</tr>
<tr>
<td> Social Determinants</td>
<td>46</td>
</tr>
</tbody>
</table>
## Acknowledgements

Thank you to the following people for their contribution to this document:

<table>
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<tr>
<th>Name</th>
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<td>Alison Little</td>
<td>Medical Director for Medicaid (PEP Member)</td>
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<td>Brad Hester</td>
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<td>Bend Family Dentistry</td>
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<td>Bruce Abernethy</td>
<td>Grant Writer (CAC Member)</td>
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<td>Retired Cardiologist</td>
<td>Professor Emeritus UCLA</td>
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<td>Quality Improvement Specialist</td>
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<td>Kristin Powers</td>
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<tr>
<td>Nikole Zogg</td>
<td>Central Oregon Regional Manager (OPs Member)</td>
<td>Advantage Dental</td>
</tr>
<tr>
<td>Pamela Ferguson</td>
<td>Nurse Program Manager</td>
<td>Deschutes County Health Services</td>
</tr>
<tr>
<td>Paul Andrews</td>
<td>Deputy Superintendent (OPs Member)</td>
<td>High Desert Education Service District</td>
</tr>
<tr>
<td>Penny Pritchard</td>
<td>Tobacco Prevention Coordinator</td>
<td>Deschutes County Health Services</td>
</tr>
<tr>
<td>Rebeckah Berry</td>
<td>Operations and Project Manager</td>
<td>Central Oregon Health Council</td>
</tr>
<tr>
<td>Regina Sanchez</td>
<td>Enrollment Assister (CAC Member)</td>
<td>Crook County Health Department</td>
</tr>
<tr>
<td>Rick Koch</td>
<td>Director of Echocardiography</td>
<td>Bend Memorial Clinic</td>
</tr>
<tr>
<td>Rick Treleaven</td>
<td>Executive Director (OPs Co-Chair)</td>
<td>BestCare Treatment Services</td>
</tr>
<tr>
<td>Robert Ross</td>
<td>Medical Director of Community Health Strategy (PEP Member)</td>
<td>St. Charles Medical Group</td>
</tr>
<tr>
<td>Robin Henderson</td>
<td>Chief Behavioral Health Officer &amp; Vice-President of Strategic Integration (OPs Member)</td>
<td>St. Charles Health System</td>
</tr>
<tr>
<td>Sarah Worthington</td>
<td>Chronic Disease Program Manager</td>
<td>Deschutes County Health Services</td>
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<tr>
<td>Scott Willard</td>
<td>Executive Director (OPs Member)</td>
<td>Lutheran Social Services</td>
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<tr>
<td>Sean Ferrell</td>
<td>Program Manager (CAC Member)</td>
<td>Forest Service</td>
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<tr>
<td>Sharity Ludwig</td>
<td>Director of Community Dental Programs (PEP Member)</td>
<td>Advantage Dental</td>
</tr>
<tr>
<td>Stephen Mann</td>
<td>Medical Director (Board Member &amp; PEP Chair)</td>
<td>High Lakes Healthcare</td>
</tr>
<tr>
<td>Steve Strang</td>
<td>Director of Operations (OPs Co-Chair)</td>
<td>Bridges Health by Mosaic Medical</td>
</tr>
<tr>
<td>Suzanne Browning</td>
<td>Executive Director (CAC Member)</td>
<td>Kemple Memorial Children’s Dental Clinic</td>
</tr>
<tr>
<td>Tammy Baney</td>
<td>Commissioner (Board Chair)</td>
<td>Deschutes County</td>
</tr>
<tr>
<td>Therese McIntyre</td>
<td>Patient Population Specialist</td>
<td>Mosaic Medical</td>
</tr>
<tr>
<td>Thomas Kuhn</td>
<td>Community Health Program Manager</td>
<td>Deschutes County Health Services</td>
</tr>
<tr>
<td>Tom Machala</td>
<td>Public Health Director (OPs Member)</td>
<td>Jefferson County Health Department</td>
</tr>
<tr>
<td>Wade Miller</td>
<td>Chief Executive Officer (OPs Member)</td>
<td>COPA</td>
</tr>
</tbody>
</table>
Introduction

What is a Health Improvement Plan?

The Centers for Disease Control and Prevention defines a health improvement plan as “a long-term, systematic effort to address public health problems on the basis of the results of health assessment activities and the health improvement process.” System partners to address priorities coordinate efforts and target resources will use the Central Oregon Regional Health Improvement Plan (RHIP). A health improvement plan is critical for developing policies and taking actions that promote health. It defines the vision for the health of the community through a collaborative process and offers strategies to improve the health status of that community.

In 2015, Central Oregon health system partners created the Central Oregon Regional Health Assessment (RHA). A health assessment gives organizations comprehensive information about the community's current health status, needs, and issues. This information provided the central guidance for creation of this health improvement plan.

Benefits of a health assessment and improvement process and plan include:
- Improved organizational and community coordination and collaboration
- Increased knowledge about health and the interconnectedness of activities
- Strengthened partnerships within local health systems
- Identified strengths, weaknesses, and gaps to address quality improvement efforts
- Measured benchmarks for public health and healthcare practice improvement

Factors that Affect Health

A person’s health is determined largely by social and economic factors, although prevention and healthcare services contribute substantially to maintaining health. According to the World Health Organization (1948), “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” Where we live, go to school, and work affects our overall health, as does the safety and livability of our communities, whether we are economically stable or struggling to get by, and whether we have strong social connections. These factors are called social determinants of health and help explain why certain segments of the population experience better health outcomes than others. They also explain how external factors influence our ability to live healthy. The public health and healthcare systems implement strategies on multiple levels to improve the health of individuals and families, as well as the population at large. The five-tier pyramid, shown below, illustrates how different types of interventions affect health.

Introduction

Factors that Affect Health (continued)

The Central Oregon RHIP necessarily incorporates strategies from all levels of the pyramid. Interventions in the top two tiers of the pyramid commonly occur in a healthcare setting. These interventions are essential to protect and improve an individual's health, but they often have a limited impact on the population's achievement of optimal health.

Interventions in the middle and at the base of the pyramid are geared toward improving the health of the entire population by focusing on prevention, making health resources readily available, ensuring the healthcare system is equipped to address health needs, and enacting policy that makes healthy choices the default and addressing socioeconomic factors that affect health. These interventions can have the greatest potential to affect health because they influence the entire population, in contrast to focusing on one individual at a time. However, it may take generations to see the effects of interventions designed to change socioeconomic factors.

Clinical-Community Linkages

Clinical-community linkages receive special attention because they are required to ensure the success of strategies identified in the RHIP. The Agency for Healthcare Research and Quality (AHRQ) recommends clinical-community linkages that help to connect healthcare providers, community organizations, and public health agencies. Creating sustainable, effective linkages between the clinical and community settings can improve patients’ access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies.

The goals of clinical-community linkages include:

- Coordinating healthcare delivery, public health, and community-based activities to promote healthy behavior.
- Forming partnerships and relationships among clinical, community, and public health organizations to fill gaps in needed services.
- Promoting patient, family, and community involvement in strategic planning and improvement activities

Strategies that improve access to clinical preventive services (such as screening and counseling), community-level activities, and appropriate medical treatment have been shown to reduce and prevent disease in communities.
Community Input

The Operations Council of the Central Oregon Health Council (COHC) used a community driven strategic planning process, “Mobilizing for Action through Planning and Partnership (MAPP),” to guide creation of the Central Oregon RHA and RHIP. The RHA includes data and information that describes the health status of Central Oregon residents. Input on the assessment was solicited from the COHC’s Board of Directors, Community Advisory Council, Provider Engagement Panel, county and regional health-related advisory boards and groups, and during community meetings in Crook, Deschutes, and Jefferson counties. During June through August 2015, partners completed a series of regional community and professional meetings to understand community, partner, and stakeholder perceptions related to health issues and forces of change that influence Central Oregon. The input and information gathered from these meetings established the RHIP priority areas and laid the foundation for the plan.

Two documents summarize results of the RHA: the “2015 Central Oregon Regional Health Assessment” and “Community Conversations: Creating the Regional Health Assessment and Health Improvement Plan, 2015.” Both of these documents can be found at this link: http://cohealthcouncil.org/regional-assessments/.

From September through December 2015, the Operations Council developed the RHIP with input solicited from local experts, the COHC’s Board of Directors, Community Advisory Council, Provider Engagement Panel, and health-related advisory boards and groups in Crook, Deschutes, and Jefferson counties. Evidence-based goals and strategies to address the priority areas were developed with input from Operations Council members, and with external expert guidance and support. These priorities, goals, and strategies became the outline for the RHIP. To ensure new information aligns with community perception, community input and collaboration will be an ongoing activity.

How This Plan Is Organized

The health issues addressed in this plan were identified by a number of processes. Healthcare professionals and community stakeholders from the Operations Council completed the initial process with a scoring method using assessment data and information. The second process was completed by members of the Community Advisory Council using selection criteria based on intimate knowledge of communities and the region. The third process was a combined meeting with members of the COHC Board of Directors, Community Advisory Council, and the Operations Council. During this meeting these members reviewed the highest priorities from the Operations Council and the Community Advisory Council meetings. The health improvement priorities that surfaced during the joint meeting were:

- Behavioral Health (Identification & Awareness/Substance Use & Chronic Pain)
- Cardiovascular Disease
- Diabetes
- Oral Health
- Reproductive and Maternal/Child Health
- Social Determinants of Health
How this Plan is Organized (continued)

The plan includes evidence-based strategies to address the health improvement priorities arranged as follows:

- Prevention/health promotion
- Clinical
- Policy
- Health equity
- Health system/access
- Childhood health

This plan has the requisite focus to ensure efforts are not so diluted as to become ineffective, but also attends to the interrelationships among the health improvement priorities selected. Arranging the plan as described above highlights where strategies impact more than one health condition and where addressing one health behavior can impact more than one health condition. For example, a prevention and health promotion strategy in Behavioral Health Identification and Awareness is alcohol, tobacco, and other drug health curriculum consistently and accurately being taught in schools to align with Oregon Department of Education (ODE) standards for health and evidence-based practice. This strategy aligns with prevention and health promotion efforts for cardiovascular disease as well, due to the linkages between tobacco and cardiovascular disease. Furthermore, while the plan focuses on specific priorities, the final chapter emphasizes the need to address the broader social determinants of health, where we have the greatest potential to impact the health of the entire population and “whole person” health.

Implementation of the plan will require further integration of public health, healthcare, behavioral health and human services at the individual, provider, system, community and regional levels. It is also intended to encourage positive change in our delivery systems to improve access, encourage efficiency, improve quality, and achieve measurable improvements in health outcomes.

The COHC did not identify workforce development as a priority area of the RHIP—largely because it is implicit in all of the work outlined in this guiding document. The COHC acknowledges that none of the work proposed in the RHIP to address regional health improvement priorities or address social determinants of health will be possible without the work conducted by community partners to recruit, train, and educate employees. The COHC, working by and through its community partners, is eager to participate in efforts to expand workforce development opportunities. It is not possible to overstate the connection between stable and living wage jobs for a well-developed workforce and a healthier Central Oregon.

Implementation and Accountability

The RHIP includes specific measurable health indicators for each of the priority areas that will be addressed from 2016 through 2019. This will allow us to track our progress, celebrate achievements, and change course when desired outcomes are not being met.

Work plans with specific timelines will guide implementation of strategies and will document progress made. The COHC and its committees will take the lead on implementing and tracking progress and will provide updates to the community. Further, regional health system partners have committed to use the RHIP as a guiding document for developing their organization-specific strategic plans.
The Problem

Stigma and the lack of integrated care pathways lead to a dramatic under-assessment and treatment of behavioral health issues in primary care settings.

There is considerable overlap between poor outcomes for chronic diseases and significant mental health and substance use problems. Approaches for preventing or treating chronic diseases need to address the whole person and their environment, particularly targeting screenings and support for mental health and substance use issues. Per capita costs among Medicaid-only beneficiaries with disabilities for coronary heart disease is nearly triple for people who also have co-occurring mental health and substance use disorders (SUDs) compared with people without either (Boyd, et al., 2010). Per capita costs are 3.8 times higher for diabetics with co-occurring mental health and substance use disorders than for diabetics with neither mental health nor substance use disorders (Boyd, et al., 2010). Individuals with depression average twice as many visits to their primary care doctor than do non-depressed patients and have nearly twice the annual healthcare costs. (Mauer & Jarvis, 2010).

The risk factors for depression and chronic diseases are bi-directional, with chronic diseases increasing the risk of depression, and conversely, depression increasing the risk of chronic diseases. Depression and unhealthy alcohol use is present in a significant percentage of people with diabetes and cardiovascular disorders. Depression has been proven to be such a risk factor in cardiac disease that the American Heart Association has recommended that all cardiac patients be screened for depression (AHA 2008). The presence of Type 2 diabetes nearly doubles an individual’s risk of depression and an estimated 28.5% if diabetic patients meet criteria for clinical depression (Mauer & Jarvis, 2010). People with mental illness, substance use disorders (SUDs), or both are at increased risk for developing diabetes. Untreated behavioral health disorders can exacerbate diabetes symptoms and complications. In addition, companion features of behavioral health disorders – such as poor self-care, improper nutrition, reduced physical activity, and increased barriers to preventive or primary care – can adversely affect management of co-occurring diabetes (SAMHSA Advisory, 2013).

The majority of people who use alcohol at levels that impact their physical health and behavioral health do not meet dependency criteria and are inappropriate for specialty treatment programs. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice that targets patients in primary care with nondependent substance use. It is a strategy for intervention prior to the need for more extensive or specialized treatment. The utilization rate of SBIRT in Central Oregon remains at a fraction of the State benchmark, blunting the impact of this evidence-based practice. When primary care practitioners do identify a severe substance use disorder in a patient, the rate of successful referral to specialty SUD care remains very low, mainly due to low readiness-to-change in the patient, no system to develop the motivation, and close collaboration necessary for a successful treatment referral.
## Behavioral Health Identification and Awareness

### Goals

#### Clinical Goals
1. Increase screenings for depression, anxiety, suicidal ideation, and substance use disorders.
2. When screenings are positive, increase and improve primary care-based interventions, and, when appropriate, referrals and successful engagement in specialty services.

#### Prevention Goal
Normalize the public's perception of accessing resources for depression, anxiety, suicidal ideation, and substance use.

### Health Indicators by 2019

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of SBIRT/CRAFFT screenings provided in healthcare settings shall exceed 12% (Oregon Health Authority, 2015).</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of Depression screenings and follow-up care provided in healthcare settings shall exceed 25% (Oregon Health Authority, 2015).</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>3. First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement benchmarks.</td>
<td></td>
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</tr>
</tbody>
</table>

### Action Area

#### Strategy

- Implement a program like the “Mind Your Mind” campaign.
- Social/emotional health curriculum taught in schools aligned with Oregon Department of Education (ODE) standards for health and evidence based practice.
- Alcohol, tobacco, and other drug health curriculum taught in schools aligned with ODE standards for health and evidence based practice.
- Implement a low risk drinking guideline (compliment to SBIRT) in the community.
Behavioral Health Identification and Awareness

**Action Area**  
**Clinical**
- Create a comprehensive identification and response system that is reflective of the entire primary care practice (from appointment scheduling to office visit).
- Use SBIRT/CRAFFT, PHQ 2 & 9, GAD-7, and other evidence-based screening tools within healthcare settings.
- Create a common response matrix that clinics could adopt, including physician intervention, BHC intervention, short-term BH intervention at PCP clinic, and referral to specialty BH services.
- Create pathway/mapping for referral to specialty care.
- Create clear referral and communication protocols.
- Health information shared with primary care coordination team for review and provider follow up.
- Ongoing regional trainings in screening tools and brief intervention response.

**Policy**
- Promote policies that support routine screening and follow-up care for Substance Use, depression and anxiety.
- Promote policies that support public awareness and acceptance of mental health and substance use wellness strategies.

**Health Equity**
- Screenings, interventions, and specialty services need to be culturally and linguistically specific in order to be successful.
- Please refer to the chapter on social determinants of health for additional strategies.

**Health System/Access**
- The creation of a common response matrix to screenings (i.e., brief provider intervention, BHC, or referral to specialty clinic) will improve the number of screenings and spread the cost-effective utilization of behavioral health interventions in healthcare settings.
- Increased public awareness of the role of behavioral health wellness in overall wellness will improve patient acceptance of behavioral health screenings.
- Assessment of resource needs within the community that will be addressed in partnership through multiple organizations, such as payees, public health, hospital, etc.
Behavioral Health

Identification and Awareness

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Health</strong></td>
<td>• Substance use and depression are significant contributors to poor childhood health. Regular screening and follow-up care will increase childhood health outcomes.</td>
</tr>
</tbody>
</table>

Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- Addictions and treatment centers
- State health promotion and prevention programs
The Problem

People with severe Substance Use Disorders (SUDs) also carry a high medical burden and respond poorly to medical interventions, leading to extremely high utilization rates. The current disjointed practice pattern between medical care and specialty SUD services actually contributes to poor medical and behavioral health outcomes and increases the number of people with Opioid Use Disorder.

In a large-scale review of adult Medicaid beneficiaries in six states in 1999, between 16% and 40% of beneficiaries had diagnoses of moderate to severe substance use disorders (SUDs). In all states SUDs, were associated with higher rates of hospitalization for inpatient psychiatric and medical care. Importantly, beginning at age 50, medical costs for persons with SUDs almost doubled (Clark, Samnaliev, & McGovern, 2009). People with moderate-to-severe SUDs have nine times greater risk of congestive heart failure (Mertons, et al., 2003), likely due to poor nutrition, little exercise, and high rates of smoking in combination with the impact of their substance use. The comorbid combination of alcohol abuse, depression, and diabetes is often common in homeless and Native American populations (Am Indian Alsk Native Mental Health Rev, 2007). According to a 2008 study by the Oregon Division of Addiction and Mental Health, people with co-occurring mental health and SUDs have an average age at death of 45 years. Providing SUD treatment to those who need it has been shown to slow disease progression and growth in medical costs (Mancuso & Felver, 2010).

There has been a dramatic increase in opioid prescription drug availability over the past 15 years, which has resulted in an equally dramatic increase in prescription drug abuse and the related increase in heroin use in Central Oregon. In this manner, prescription practices by physicians can have serious public health consequences. The opioid-related unintentional prescription drug mortality rate has tripled in Oregon since 2000. The 5-year average age-adjusted opioid-related unintentional prescription drug mortality rate in Central Oregon was 3.6/100,000 population (95% CI 2.5-5.1) (CDC Wonder, 2009-2013). The 5-year average rate in Oregon during this time period was 4.1/100,000 population (95% CI 3.8-4.4). Injection drug users are the largest single risk group for Hepatitis C (CDC Surveillance for Viral Hepatitis 2013). Surveys have indicated that within one year of use, 50-80% of injection drug users test positive for the Hepatitis C antibody. Nationally, there was a 151.5% increase in acute Hepatitis C cases from 2010 to 2013, largely attributed to drug use (CDC 2013). With Central Oregon experiencing a significant increase in prescription opiate and heroin use, the region can expect to see an increase in Hepatitis C rates. Finding alternative resources to opioids for people suffering from chronic, non-cancer pain is one of the highest priorities identified by local physicians. To decrease the chronic over-availability of prescription opiates in our community requires, in part, providing evidence-based holistic approaches to chronic, non-cancer pain.
**Goals**

**Clinical Goal**
Create a bi-directional integration approach for people with severe substance use disorders.

**Prevention Goal**
Implement a community standard for appropriate and responsible prescribing of Opioids and Benzodiazepines.

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the rate of successful referrals from medical settings to specialty SUD services of people with moderate-to-severe SUDs.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. First year develop a baseline on the pharmacy, hospital, acute psychiatric, and emergency department expense related to people with moderate-to-severe SUDs. Second year set performance improvement benchmarks.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3. First year develop a baseline for number of people receiving greater than 120 mg morphine equivalent for more than three months.</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Action Area**

**Prevention and Health Promotion**

- Expand Prescription Drug Monitoring Program (PDMP) use by primary care providers.
- Develop plan for implementing alternative & complimentary pain treatment therapy.
- Compassionate care education for community providers.
- Expand needle exchange programs.
- Expand the availability of Naloxone.
- Expand medication disposal programs.
- Develop a process and care path for affected family and children to impact ACEs and behavioral health factors.
# Behavioral Health

## Substance Use and Chronic Pain

### Action Area Strategy

#### Clinical

- Develop high functioning patient pathways from hospital and primary care settings into SUD specialty care.
- Create a “Hub and Spoke” model for Medically Assisted Treatment (MAT) that links the MAT specialty provider with (a) other SUD and mental health providers, and (b) primary care providers.
- Create an efficient, effective, and coordinated system of outreach, engagement, and care coordination services to medically significant populations, including: pregnant women who still use drugs, people who use illicit IV drugs, identified high utilizers of medical and pharmacy services, identified utilizers of mental health acute care services, and identified hospital patients.
- Provision of cost-effective medical/nursing support and alternative chronic pain management/chronic disease management skills training in selected SUD specialty care programs.
- Implementation of an outcomes system for each of the above four strategies focused on engagement and retention in specialty SUD services and on patterns of healthcare utilization.

#### Policy

- Support the efforts of the Chronic Pain Task Force to educate physicians to best practice standards and to support alternative pain management strategies.
- Advocate with OHA to make alternative and complimentary pain treatment therapy a reimbursable service.
- Support legislation to make Naloxone available through the pharmacy without a physician's prescription.
- Expand needle exchange and harm reduction education for people injecting illicit drugs.
- Expand prescription drug return programs.

#### Health Equity

- Cultural and language specific treatment strategies for Latino clients.
- Safe and sober housing availability.
- Intentional Peer Support outreach for severely disadvantaged people with SUDs, including people who are homeless, Native American public inebriates, IV drug users, and pregnant women who use drugs.
- Support employment strategies for people with criminal records.
- Please refer to the chapter on social determinants of health for additional strategies.
Behavioral Health
Substance Use and Chronic Pain

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Strategy</th>
</tr>
</thead>
</table>
| Health System/Access | • Make available SUD engagement services at hospitals and primary care clinics.  
• Identification of clients in SUD services who have high medical burden and develop, with the PCP, a whole healthcare and support plan.  
• Development of alternative and complementary pain programs widely available in the community.  
• Develop a community care plan for impacted children and family. |
| Childhood Health     | • Substance use is a significant predictor to all of the Adverse Childhood Events (ACEs). Treating the parent, who has a severe substance use disorder, decreases the number of ACEs a child experiences and increases that child's resiliency, thus improving long-term health status. |

Examples of Key Partnerships

• Health systems and healthcare providers  
• Public health departments  
• High schools (school nurses, school-based health centers)  
• School boards  
• Places of worship  
• Employers  
• Colleges  
• Addictions and treatment centers  
• State health promotion and prevention programs  
• Sheriff and Police Departments in Central Oregon
Cardiovascular Disease

The Problem

Cardiovascular disease (CVD) is a classification of diseases of the heart and blood vessels that includes chest pain, heart attack, and other conditions that affect the heart muscle, rhythm, or valves. Cardiovascular diseases are preventable with good nutrition and exercise, and by remaining tobacco free. People with cardiovascular disease or who are at high cardiovascular risk (due to the presence of one or more risk factors such as hypertension, diabetes or hyperlipidemia) need early detection and management using counseling and medications, as appropriate.

Smoking causes one of every three deaths from CVD, according to the 2014 Surgeon General's Report on smoking and health. It is a leading cause of preventable death in the US and doubles a person’s risk for stroke (USDHHS, 2014). Nearly one in three adults in Crook County, one in six adults in Deschutes County, and one in four adults in Jefferson County report smoking tobacco.

The most common type of CVD in the United States is coronary artery disease, which affects the blood flow to the heart. It is one of the leading causes of death in Oregon and the US. In fact, among males and females admitted to St. Charles facilities in Central Oregon, 21% and 14%, respectively, were for CVD events (St. Charles Health System, 2014).

Cerebrovascular disease is another major form of CVD that affects blood flow in the brain. Stroke is one of the cerebrovascular diseases and is a leading cause of death and disability. A stroke is caused by a blood vessel breaking or an artery becoming clogged in the brain, which leads to reduced blood flow and brain damage. Knowing the signs and symptoms of stroke can save lives.

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Age-adjusted prevalence of adult current smokers (Oregon BRFSS, 2010-2013)

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>19.0</td>
</tr>
<tr>
<td>Crook</td>
<td>31.0</td>
</tr>
<tr>
<td>Deschutes</td>
<td>16.3</td>
</tr>
<tr>
<td>Jefferson</td>
<td>24.1</td>
</tr>
</tbody>
</table>

§National Health Interview Survey, 2011
Cardiovascular Disease

Goals

Clinical Goal
Improve hypertension control.

Prevention Goal
Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

Health Indicators by 2019

<table>
<thead>
<tr>
<th></th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the percentage of OHP participants with high blood pressure that is controlled (&lt;140/90mmHg) from 64% to 68% (Baseline: QIM NQF 0018 - Controlling high blood pressure, 2014).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>2. Decrease the prevalence of cigarette smoking among adults from 18% to 16% (Baseline: Oregon BRFSS, 2010-13; QIM Cigarette Smoking Prevalence).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Decrease the prevalence of smoking among 11th and 8th graders from 12% and 6%, respectively to 9% and 3%, respectively (Baseline: Oregon Healthy Teens Survey, 2013).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4. Decrease the prevalence of adults who report no leisure time physical activity from 16% in Crook County, 14% in Deschutes County and 17% in Jefferson County to 14%, 12%, and 15 % respectively (Baseline: Oregon BRFSS, 2010-13).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Decrease the prevalence of 11th graders and 8th graders who have zero days of physical activity from 11% and 6% to 10% and 5%, respectively (Baseline: Oregon Healthy Teens, 2013)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Action Area Strategy

Prevention and Health Promotion

- Encourage healthcare providers to increase referrals, including electronic referrals, to the Oregon Tobacco Quit Line.
- Promote the Oregon Health Authority statewide Smokefree Oregon campaign for youth.
- Offer training and assistance to healthcare providers to implement “2As and R” or “5As” tobacco cessation counseling.
- Implement a community-based educational campaign on blood pressure control (i.e., Measure Up/Pressure Down).
- Engage community-based organizations (schools, dentists, colleges, employers, hospital, etc.) in an educational program/campaign around BP control and monitoring and CVD relationship.
- Engage employers to offer worksite health promotion programs that support improved employee weight status by targeting nutrition and physical activity.
Cardiovascular Health

Action Area Strategy

Clinical

- Implement evidence-based guidelines for the control of hypertension.
- Provide assistance to patients to self-monitor blood pressure, either alone or with additional support.
- Increase referrals to the Oregon Tobacco Quit Line.
- Implement “2As and R” or “5As” tobacco cessation counseling.

Policy

- Implement a tobacco retail licensing program that will eliminate illegal sales to minors, prevent retailers from selling tobacco within 1000 feet of schools, raise the age of purchase to 21, and eliminate sales of flavored tobacco products.
- Increase the number of schools using the CDC School Health Index to improve their health policies and programs.
- Encourage healthy community design and policies that increase opportunities for physical activity, access to healthy foods, and other health-enhancing features.

Health Equity

- Identify, develop and implement culturally competent materials and programs such as Smokefree Oregon ads for culturally disparate populations.
- Please refer to the chapter on social determinants of health for additional strategies.

Childhood Health

- Engage schools to promote CVD prevention using best-practice, school-based model.

Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- State health promotion and prevention programs
- Farmers markets
- Grocery stores
Diabetes

The Problem

Diabetes is characterized by having high blood sugar levels and can lead to serious adverse outcomes if left untreated. There are several types of diabetes, including type 1, type 2, and gestational diabetes. Type 1 diabetes is an autoimmune disorder usually diagnosed at an early age. Type 2 diabetes, which makes up 95% of diabetes cases, is often diagnosed in adulthood (Lloyd-Jones D, et al., 2009). Gestational diabetes is a condition that affects pregnant women and often goes away once the baby is born. If left untreated, gestational diabetes may cause problems for the mother and baby. In addition, gestational diabetes puts women at increased risk for later developing type 2 diabetes. Prediabetes is a condition in which an individual has blood sugar levels that are elevated but not high enough to be considered diabetes.

In all cases, a diagnosis of diabetes has significant impacts on quality of life. If left untreated or poorly managed, diabetes can lead to major life-threatening and costly complications including kidney disease, blindness, cardiovascular disease and lower extremity amputations.

Many of the risk factors for prediabetes, diabetes and cardiovascular disease are the same and include physical inactivity, overweight/obesity, high blood pressure, tobacco use, and an unhealthy diet. This means that many individuals can focus on adopting the same healthy strategies to prevent the most common chronic health problems. Strong evidence shows that lifestyle interventions for persons at risk for developing diabetes significantly reduces risk of developing type 2 diabetes (DPP Research Group, 2009). These programs include coaching and counseling to maintain a healthy weight, increasing physical activity, eating healthy, and controlling hypertension, and can reduce the risk of developing type 2 diabetes as well as cardiovascular disease.

In Oregon, 9% of adults reported having diabetes in 2013, reflecting a doubling in prevalence over the past 20 years (Oregon Health Authority, 2015). For these adults, a key element of diabetes control is self-management education. Recent studies estimate that more than 1 out of 3 US adults (38%) – or 1 million Oregon adults have prediabetes; 9 out of 10 adults with prediabetes are not aware they have it (CDC, 2014). American Indians/Alaska Natives, African Americans and Latinos have a higher prevalence of diabetes than non-Latino Whites.
**Goals**

**Clinical Goal**
Improve control of type 2 diabetes.

**Prevention Goal**
Decrease the proportion of adults and children at risk for developing type 2 diabetes.

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Baseline: Oregon BRFSS 2010-13).</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>2. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively, to 13% and 14%, respectively (Baseline: Oregon Healthy Teens, 2013).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3. Decrease the percentage of OHP participants 18-75 years of age with diabetes who had HbA1c &gt;9.0% from a baseline of 14.7% to 11% (Baseline: QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014).</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>4. Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (Baseline: NQF 0057 - Oregon State Performance Measure, 2014).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>5. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Baseline: Oregon State Core Performance Measure, MBRFSS 2014).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Action Area   Strategy**

- Implement a Diabetes Prevention Program (DPP).
- Increase availability of diabetes self-management programs.
- Engage employers to offer worksite health promotion programs that support improved employee weight status by targeting nutrition and physical activity.
- Partner with grocery stores and farmers markets to increase pre-diabetes and diabetes awareness programs.
- Develop targeted strategies to improve Diabetic Medication Adherence (i.e.: refrigeration, MedMinders, etc.).
- Create partnership with Parks and Recreation offices to offer peer led exercise sessions.
**Diabetes**

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Strategy</th>
</tr>
</thead>
</table>
| **Clinical** | • Increase referrals to diabetes self-management and prevention programs.  
• Improve medication adherence among patients with diabetes.  
• Increase postpartum screening and follow-up for patients with gestational diabetes.  
• Increase the use of case management interventions for patients with diabetes with CCO support for clinic innovations.  
• Improve coordination between medical and dental providers to provide the tools and education needed about the correlation between oral health and diabetes (i.e.: Dental Medical Integration (DMI) Project). |
| **Policy** | • Increase the number of schools using the CDC School Health Index to improve their health policies and programs. |
| **Health Equity** | • Increase provider and community referrals to the Spanish language Tomando Control chronic disease self-management program.  
• Create diabetes awareness campaigns that are culturally aligned, health literate, and community specific.  
• Encourage healthy community design and policies that increase opportunities for physical activity, access to healthy foods, and other health-enhancing features.  
• Please refer to the chapter on social determinants of health for additional strategies. |
| **Health System/Access** | • Engage health systems to implement systematic EHR referrals to diabetes self-management and prevention programs.  
• Improve provider and community awareness of diabetes self-management programs. |
| **Childhood Health** | • Promote coordinated school health programs that prevent risk behaviors that contribute to heart disease and stroke:  
  o Maintain or establish enhanced physical education classes.  
  o Prohibit withholding recess as punishment.  
• Engage schools to provide evidence-based interventions to promote physical activity and nutrition education in schools. |
Diabetes

Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- Grocery stores
- Farmers markets
- Schools (policies around PE and physical activity during school hours)
- Parks and Recreation officials
- Pharmacies
- Employers
- Health clubs
- Places of worship
- Non-profit organizations
The Problem

The health of the mouth and surrounding structures is central to a person’s overall health and well-being. Dental caries (cavities) is a communicable infectious disease most frequently caused by the bacterium Streptococcus mutans. Preventing the transmission from one person to another or controlling bacteria load in the mouth is possible and can eliminate or decrease tooth decay.

Dental caries is the most common chronic disease among children and is 5 times more common than asthma (American Academy of Pediatric Dentistry, n.d.). Untreated decay or other oral health problems in children can result in attention deficits, learning and behavior challenges in school, and problems speaking, sleeping and eating (The California Society of Pediatric Dentistry and California Dental Association, n.d.). In Central Oregon, one-quarter to one-half of first and second graders that were screened in selected Central Oregon schools had untreated tooth decay (Kemple Memorial Children’s Dental Clinic, n.d.). Moreover, between 71.7% and 76.3% of Central Oregon 8th graders reported having at least one cavity, and between 4.8% and 6.4% missed one or more hours of school due to going to the dentist because of tooth or mouth pain (Oregon Health Authority, 2015).

Among adults, poor oral health may negatively affect a person’s ability to obtain or keep a job and form relationships (National Institute of Dental and Craniofacial Research, 2000). In Central Oregon, one safety net clinic reported 40% of low-income patients seeking care for their physical health had dental issues that impacted their ability to eat or sleep (Volunteers in Medicine, 2013). Nationally, employed adults lose more than 164 million hours of work each year due to dental disease and dental visits (Centers for Disease Control and Prevention, 2006). Poor oral health is also associated with adverse pregnancy outcomes and other disease and conditions such as diabetes, cardiovascular disease, stroke and respiratory disease (National Institute of Dental and Craniofacial Research, 2000). Limited data exists regarding the older population but the 2014 Strategic Plan for Oral Health states that 33% of Oregonians ages 33-44 still have all of their teeth, while 37% of individuals age 65 and over have lost six or more teeth (Oregon Oral Health Coalition, 2014). Minorities and low-income populations are significantly more likely to report oral health problems (World Health Organization, 2012).
Goals

Clinical Goal
Improve oral health for pre and post-natal women.

Prevention Goal
Keep children cavity-free.

Health Indicators by 2019

<table>
<thead>
<tr>
<th></th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>By 2019, increase the percent of pre and postnatal women who had a dental visit from 55.2% to 60% (Baseline: PRAMS, 2011).</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>2.</td>
<td>By 2019, increase the percent of children 6-14 years who received a dental sealant to 20% (Baseline: Oregon Health Authority, 2015).</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>3.</td>
<td>By 2019, decrease the percent of 1st and 2nd graders with untreated dental decay in schools that participate in the School Dental Sealant Program by 5% (Baseline: School Dental Sealant Program, 2013-2014).</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>4.</td>
<td>By 2019, decrease the percent of 8th graders who missed one or more hours of school due to going to the dentist because of tooth or mouth pain by 0.5% (Baseline: Oregon Health Teens Survey, 2013).</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>5.</td>
<td>By 2019, increase the percent of children 0-5 years who received a dental service within the reporting year to 40% (Baseline: PRAMS, 2011).</td>
<td>✔️</td>
<td></td>
</tr>
</tbody>
</table>

Action Area  Strategy

Prevention and Health Promotion

- Partner Dental Care Organizations (DCOs) with pediatricians to provide post-natal moms with oral hygiene instruction and 90 day supply of xylitol at two-week post-natal visit.
- Provide education to providers asking the One Key Question* regarding importance of a dental visit prior to pregnancy.
- Decrease fear of the dentist by increasing provider awareness of Adverse Childhood Experiences (ACEs).
- Work with schools to ensure children receive toothbrush kits on a regular basis.
- Work with community-based entities to increase outreach, education, and intervention to underserved individuals.
- Assess oral health literacy.
- Implement Brush, Book, Bed (AAP).
- Provide nutrition counseling.
- Provide tobacco cessation resources.
Oral Health

Action Area  Strategy

**Clinical**

- Patients who indicate they plan to get pregnant in the next year get referred into dental care.
- Deliver preventive dental services to children and pregnant women in non-traditional settings.
- Primary care clinician prescribes oral fluoride supplementation starting at 6 months of age for children whose water supply is deficient in fluoride.
- Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.

**Policy**

- Develop policies and practices to fast track pregnant women into dental care.
- Work with legislators to include fluoridated toothpaste in the SNAP benefits.
- Work with legislators to get fluoridated toothpaste to be covered as a prescription benefit for OHP members.
- Adopt trauma-informed care model policies within dental practices.
- Adopt a policy to see patients in the first year of life within dental practices.
- Establish optimally fluoridated community water systems.

**Health Equity**

- Business practices and services will be culturally and linguistically competent in all dental locations.
- Please refer to the chapter on social determinants of health for additional strategies.

**Health System/Access**

- Integrate oral healthcare into the standard practice of care for all healthcare settings.
- All providers, including school-based health centers, shall adopt a minimum of two questions to assess oral health status and refer as appropriate.
- All primary care providers and primary care dentists shall adopt the One Key Question* and make appropriate referrals based on intent to become pregnant.
- All primary care providers, behavioral health professionals, and primary care dentists will administer or have knowledge of their patients’ ACEs score.
- OB/GYN practices shall adopt policies/practices to assess oral health and refer to care.
- Expand comprehensive community-based oral health.
- Expand First Tooth program beyond clinic providers to include home visitors and lay persons such as licensed childcare workers and school nurses.
Oral Health

Action Area Strategy

**Childhood Health**

- See previous Oral Health Action Areas and Strategies that address Childhood Health through their efforts.

Examples of Key Partnerships

- Health systems and healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School boards
- Places of worship
- Employers
- Colleges
- State health promotion and prevention programs
Reproductive & Maternal Child Health

The Problem

Maternal and child health indicators describe the health and well-being of mothers, infants, children, and families. A mother’s health and well-being before, during, and after pregnancy has direct and sometimes lifelong effects on the health of her child.

As a focus of maternal child health, low birth weight (LBW) is a serious public health challenge. Babies who have very LBW can be at higher risk of death and other complications as they grow up. LBW infants are more likely to die before their first birthday and more likely to suffer from cognitive development issues and chronic health conditions, such as high blood pressure and asthma. The problems associated with LBW also continue into adulthood: Compared to their peers, LBW individuals attain less education and earn less income. LBW is associated with tobacco, alcohol, and drug use; lack of early prenatal care, lack of maintaining a healthy weight.

In Central Oregon, 77.9% of infants received prenatal care in the first trimester as compared to 77.8% in Oregon (OHA – Performance Measures, 2015). Differences between the counties in 2014 show Deschutes at 81%, Crook at 70.4%, and Jefferson at 68.5% (OHA, 2014). Timeliness of prenatal care is a current quality incentive measure for the CCO.

The rate per 1000 for smoking during pregnancy was six times higher among women enrolled in OHP in Central Oregon than those with private insurance as demonstrated by the inset table.

Cigarette smoking prevalence is a 2016 CCO quality incentive measure.

Unintended pregnancy refers to pregnancies that are mistimed, unplanned, or unwanted. About 51% of pregnancies in the United States are unintended (Guttmacher Institute, 2015). Measuring rates of unintended pregnancy helps gauge a population’s needs for contraception and family planning. Unintended pregnancy is associated with increased risk of health problems for the baby as the mother may not be in good health or delay prenatal care upon learning of the pregnancy. Almost 50% of pregnancies in Oregon are unintended, and have been for more than three decades (Finer & Kost, 2011). In 2011, the most recent year for which there is state-level data on pregnancy intentions, there were 45,136 births, 37% of which were considered unintended. That year there were 9,567 elective abortions. Also in 2011, the unintended pregnancy rate was 36.6% for Oregon, 38.8% for Central Oregon, 37.7% for Deschutes County, and 35.3% for Jefferson County. The total unweighted denominator for Crook County was too small to report. (OHA, 2011; PRAMS, 2011).

A published study in 2013 found that Medicaid paid for approximately 63% of unintended births in Oregon (Sonfield & Kost, 2013). Among women ages 19 and younger, more than four out of five pregnancies were unintended. The proportion of unintended pregnancies is highest among teens younger than 15 years, with 98 percent of these pregnancies being unintended (Finer and Zolna, 2014).

Immunizations are a key public health measure for preventing the spread of disease. A series of immunizations are delivered to children to ensure their immunity to many diseases. The trend over the past few years has shown a decrease in the immunization rates and there have been outbreaks throughout the nation. Central Oregon’s rates have decreased to a point of concern. As noted in the 2015 Regional Health Assessment, two-year-olds in Jefferson County were more frequently up to date with immunizations than were two-year-olds in Crook and Deschutes County. Central Oregon practices and public health departments who provide vaccinations should assess and develop approaches to increase immunization rates in their practices to improve the health of Central Oregon children.

Table 1. Percent of women on OHP versus private insurance who smoked during pregnancy

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
<th>Central Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP</td>
<td>19.1</td>
<td>28</td>
<td>17.7</td>
<td>14.4</td>
<td>17.9</td>
</tr>
<tr>
<td>Private</td>
<td>3.9</td>
<td>6.6</td>
<td>2.5</td>
<td>3.1</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Attachment 10-Community Health Improvement Plan
## Goals

### Clinical Goal
Reduce the prevalence of low birth weight among live-born infants by improving prenatal/postnatal care for mothers and infants.

### Prevention Goals
Prevent unintended pregnancies.
Improve immunization rates of children birth to two years.

### Health Indicators by 2019

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>QIM Measure</th>
<th>State Measure</th>
<th>HP 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2019, increase the number of women in Central Oregon who receive prenatal care beginning in the first trimester from 86% to 90% (Baseline OHA: Performance Measures – Central Oregon Region – PS – May 2015; Oregon Health Authority 2013: Crook (77.8) Deschutes (81.0) Jefferson (66.3) (Baseline: Healthy 2020 – 70.8%).)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>By 2019, decrease the percent of tobacco use among Central Oregon pregnant women from an average of 12.1% to 7.0% (Baseline: Oregon Health Authority Annual Report, 2013; Crook (15.0%) Deschutes (9.8%) Jefferson (11.4%) (Tobacco Smoking Prevalence – 2016 Metric).)</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>By 2019, reduce low birth weight (LBW) (less than 2500 g {less than 5 lbs. 8 oz.}) to an incidence of no more than 5% of live-born infants in Central Oregon (Baseline: OHA, 2014; Healthy People 2020 - Goal).</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>By 2019, increase effective contraceptive use among women of childbearing age in Central Oregon from 31.4% to 50% (Baseline OHA: Performance Measure – Central Oregon Region – PSCS – May 2015).</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>By 2019, increase the Central Oregon State Performance Measure – Child Immunization Status rate (0-24 months) (NQF 0038) from 62.1% to 80% (Baseline OHA: Performance Measure – Central Oregon Region – PS – May 2015; Immunization Rates, Oregon, 2014 (4.3.1.3.3.1.4) Crook (63%) Deschutes (60%) Jefferson (70%); Healthy People 2020 – 80%.)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Prevention and Health Promotion

- Increase 2-year-old children immunization rates by implementing the Central Oregon Regional Immunization Rate Improvement Project (IRIP) in Deschutes, Crook and Jefferson County using the AFIX Program in Coordinated Care Organization (CCO) participating clinics.
- Expand prenatal and postnatal home visiting services to high-risk women in Central Oregon (NQF 1517).
- Provide home visits with the intent of educating on topics that include vaccinations, tobacco, alcohol, and key referrals for community resources.
- Screen women for their pregnancy intention on a routine basis by implementing “One Key Question© with all providers in Central Oregon.
- Support and promote contraception immediately following pregnancy.
- Provide referral to oral health services in pregnancy.
- Provide evidence-based community messaging and curricula to adolescents focusing on preventing unintended pregnancy, HIV/AIDS, and STIs.
- Ensure timely access to contraceptives and STI support.
- Support the initiation and sustainment of breastfeeding for new mothers with programs such as WIC, home visiting and “Baby-Friendly” hospitals.

Clinical

- Screen 100% of pregnant women and refer them to appropriate medical, dental, behavioral and social services.
- Implement the “2As and R” and “5As” tobacco cessation and counseling in all healthcare settings.
- Increase referrals of pregnant women who use tobacco to the Oregon Tobacco Quit Line.

Policy

- Promote the inclusion of age appropriate, medically accurate sexual health education in our schools (ODE, HB2509 – ORS336.455).
- Promote policies that support barrier free access to contraceptives.
- Promote policies that increase access to prenatal care with equity and rural concerns considered.
- Promote policies that support the use of LARC (long acting reversible contraceptives) as the most effective birth control option for women at highest risk for pregnancy.

Health Equity

- Please refer to the chapter on social determinants of health for additional strategies.
Reproductive & Maternal Child Health

Action Area  Strategy

Health System/ Access

• Implement universal nurse home visiting (Family Connects) as part of a regional perinatal continuum of care system in partnership with public health, primary care medical providers and the CCO.
• Expand access/marketing to improve effective contraceptive rates in primary care and public health.

Childhood Health

• Reduce child maltreatment using evidence-based home visiting programs (i.e., Family Connects, Healthy Families) that work to improve family well-being and to reduce child maltreatment by coordinating services for high-risk families.
• Provide referrals that link clients to community services, resources and support (Early Learning Metric).

Examples of Key Partnerships

• Health systems and healthcare providers
• Public health departments
• High schools (school nurses, school-based health centers)
• School boards
• Places of worship
• Employers
• Colleges
• State health promotion and prevention programs
The Problem

Healthy People 2020 highlights the importance of addressing the social determinants of health (SDOH) by including “create social and physical environments that promote good health for all” as one of its four overarching goals for the decade. The initiative has created a “place-based” organizing framework that categorizes SDOH into five (5) key areas:

- Economic Stability
- Education
- Social and Community Context
- Health and Healthcare
- Neighborhood and Built Environment

The SDOH span a wide range of complex and intertwined social conditions. Few, however, would argue that without a good education, people are significantly less likely to find stable employment with living-wage earnings. They are more likely to be living in poverty – which involves unstable/low-quality housing, unsafe neighborhoods, limited access to healthcare, transportation disadvantages and limited access to basic needs like affordable, healthy food (Low et al, 2005). While this is logical, what may be less intuitive is how strongly educational attainment is linked to health outcomes.

The Robert Wood Johnson Foundation, arguably the largest and most powerful think tank related to SDOH in the United States, commissioned a white paper in 2011 highlighting strong evidence that consistently connects educational attainment and health, even when other SDOH factors, such as income, are taken into account (Mirkowsky et al, 1999 and 2003). The study examined the interrelated pathways in which education is linked with health, including health knowledge and behaviors; employment and income; and social and psychological factors, including sense of control, social standing, familial context and social networks. One could conclude from this study that to impact SDOH at a population level, educational achievement should be a primary focus.

Figure 1. Percent of adults, ages 25-74 years, in less than very good health*

**Based on self-report and measured as poor, fair, good, very good or excellent.  
***Age-adjusted.
Kindergarten Readiness and Third-grade Reading Scores

There are several early milestones that are closely linked to a child’s future academic achievement. In elementary school, these include kindergarten readiness, third grade reading and fourth grade math. Data from across the states suggest that as a child’s kindergarten readiness scores improve, the later milestone scores rise accordingly (Duncan et al, 2008). Furthermore, third grade reading level scores has been linked to high school graduation rates (Silver and Saunders, 2008). Both kindergarten readiness and third-grade reading are key indicators of future success because children with low scores at these milestones face a confounding learning disadvantage going forward (Maryland Department of Education, 2010).

Equity, Disparities and Vulnerable Populations

There are a variety of SDOH factors that are barriers to educational achievement. These include adverse family context, food insecurity, culture and language differences and presence of childhood trauma (toxic stress). Though we know less education is linked with worse health across all racial and ethnic sub-groups (see Figure 1), there are populations that have different experiences and levels of exposure to these barriers.

Many school boards across Oregon struggle to meet the needs of students and families who have cultural or linguistic needs, special needs, live in poverty or have other barriers such as adverse family situations. Just as healthcare reform highlights the need for an equity lens as a key strategy, education reform has a similar calling. This focus on equity on both sides means that programs and policies aimed at outcomes such as increasing educational achievement should take all differences between and within subgroups into account and all programs should be tailored to address such differences.

In Central Oregon, geographic differences also need to be examined and any programs and efforts to address educational achievement need to be in balance with community needs and demographics. For example, the 501J School District in Jefferson County is one of the most diverse in the state. One-third of students are Latino, one-third White non-Hispanic, and one-third Native American.

Early Childhood Adversity, Toxic Stress, and the Role of Community

Neuroscience is catching up with what we have long suspected about social determinants of health affecting children’s learning and development. The original study on Adverse Childhood Experiences (ACEs) was published almost 20 years ago in collaboration between the CDC and Kaiser Permanente. Recently, growing understanding of the science behind toxic stress outcomes is generating renewed interest and investment, resulting in a push for strategies and practices that would prevent ACEs by targeting protective changes in the child’s early life context. The American Academy of Pediatrics (AAP) calls these contexts “early childhood ecology.” In their 2012 policy statement, the AAP states: “The effective reduction of toxic stress in young children could be advanced considerably by a broad-based, multi-sector commitment in which the profession of pediatrics plays an important role in designing, implementing, evaluating, refining, and advocating for a new generation of protective interventions.”
United Way in Central Oregon is pursuing collective impact methods to heighten its impact on important social determinant needs and issues. As part of a long-term planning process, childhood trauma or Adverse Childhood Experiences (ACEs) has emerged as a critical issue of strategic importance to both United Way and its partnering agencies. The organization has initiated a broad-based effort to advance the prevention and treatment of childhood trauma. Goals include:

- Increasing awareness of ACEs and their negative impact on health and education outcomes
- Developing shared understanding and language for discussing ACEs, toxic stress, and resiliency
- Aligning agencies and programs around common goals
- Integrating trauma informed practices in programs and services
- Ensuring consistent, quality training and support for front-line workers

As a community-based organization, United Way is uniquely positioned to build the capacity of the community to address ACEs and trauma. They have a track record of community impact, as well as competencies that include a broad-based network of partner agencies and donors, and a proven ability to raise and manage significant funds. For all these reasons, United Way will be a critical partner throughout implementation of the RHIP education and health strategy.

Central Oregon has the right combination of state and local healthcare, community-based, public health and education system reform initiatives that if properly aligned, could have the potential to change health-shaping contexts for children and families. The following initiatives are either in development or being implemented regionally:

- Coordinated Care Organizations (CCO) – transformation of the Medicaid delivery system (60+% children, disproportionate poverty).
- Cradle to Career: Early Learning Hub/Regional Achievement Coalition (Better Together).
- Health and housing.
- Public health/primary care partnership (Perinatal Collaborative) to improve outcomes for at-risk moms, children and families.
- A growing interest in addressing Adverse Childhood Experiences (ACEs) and toxic stress (EL Hub, United Way of Deschutes County, Pacific-Source CCO).

Rather than coming at ACEs, child development and education from separate silos, what if all these stakeholders were to come together and adopt one, unified and powerful goal – that all children in Central Oregon enter kindergarten ready to learn, graduate from high school and go on to college? Given the strong and conclusive evidence that intertwines ACEs, educational achievement and long-term health, impact indicators, such as kindergarten readiness, could be easily tracked – with positive results giving us good confidence that we are removing SDOH barriers for both children and their families. Furthermore, if the perinatal population is targeted and children and their families are followed through their first 4-5 years with strong evaluation supports in place, the community will learn and improve upon how our multi-sectoral approach is performing with data and information as soon as the end of this RHIP cycle.
Example Successful Cross-Sectoral Interventions

Fortunately, Central Oregon would not have to start from scratch in organizing and developing a strategy to change the early childhood ecology for vulnerable children and families. There is already momentum and planning taking place with healthcare representation through the work of the Early Learning Hub. There are also many best practices that could be studied to inform a community strategy that addresses ACEs by wrapping education, health and social supports (i.e. housing, transportation, employment) around families to impact children and youth educational achievement goals (Department of Vermont Health Access, 2015). Listed below are a few examples of multi-sectoral programs that are showing positive results nationally:

- **Child-Parent Education Centers (CPC):** CPC programs provide comprehensive educational, family support and healthcare services to economically disadvantaged children from ages 3-9. First developed in the 1960s, CPC initially launched in 25 sites in Chicago. The key goals were to improve school achievement, attendance, and parent engagement.

- **Northside Achievement Zone:** The Northside Achievement Zone (NAZ) exists to permanently close the achievement gap and end generational poverty for communities of color in North Minneapolis. Similar to Harlem's Children Zone, NAZ uses a family-centered, wraparound framework (housing, healthcare, parenting education supports) starting in the perinatal years, effectively supporting low-income families overtime so that their “scholars” will graduate from high school and be prepared for college. NAZ-enrolled families are making remarkable strides. Children are not only showing improved academic outcomes at key kindergarten and third grade benchmarks, but families are stabilizing their housing, employment, and health. A study by Wilder Research demonstrated that each dollar invested in NAZ provides more than a $6 societal return.

- **Durham Connects:** Increases child well-being by bridging the gap between new parent needs and community resources. The project is a collaborative effort among the Center for Child & Family Health, The NC Department of Social Services, and the Durham County Health Department. Durham Connects hires and trains nurses to provide in-home health assessments of mothers and newborns, as well as to discuss the social conditions affecting the family. A study conducted between July 2009 and December 2010 showed increased positive parenting behaviors, father involvement, childcare selection, and reduced infant hospitalization among Medicaid recipients.

- **Center-Based Early Childhood Education:** Prepares children by providing skills development and readiness training, while also focusing on health and social development. ECE programs aim to improve the cognitive and social development of children ages 3 or 4 years.

**COMMUNITY SPOTLIGHT: M.A. Lynch Elementary School**

M.A. Lynch Elementary School had the highest percentage of students impacted by poverty in Deschutes County. After becoming a full-service Community School, it went from a “School in Improvement,” status under No Child Left Behind to a “Champion School,” within three years. At the time of the State Recognition, 93% of students met or exceeded the reading benchmark, and 88% met or exceeded the math benchmark.

The Community School model expands before and after school programs for students and families and maximizes instructional time during the day. Enrichment and targeted academic support is provided for students and a wide range of services are provided to support parents such as GED programming, English language instruction, workshops on parenting and how to cope with stress, and financial preparation. To serve its growing Latino population, Lynch brought on a bilingual Community School Coordinator. Health was also a key support. Deschutes County Health Services and FQHC Mosaic Medical teamed up to open a school-based health clinic at Lynch to provide a range of physical and behavioral health services. More recently, the school has hosted a Head Start preschool program, creating a new bridge between early learning and the K-12 education system.
Education & Health Strategy Implementation Recommendations

1. There are five key strategies that the Central Oregon CCO and larger health system can take to advance educational achievement (i.e. kindergarten readiness) as a central SDOH goal (depicted as inputs in figure 2):

2. Inventory and understand the potential confluences that could be strengthened in partnership with community and education-based systems, such as the Early Learning Hub and public health nurse home visiting programs.

3. Align with and leverage the growing interest from healthcare, education and community-based organizations (i.e. United Way), in the prevention and treatment of early childhood trauma.

4. Support the formation of a workgroup that would bring together, education (Early Learning/Better Together), community-based and health system partners to identify achievement gaps “hot spots” and develop strategies to health, social service and education supports around children and families.

5. Intervene as early as possible to build resiliency in children and families, but also support youth whose lack of basic needs or poor health gets in the way of learning while already in school. The health system can support all children, youth and families by:
   - Promoting and providing annual well-child visit and conducting developmental screenings in the first 3 years of life
   - Promoting and providing annual adolescent well visits
   - Screening for ACEs (parents and children) and referring to treatment when appropriate
   - Meaningful and measurable collaboration with education, community and social support system
   - Develop innovative funding mechanisms to sustain outcome-producing models

The COHC, through the Operations Council, will develop a four-year work plan, in partnership with the above mentioned stakeholders, to implement strategies that pertain to the health system's role, starting with Board adoption of kindergarten readiness as a system metric. This work plan should be vetted by numerous stakeholder groups and by the COHC, to be given final approval by no later than April 1, 2016.

Figure 2. Education & Health Strategy At a Glance

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System: Community-clinic linkages; focus on ACEs/toxic stress</td>
<td>Partners: $s donated, # people helped, number of partnering orgs, activities delivered</td>
<td>Partners: Each organization adopts measures related to desired change for pax served</td>
</tr>
<tr>
<td>Education and Early Learning: Better systems alignment, program development</td>
<td>Families &amp; Children: # families engaged, # children served, testimonials, parenting classes completed</td>
<td>Families &amp; Children: Dom. violence rates down; ACEs lowered or prevented; children in stable housing, parents employed, increase in kindergarten readiness, 3rd grade reading</td>
</tr>
<tr>
<td>Programming: Cross-sectoral intervention (such as NAZ, Harlem modeled, TDD)</td>
<td>Health System/Triple Aim: Well-child visits (infant, child and adolescents), development screens, ACEs screening, optimize nurse home visiting and perinatal model</td>
<td>Health System/Triple Aim: Lower overall medical costs, higher quality of care for at-risk families; Reduced ED visits – 0-4; Improved birth outcomes</td>
</tr>
</tbody>
</table>
| Social Partners Aligned United Way, DHS, FAN, food systems, housing | Funding: Innovative/sustainable payment model | }
The Problem

The home has deep cultural ties in America – a place where friends and families gather. The home is an anchor in the larger community, where connections and health-protective social networks flourish. As is the case with education, access to safe and stable housing constitutes one of the most basic and powerful social determinants of health. In addition to what we know intuitively about housing and health, there is growing scientific evidence that links access to safe and affordable housing with good health outcomes. Ensuring both housing stability and safety – i.e. free of health structural, bio-chemical health hazards, has become a public health priority worldwide. The World Health Organization recommends using the growing body of evidence linking housing and health to guide “primary preventive measures related to housing construction, renovation, use and maintenance, which can promote better overall health.”

The lack of safe and affordable housing has become a public health crisis in Central Oregon. Low-income families in all three counties struggle to find affordable housing. Even mid-income families, who do not normally struggle to find housing, are now finding it harder and harder to make ends meet as escalating rent and mortgage costs squeeze out room to budget for other living expenses. In Bend, Central Oregon’s largest city, affordable housing is not the only problem. Simply finding a place to live is also extremely difficult with low housing and apartment inventory and high market demand. Given all we know about the importance of housing to health, the current housing environment in this region has the potential to widen and exacerbate inequities and health disparities that impact people with fewer financial and support resources. This is particularly true for individuals and families trapped in a cycle of crisis and housing instability due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions.

Promising Approach

The state of Massachusetts provides housing and supportive services to chronically homeless individuals through their Healthy and Home for Good (HHG) model. This has proven less costly and more effective overall than managing their homelessness and health problems on the street or in a shelter. As of their latest evaluation report, 766 chronically homeless individuals were placed in supportive housing. In the six months prior to housing, those participants accumulated 1,812 emergency department visits, 3,163 overnight hospital stays, 847 ambulance rides and 2,494 detox stays. The estimated total cost per person for measured services, including Medicaid ($26,124), shelter ($5,723) and incarceration ($1,343) amounted to $33,190 per year (Massachusetts Housing and Shelter Alliance, 2014). After one year in the program, the total per person costs for these same services fell to $8,603. With the cost of housing and services through the HHG program amounting to $15,468 per tenant, the total estimated return on investment to the state was $9,118 per person. This is just one of dozens of studies that have shown health care and societal returns as a result of wrapping housing and supportive services around individuals with chronic, unstable housing conditions.
Housing

Implementation Recommendation

As part of its contract with the Oregon Health Authority, PacificSource Community Solutions, Central Oregon’s Coordinated Care Organization, has outlined a plan to begin to address the housing crisis by bridging housing solutions with the health system (Transformation Plan Element 4.2). The COHC, through the Operations Council, will develop a four-year work plan around housing and health in alignment with the 2-year Transformation Plan deliverables as described below. Strategies that pertain to the health system’s role will be endorsed by the COHC Board of Directors, with Board adoption of one or more housing related metrics to track and monitor performance toward this goal. This work plan should be vetted by numerous stakeholder groups and by the COHC, to be given final approval by no later than May 1, 2016.

Transformation Plan Milestone (July 30, 2016) and Benchmark (July 30, 2017):

- By July 30, 2016: Study promising and existing local, regional and national strategies. CCO, COHC and key partners secure funding for a pilot program that bridges housing and health care for those members who are homeless or at-risk for homeless and also have complex medical and behavioral health needs.
- By July 30, 2017: Partnerships are formalized (e.g. developer, property owner, housing agency). Pilot program begins implementation, dissemination of early findings provided to COHC and CAC.
Appendix A: Acronyms

**Adverse Childhood Experiences (ACEs):** An adverse childhood experience (ACE) describes a traumatic experience in a person’s life occurring before the age of 18 that the person remembers as an adult. The ACE score is a measure of cumulative exposure to adverse childhood conditions.

**Acquired Immunodeficiency Syndrome (AIDS):** A condition caused by a virus, in which lymphocytes are destroyed, resulting in a loss of the body’s ability to protect itself against disease.

**Assessment, feedback, incentive, and exchange (AFIX):** A quality improvement program used to raise immunization coverage levels, reduce missed opportunities to vaccinate, and improve standards of practices at the provider level.

**American Academy of Pediatrics (AAP):** An organization dedicated to the health and well-being of infants, children, adolescents and young adults.

**American Heart Association (AHA):** A non-profit organization in the United States that fosters appropriate cardiac care in an effort to reduce disability and deaths caused by cardiovascular disease and stroke.

**Behavioral Health Consultants (BHC):** Behavioral health generalists who provide treatment within a healthcare setting for a wide variety of mental health, psychosocial, motivational, and medical concerns. BHCs also provide support and management for patients with severe and persistent mental illness and tend to be familiar with psychopharmacological interventions.

**Behavioral Risk Factor Surveillance System (BRFSS):** A phone survey conducted among randomly selected non-institutionalized adults that asks about a variety of health risks and behaviors.

**Blood Pressure (BP):** The pressure of the blood in the circulatory system.

**Body Mass Index (BMI):** Use both weight and height to determine the size of an individual. BMI is divided into four categories: underweight (<18.5), normal (18.5-24.9), overweight (25.0-29.9), obese (30.0 or greater).

**Cardiovascular Disease (CVD):** A classification of diseases of the heart and blood vessels that includes chest pain, heart attack, and other conditions that affect the heart muscle, rhythm, or valves.

**Centers for Disease Control and Prevention (CDC):** A federal organization that protects the health of the nation's residents and helps local communities do the same.

**Central Oregon Health Council (COHC):** The COHC is the governing body of our region’s CCO. The COHC is dedicated to improving the health of the region and providing oversight of the Medicaid population and Coordinated Care Organization (CCO). The COHC’s mission is to serve as the governing Board for the CCO and to connect the CCO, patients, providers, Central Oregon, and resources.

**Child-Parent Education Centers (CPC):** CPC programs provide comprehensive educational, family support and healthcare services to economically disadvantaged children from ages three to nine.

**Community Advisory Council (CAC):** The overarching purpose of the CAC is to ensure the CCO and COHC remains responsive to OHP consumer and community health needs. The CAC includes healthcare consumers of the CCO as well as representatives of public and private agencies that serve CCO members.
Coordinated Care Organization (CCO): Is a network of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid).


Dental Care Organizations (DCO): There are eight DCOs in Oregon and they provide dental services to over 96 percent of the OHP clients eligible to receive dental benefits and services.

Diabetes Prevention Program (DPP): A prevention program aimed at improving Diabetes in a specified population. The program should be evidence-based.

Dental Medical Integration (DMI): Dental medical integration is the effort in improve coordination between medical and dental providers to improve client health.

Early Childhood Education (ECE): A program that prepares children by providing skills development and readiness training, while also focusing on health and social development.

Electronic Health Record (EHR): An electronic version of a patient's medical history.

Generalized Anxiety Disorder-7 (GAD-7): A concise self-administered screening and diagnostic tools for mental health disorders.

Glycated hemoglobin (HbA1c): A form of hemoglobin that is used to measure blood glucose concentration over time.

Healthy Eating and Active Living (HEAL): A coalition with diverse membership with the goal of health promotion.


Human Immunodeficiency Virus (HIV): A virus that causes HIV infection and over time acquired immunodeficiency syndrome.

Intravenous drug (IV drug): A drug that is administered into a vein or veins.

Immunization Rate Improvement Project (IRIP): A program to increase immunization rates in children.

Low Birth Weight (LBW): The birth weight of a live-born infant of less than 5 pounds 8 ounces regardless of gestational age.

Long-Acting Reversible Contraception (LARC): Birth control methods that provide effective, reversible contraception for extended periods of time without requiring user action.

Medically Assisted Treatment (MAT): A program that combines behavioral therapy and medications to treat substance use disorders.

Coordinated Care Organization (CCO): Is a network of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid).


Dental Care Organizations (DCO): There are eight DCOs in Oregon and they provide dental services to over 96 percent of the OHP clients eligible to receive dental benefits and services.

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Appendix A: Acronyms

**Coordinated Care Organization (CCO):** Is a network of all types of healthcare providers who have agreed to work together in their local communities for people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

**Car, Relax, Alone, Forget, Friends, and Trouble (CRAFFT):** A short clinical assessment tool designed to screen for substance-related risks and problems in adolescents.

**Dental Care Organizations (DCO):** There are eight DCOs in Oregon and they provide dental services to over 96 percent of the OHP clients eligible to receive dental benefits and services.

**Diabetes Prevention Program (DPP):** A prevention program aimed at improving Diabetes in a specified population. The program should be evidence-based.

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**Generalized Anxiety Disorder-7 (GAD-7):** A concise self-administered screening and diagnostic tools for mental health disorders.

**Glycated hemoglobin (HbA1c):** A form of hemoglobin that is used to measure blood glucose concentration over time.

**Healthy Eating and Active Living (HEAL):** A coalition with diverse membership with the goal of health promotion.

**Healthy People 2020 (HP 2020):** National goals to meet by the year 2020.

**Human Immunodeficiency Virus (HIV):** A virus that causes HIV infection and over time acquired immunodeficiency syndrome.

**Intravenous drug (IV drug):** A drug that is administered into a vein or veins.

**Immunization Rate Improvement Project (IRIP):** A program to increase immunization rates in children.

**Low Birth Weight (LBW):** The birth weight of a live-born infant of less than 5 pounds 8 ounces regardless of gestational age.

**Long-Acting Reversible Contraception (LARC):** Birth control methods that provide effective, reversible contraception for extended periods of time without requiring user action.

**Medically Assisted Treatment (MAT):** A program that combines behavioral therapy and medications to treat substance use disorders.

**Medicaid Behavioral Risk Factor Surveillance Survey (MBRFSS):** The BRFSS conducted among adults enrolled in Medicaid (OHP).

**Northside Achievement Zone (NAZ):** Exists to permanently close the achievement gap and end generational poverty for communities of color in North Minneapolis.

**National Quality Forum (NQF):** A non-profit organization that works to improve quality of healthcare through several mediums, including the endorsement of evidence-based measures.

**Obstetrics/ gynecology (OB/GYN):** An obstetrician is a physician who delivers babies. A gynecologist is a physician who specializes in treating diseases of the female reproductive organs.
Appendix A: Acronyms

**Operations Council (OPs):** OPs is housed within the COHC, and member promote and facilitate accessible, affordable, quality health services including mental, behavioral, oral, and physical health for Central Oregon residents. This group provides strategic, fiduciary, and operational advice to the COHC in an effort to design and implement key initiatives.

**Oregon Department of Education (ODE):** The Oregon Department of Education is responsible for implementing Oregon’s public education policies, including academic standards and testing, credentials, and other matters not reserved to the local districts and boards.

**Oregon Health Plan (OHP):** Healthcare coverage program for low-income Oregonians.

**Patient Health Questionnaire (PHQ):** A concise, self-administered screening and diagnostic tools for mental health disorders.

**Performance Improvement Project (PIP):** The purpose of a PIP is to assess areas of need and develop a project intended to improve health outcomes. The Oregon Health Authority (OHA) contract requires Coordinated Care Organizations (CCO’s) to conduct PIP’s that are “designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have favorable effect on health outcomes and OHP Member satisfaction.

**Prescription Drug Monitoring Program (PDMP):** A state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.

**Primary Care Provider (PCP):** A healthcare practitioner who sees people that have common medical problems.

**Pregnancy Risk and Monitoring Survey (PRAMS):** A survey of mothers who recently gave birth that addresses prenatal care, health behaviors and risks, and post-partum topics.

**Provider Engagement Panel (PEP):** This is a committee housed within the COHC, and provides a highly valued clinical perspective to the work the CCO and the COHC. Providers of the PEP represent a variety of healthcare organizations that serve the OHP population.

**Quality Improvement Measure (QIM):** State defined tolls that help measure and track the quality of healthcare services provided by eligible professionals and eligible providers of Medicaid within our healthcare systems.

**Screening, Brief Intervention and Referral to Treatment (SBIRT):** An evidence-based practice that targets patients in primary care with nondependent substance use.

**Social Determinants of Health (SDOH):** Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Substance Use and Mental Health Services Administration (SAMSHA):** The Substance Use and Mental Health Services Administration is a branch of the U. S. Department of Health and Human Services.

**Sexually Transmitted Infection (STI):** An infection transmitted through sexual contact, caused by bacteria, viruses, or parasites.

**Supplemental Nutritional Assistance Program (SNAP):** Nutrition assistance program for low-income families.

**Substance Use Disorder (SUD):** A condition developed when the use of one or more substances leads to a clinically significant impairment or distress.

**To Be Determined (TBD):** Indicates the need to further develop a particular idea or strategy.

**Women, Infants, and Children (WIC):** A Federal program for low income and nutritionally at risk women, infants and children. Participants receive education, screening, and support in purchasing nutritious food.
Behavioral Health


Cardiovascular Disease


Diabetes


Appendix B: References

**Oral Health**


**Reproductive and Maternal Health**


Finer, L. and Kost, Unintended Pregnancy Rates at the State Level, Perspectives on Sexual and Reproductive Health, 2011, 43(2): 78-87.


Reproductive and Maternal Health (continued)

Healthy Families America. www.healthyfamiliesamerica.org
https://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html
http://www.cdc.gov/reproductivehealth/unintendedpregnancy/
http://www.onekeyquestion.org/

Injury Prevention & Control: Division of Violence Prevention; Child Maltreatment Prevention Strategies; http://www.cdc.gov/violenceprevention/childmaltreatment/prevention.html


Oregon Pregnancy Risk Assessment Monitoring System, 2011 Results
https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/index.aspx

Social Determinants of Health: Know What Affects Health; Tools for Putting Social Determinants of Health into Action; http://www.cdc.gov/socialdeterminants/tools/index.htm


Social Determinants of Health


Social Determinants of Health and Health Equity (SDOH-HE) Spending Policy

State(s):
- [ ] Idaho
- [X] Montana
- [X] Oregon
- [ ] Washington
- [ ] Other:

LOB(s):
- [ ] Commercial
- [ ] Medicare
- [X] Medicaid
- [ ] PSA

Government Policy

Purpose:
To describe the plan for choosing SDOH-HE spending priorities and outlining the process for spending while adhering to CCO 2.0 requirements.

Procedure: Department

1a. SDOH-HE Spending from annual net income or reserves and SDOH-HE Bonus Fund

- CCOs must spend a portion of annual net income or reserves, on Health Disparities and SDOH; a “portion” has not been set by OHA but will be defined through the state’s rule-setting process and will be based on the CCO’s adjusted net income, risk based capital, payments to shareholders or parent companies, and/or an amount taken from excess reserves.
- By March 15, 2020 and January 2 of each following year, each CCO must use the OHA-provided template to submit to OHA an implementation plan for this spending which includes selected priorities for health disparities and SDOH-HE spending in the subsequent year and identifies any infrastructure needs/gaps for addressing selected priorities and ways to satisfy those needs/gaps.
- The implementation plan priorities shall be aligned with the CHP and Transformation and Quality Strategy Plan (TQS) and also fall in one of the four SDOH-HE domains:
  - Economic Stability
  - Neighborhood and Built Environment
  - Education
  - Social and Community Health
- The implementation plan must include the OHA-identified statewide priority, which for the first year is housing-related services and supports, including supported housing.
- By April 30, 2021, each CCO will submit to OHA a proposal for how SDOH-HE funds will be spent. This spending plan must include how SDOH-HE partners were selected, an evaluation plan for each project/initiative including expected outcomes, a budget proposal with amount of funding that will be directed to each SDOH-HE partner, copies of all agreements with SDOH-HE partners, and a description of the CAC’s role in selecting proposed projects.
RFA OHA-4690-19-PacificSource Community Solutions-Central Oregon

- In executing this spending plan, each CCO shall be required to execute formal, written agreements with SDOH-HE partners which will be submitted to OHA within 30 days of execution and again by April 30, 2021 with the spending plan.
- Contingent on available funding, OHA will pay money during CY 2021 and 2022 to CCOs that meet requirements (still to be defined) as a SDOH-HE Bonus Fund. That money must be spent in alignment with the spending plan described above.
- The CAC role in this spending will be to identify 2-4 priorities and infrastructure needs/gaps for the implementation plan based on the CCO Contract criteria by the end of January of 2020 and by the end of November preceding any later contract year. The Health Council Board shall approve or reject the recommendation within 30 days based on its evaluation against the stated process but shall not have the authority to alter the CAC recommendation. If the CAC recommendation is rejected or not approved within 30 days, PacificSource will have the authority to review the CAC and Health Council Board recommendations and submit an implementation plan that meets the OHA requirements, integrates the concerns of the CAC and Health Council Board as articulated in their meeting minutes, and aligns with the CHP and TQS.

1b. SDOH-HE Spending from CCO shared savings

- The CCO and the regional Health Council have a Joint Management Agreement that stipulates how shared savings are handled after provider risk arrangements and capped margin for PacificSource have been paid.
- Anything in excess of PacificSource’s 2% margin is returned to the Health Council as shared savings for spending to improve community health, with decision-making by the Health Council board.
- At Health Council discretion, additional money from shared savings may be added to the SDOH-HE spending plan articulated in 1a.

2. SDOH-HE Spending of a portion of State Quality Pool

- See State Quality Pool spending plan. Current proposal is for 10% of payout from State Quality Pool to fund this requirement
- In addition to any payments made from other portions of the State Quality Pool, this portion of the annual Quality Pool (including the Challenge Pool) will be paid out to Social Determinants of Health and Health Equity (SDOH-HE) priorities by passing the funds to each region’s public health department or district for use to address population health and prevention activities. The expenditure and activities will be under the oversight of the Community Advisory Council. Public health agencies will receive CAC approval for the annual implementation plan and report quarterly on progress against pre-established criteria. The CAC will review public health performance during 2021 and annually and recommend to the CCO Governing Board whether to continue this arrangement.

3. Community Benefit Initiatives as a portion of Health Related Spending

- In past years, PacificSource CCOs have chosen not to spend money using the Community Benefit Initiative (CBI) model because the Health Council spending decisions about shared savings from the CCO have the same objective. The CCOs have only used the Health Related Services provision to directly spend money under the Flexible Services provision.
- Starting in 2020, each CCO must make commitments about the process that will be used for this spending and the involvement of the CAC in decision-making.
In Central Oregon, the CCO has allocated 1% of revenue to SDOH-HE spending, and 10% of this amount will be designated for CBI. CBI spending will be accomplished by the Health Council, under terms specified in the JMA between its Board and PacificSource.

In other regions, a similar amount, 0.1% of revenue, will be budgeted for CBI and retained and paid by PacificSource. The CAC implementation plan recommendations made in 1a will be used as the funding criteria for this money, with disbursements to organizations in a semi-annual, publicly announced grant cycle of 3-5 grants annually per CCO.

**Appendix**

Policy Number: [Policy Number]

Effective: 4/1/2019  
Next review: 4/1/2020

Policy type: Government

Author(s):

Depts: Medicaid Admin, Health Services

Applicable regulation(s): [Applicable Regulation(s)]

External entities affected: [External Entities Affected]

Approved by:
Accessibility for Limited English Proficiency (LEP) and Hearing Impaired

**State(s):**
- Idaho
- Montana
- Oregon
- Washington
- Other:

**LOB(s):**
- Commercial
- Medicare
- Medicaid
- PSA

**Government Policy**

In accordance with Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act, OAR 410-141-3220 and the National Culturally and Linguistically Appropriate Services (CLAS) Standards it is the policy of PacificSource to provide timely, meaningful access for Limited English Proficiency (LEP) persons including deaf or hard of hearing to all programs, activities and other benefits. All personnel shall provide free language assistance services to LEP individuals whom they encounter or whenever an LEP person requests language assistance services or TTY services. All personnel will inform members and potential members that language assistance services are available free of charge to LEP persons and that PacificSource (PS) will ensure that these services are available to them. This policy also provides for communication of information contained in vital documents. This policy also applies to any provider who provides services to a member of PS.

PS will conduct a regular review of the language access needs of our members, as well as update and monitor the implementation of this policy as necessary. PS will utilize the data provided by OHA in the 834 files as well as REAL+D (race, ethnicity, age, language, and disability) to measure any meaningful changes to the population that it services. In addition, PS will capture data about any member who self identifies as LEP and/or who self identifies as having difficulty communicating due to a disability. PS incorporates this information into its systems for reporting and analysis.

**Procedure Identifying LEP Persons and Their Language**

PS will promptly identify the language and communication needs of the LEP member or potential member. This will be accomplished through the use of any information provided by the member in the application process, REAL+D Data, self-identification by the member, or any other available resource. All required materials for PS’ Medicare and Medicaid line of business that are produced in English contain information that tells the member how to obtain the document in an alternative format. In addition, posters are displayed in the lobbies of all PS offices along with our website to inform members and potential members of the availability of language assistance free of charge.
Procedure: Obtaining a Certified or Qualified Interpreter or Accessing TTY Service

PS offers a toll free TTY line available to accommodate any caller that may need this service. We provide this through State relay services, (800) 735-2900. This information is also available in the member handbook and on our websites.

If a member calls speaking a language not fluently spoken by qualified PS Customer Service Representatives, PS must ensure that the member is able to speak with an interpreter who speaks their language. PS contracts with a certified or qualified interpreter service to satisfy this requirement. Once the PS Customer Service Representative has both the member and the interpreter on the line, the PS Customer Service will request that the interpreter advise the member that this is a free service.

PS partners with providers by providing certified or qualified interpreter services including American Sign Language for members during interactions with our providers, regardless of whether the service is provided in-person or telephonically, at no charge to the provider or member.

Procedure: Providing Written Translations

When translation of vital documents is needed or requested, PS will update the member’s record to reflect the member’s communication preference. If the document has not already been produced in the alternative format, the PS staff member will work with the appropriate vendor to have the document produced in the requested format. Documents regularly used in the normal course of business for the Medicaid line of business are translated as they are created.

Procedure: Monitoring and Oversight

On an ongoing basis, PS will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. It will ensure that any changes to the LEP Plan are incorporated into the policy as needed. In addition, PS will regularly assess the efficacy of these procedures, including but not limited to mechanisms for certified or qualified securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback provided by members and community organizations, and responses to surveys sent to members who utilize these services. The surveys will be based on a random sample of the members who have used interpreter services. The results of these surveys will be collected, tracked and reported to management on a monthly basis.

Appendix

Policy Number: [Policy Number]
Policy type: Government
Author(s):
Depts: Administration, Customer Service, Health Services, Pharmacy, Provider Network
Applicable regulation(s): Title VI of the Civil Rights Act of 1964; Title II of the Americans with Disabilities Act National Standards for Culturally and Linguistically appropriate Services (CLAS) in Health and Health Care; OAR 333-002-000; OAR 410-141-3220ORS 413.550; ORS 413.558

External entities affected: N/A
Alternative Format for Materials Medicaid

State(s):
- Idaho
- Montana
- Oregon
- Washington
- Other:

LOB(s):
- Commercial
- Medicare
- Medicaid
- PSA

Government Policy

In order to be compliant with CCO Contract provisions, the Oregon Health Authority (OHA), the Centers for Medicare and Medicaid Services (CMS), and the Americans with Disabilities Act (ADA), PacificSource (PSCS) must:

- Make written material available in alternative formats including auxiliary aids, and in an appropriate manner that takes into account the special needs of those who for example, are visually limited or have limited reading proficiency;
- Inform all members and potential members that written information is available in alternative formats, free of charge;
- Inform members and potential members of how to access these formats;
- Be able to produce written communications in alternative formats that include Braille, large print, audiotape, oral presentation and electronic format;
- Ensure that all subcontractors comply with these requirements.

Procedure:

PacificSource will:

- Ensure its systems accept and retain member communication preferences to adhere to requirements established by CCO Contracts, the OHA, CMS, and the ADA. This is applicable to any material that is substantive, including, but not limited to ad hoc letters, system-generated letters, Dynamo letters, annual materials, etc.
- Deliver membership materials in the method preferred by the member.
- Accommodate prospective/potential members who require alternative formats.
- Provide information to potential members and members that directs them to call PSCS Customer Service if they need information in another format;
- Make information available on our website and in matters like member and provider handbooks about how members can make requests for alternative formats and how to accommodate those requests.
- Ensure that third party vendors and subcontractors, including those that provide IT tools, as well as providers, provide materials that comply with the alternative format requirements;
- Provide education and tools for providers to use to assist in the culturally and linguistically appropriate education of members about Care Coordination and the responsibilities of both providers and members in assuring effective communication.
- Contract with interpreter services for providers to use if they do not have certified or qualified interpreters in their offices.
- Ensure that all materials that are printed and mailed to the member inform the member that the document can be provided in an alternative format.
Monitor provider compliance with this Policy during site visits by Provider Network staff. If a provider is out of compliance, PSCS will provide education about the identified discrepancy during the site visit. We will escalate concerns using corrective action processes through contracts via the Credentialing Committee, and through our quality improvement infrastructure as discussed below.

- Any provider that receives two complaints regarding physical access or appearance in a six-month period of time will require a site visit by PSCS credentialing staff. The site visit will be conducted within 60 days of discovery that the threshold has been met. A completed site visit form will be provided to the provider within 30 days of completion of the site visit.

- Any providers that do not receive the minimum acceptable score as outlined above for each scoring section, will be subject to corrective action plan. A corrective action plan will be provided to the office site within 30 days of completion of the site visit. The corrective action plan will clearly document the areas of deficiency identified, expectations of PSCS in rectifying the deficiencies, time frame expected for completion of the deficient items, and plan for follow-up site visit to monitor and ensure progress in curing the deficiencies. A follow-up site visit will be conducted within six months of implementation of the corrective action plan and every six months thereafter until deficient offices meet the threshold.

- Monitor subcontractor compliance with this Policy during their Compliance Review. If the subcontractor is found to be out of compliance, PSCS will follow its’ Subcontractor Corrective Actions policy.

**Applicable Policies**

**Policy: Subcontractor Corrective Actions**

**Appendix**

**Policy Number:** [Policy Number]

**Effective:** 9/1/2018  
**Next review:** 9/1/2020

**Policy type:** Government

**Author(s):** [Authors]

**Depts:** Operations, Compliance, Health Services, Quality, Provider Network

**Applicable regulation(s):** 42CFR 438.10 and OAR 410-141-3280

**External entities affected:** N/A

**Approved by:**
CCO Member Rights

State(s):
- Idaho
- Montana
- Oregon
- Washington
- Other:

LOB(s):
- Commercial
- Medicare
- Medicaid
- PSA

Government Policy

Purpose:
To describe how providers, members, and potential members are educated about PacificSource Community Solutions (PSCS) CCO members’ rights, to discuss the methods PSCS uses to ensure that members and potential members are aware of their rights, and to monitor to ensure that providers are complying with member or potential members’ rights.

Procedure:
Individuals enrolled in the Oregon Health Plan are afforded certain rights under Exhibit B of the CCO contract, OAR 410-141-3320, and as well as civil rights afforded under Title VI of the Civil Rights Act and ORS Chapter 659 A. Under its contract with the Oregon Health Authority (OHA), PSCS is responsible for communicating these rights to contracted providers and monitoring these providers to ensure their compliance.

Member Rights
Members shall have the following rights:
- The CCO shall require and cause its Participating Providers to require, that members are treated with dignity and respect with due considerations for his or her dignity and privacy, and the same as non-members or other patients who receive services equivalent to Covered Services;
- To be treated by Participating Providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member’s care team, including providers and community resources appropriate to the member’s needs.
- To choose a health care professional from available Participating Providers and facilities to the extent possible and appropriate and to change those choices as permitted in the CCO’s administrative policies. For a member in a Service Area serviced by only one PHP, any limitation the CCO imposes on his or her freedom to change between PCPs or to obtain services from Non-Participating Providers if the service or type of provider is not available with the CCO’s Provider Network may be no more restrictive that the limitation on Disenrollment under Exhibit B, Part 3, Section 6b.
- To refer oneself directly to mental health, Chemical Dependency or Family Planning Services without getting a referral from a PCP or other Participating Provider;
- To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;
To be actively involved in the development of his/her treatment plan if Covered Services are to be provided and to have family involved in such treatment planning;

To be given information about his/her condition and Covered and Non-Covered Services to allow an informed decision about proposed treatment(s);

To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

PSCS will have a mechanism to help members and potential members understand the requirements and benefits of the Plan and develop and provide written information, materials and educational programs consistent with the requirements of OAR 410-141-3280 and 410-141-3300.

To have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;

To receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

To receive oversight, care coordination and transition and planning management from their CCO within the targeted population of Division to ensure culturally and linguistically appropriate community based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

To receive necessary and reasonable services to diagnose the presenting condition;

To have a Clinical Record maintained which documents conditions, services received, and referrals made;

To have the right to request and receive a copy of one’s own Health Record, unless restricted in accordance with ORS 179.505 or other applicable law and to request that the records be amended or corrected as specified in 45 CFR Part 164. To transfer a copy of his/her Clinical Record to another Provider;

PSCS requires its Participating Providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member’s condition, preferred language and ability to understand.

Has the guaranteed right to participate in decisions regarding his or her health care, including the right to refuse treatment and has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health.
The CCO shall ensure and cause it’s Participating Providers to ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CCO, its staff, Subcontractors, Participating Providers or OHA, treat the member. The CCO shall not discriminate in any way against members when those members exercise their rights under the OHP;

- To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;
- To be able to make a complaint or appeal with the CCO and receive a response;
- To request a contested case hearing;
- To receive Certified or Qualified Health Care Interpreter services free of charge whether a Potential member or a member of the CCO. This service applies to all non-English languages, not just those that OHA identifies as prevalent. The CCO will notify its members and potential members that oral interpretation is available free of charge for any language and that written information is available in prevalent non-English languages in the Service Area(s) as specified in 42 CFR 438.10(d)(4). PSCS will also notify its members on how to access oral interpretation and written translation services;
- To receive a notice of an appointment cancellation in a timely manner;
- To receive a second opinion from a qualified Health Care Professional within the Provider Network, or have the Plan arrange for member to obtain a qualified Health Care Professional from outside the Provider Network, at no cost to the member.
- To report a complaint of discrimination by contacting the Plan, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR) and that they are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A;
- To receive notice of Plan’s nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A
- To receive equal access for males or female identified under 18 years of age to appropriate facilities, services and treatment under the current CCO Contract, consistent with OHA obligations under ORS 417.270;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations as specified in federal regulations on the use of restraints and seclusion.
- To only be responsible for cost sharing authorized under this Contract in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.
- PSCS will notify members of their responsibility for paying a Co-Payment for some services as specified in OAR 410-120-1230;
- PSCS will furnish to each of its members the information specified in 42 CFR 438.10(f)(2)-(3) and 42CFR 438.10(g), if applicable, as specified in the CFR within 30 days after PSCS receives notice of the member’s enrollment from OHA or for members who are Fully Dial Eligible, within the time period required by Medicare. PSCS will notify all members of their right to request and obtain the information described in this section at least once a year.
- To utilize electronic methods of communications upon request and if available; PSCS will utilize electronic communications for purposes described in the subsection above only if:
  - The recipient has requested or approved electronic transmittal;
  - The identical information is available in written form upon request;
  - The information does not constitute a direct member notice related to an adverse Action or any portion of a Grievance, Appeals, Contested Case Hearings or any other member rights or member protection process;
  - Language and alternative format accommodations are available; and
  - All HIPAA requirements are satisfied with respect to personal information.
In addition to the rights listed above, every individual receiving residential services has the following rights:

- To a safe, secure and clean living environment;
- To a humane service environment that has:
  - Reasonable protection from harm;
  - Reasonable privacy;
  - Daily access to fresh air and the outdoors;
  - To keep and use personal clothing and belongings;
  - To have enough private, secure storage space;
  - To express sexual orientation;
  - Gender identity and presentation;
  - To get to and participate in social, religious and community activities;
- To private and uncensored communications by mail, telephone and visitation, subject to the following restrictions:
  - This right may be restricted only if the provider documents in the individual's record that there is a court order that says something else, or
  - That in the absence of this restriction, significant physical or clinical harm will result to the individual or others. (The nature of the harm must be specified in reasonable detail. Any restriction of the right to communicate must be no broader than necessary to prevent harm) and
  - The individual and his or her guardian, if applicable must be given specific written notice of each restriction of the individual's right to private and uncensored communication.

- The provider must make sure that correspondence:
  - Can be conveniently received and mailed;
  - That telephones are reasonable able to use and allow for confidential communication. (Reasonable times for the use of telephones and visits may be established in writing by the provider.)
  - That space is available for visits;
  - To have access to and get available applicable educational services in the most integrated setting in the community;
  - To communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals;
- To participate regularly in indoor and outdoor recreation;
- To not be required to perform labor;
- To have enough food and shelter;
- To a reasonable accommodation if, due to a disability, the housing and services are not sufficiently accessible.

Provider Communication

Each contracted provider has access to our Provider Manual on the company website. If a provider cannot access the website, a printed copy of the manual can be supplied upon request. Member rights and the provider’s responsibilities to comply with these rights are outlined in the Provider Manual. The Provider Manual encompasses all services rendered under PSCS, including physical health, behavioral health, oral health, and Non-Emergent Medical Transportation.

The Provider Network department will also communicate these rights annually via the Provider Bulletin.

Staff Communication

All PSCS staff will be trained on member rights during the onboarding process. Additionally this will be added to our internal annual training that is required to be completed by all PSCS employees. PSCS
Enrollee Communication
PSCS notifies members of their rights upon each enrollment segment with the CCO, unless they were previously enrolled in the CCO within the last 6 months. PSCS sends the member the PSCS Member Handbook, which includes the member rights. The member rights are also available on the PSCS website at https://communitysolutions.pacificsource.com/Member, which can be accessed 24 hours a day, 7 days a week. If a member cannot access the website, a printed copy of the member rights can be supplied upon request. In addition, PSCS conducts a Verification of Services Survey on one percent of claims that are adjudicated. Included in this survey are questions pertaining to member rights. The responses to these questions are reviewed and any issues identified are addressed.

Provider Monitoring and Corrective Action
PSCS will educate, oversee, and monitor providers to ensure they are complying with the rights and responsibilities listed above. The monitoring process will be conducted through an annual Provider Member Rights Survey. Results from the survey will be analyzed, delinquent providers outlined from the results of the survey will be contacted for education. Education will be provided within Provider Network by the Service department. Additional monitoring will occur through the Grievance and Appeals process. Any complaint received that is regarding a possible violation of a member’s rights will be logged and tracked as a member rights grievance. These complaints will be reviewed by the Clinical Quality and Utilization Management (CQUM) Committee on a monthly basis. If a provider is found to have violated a member’s rights, the CQUM Committee will determine appropriate corrective action.

Appendix

Policy Number: [Policy Number]
Effective: 2/1/2017  Next review: 4/1/2020
Policy type: Government
Depts: Provider Network, Claims, Health Services, Grievance and Appeals
Applicable regulation(s): OAR 410-141-0320: OAR 410-141-3320
External entities affected: [External Entities Affected]
Approved by:
## Member Responsibility Policy

**State(s):**
- Idaho
- Montana
- Oregon
- Washington
- Other:

**LOB(s):**
- Commercial
- Medicare
- Medicaid
- PSA

### Government Policy

## Member Responsibilities

PacificSource Community Solutions (PSCS) ensure that CCO members are notified timely of member rights and responsibilities. Members have the following responsibilities pursuant to Exhibit B of the CCO contract, the PSCS member handbook, and OAR 410-141-3320:

- To choose, or help with assignment to, a managed care plan (such as PSCS).
- To choose a primary care provider (PCP).
- To choose or help us assign you to a behavioral health provider.
- To take your PSCS Identification (ID) card with you whenever you need care.
- To treat PSCS staff and health provider staff with respect.
- To be on time for appointments or call in advance to cancel if you are not able to make it or if you are running late.
- To tell your provider of your behavioral health problems.
- To decide about care before you receive it.
- To get behavioral health services from in-network providers. You may get services from an out-of-network provider only in an emergency.
- To call PSCS Customer Service to tell us if you had an emergency within three days.
- To use only your assigned behavioral health provider for your behavioral health needs.
- To get regular health exams and preventive services from your providers.
- To have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy.
- To use your PCP or clinic for diagnostic and other care except in an emergency.
- To get a referral from your PCP before going to a specialist.
- To use urgent and emergency services appropriately.
- To give accurate information for your medical records.
• To help your providers obtain your medical records from other providers, which may include signing a release of information form.

• To ask questions about conditions, treatments, and other issues about your care that you don’t understand.

• To use information to make informed decisions before receiving treatment.

• To be honest with your providers to get the best service possible.

• To help create treatment plans with your providers.

• To follow prescribed treatment plans to which you have agreed.

• To tell the provider that you have OHP coverage before receiving services and to show your plan ID card upon request.

• To tell your case worker if you change your address or phone number.

• To tell your case worker if you become pregnant, let him or her know when you are no longer pregnant or when your baby is born.

• To tell your case worker if any family members move in or out of your house.

• To tell your case worker if you have any other insurance available.

• To pay for services that are not covered by your plan.

• To help the plan in pursuing any third party resources available (such as Workers Compensation or auto insurance).

• To pay the plan the amount of benefits it paid for an injury from any payment received for that injury.

• To tell the plan of any issues, complaints, or grievances about your care.

• To sign an authorization for release of healthcare information so that OHP and the plan can get information needed to respond to an Administrative Hearing request.

Procedure: Customer Service

PSCS conducts new member welcome calls to every new Medicaid member within 60 days of their enrollment. During this call, Customer Service informs the member of their responsibilities as a member of the PSCS plan.

Procedure: Marketing and Communications and Regulatory Communications

PSCS mails to every new Medicaid member a Member Handbook, which contains information regarding the member’s benefits as well as their rights and responsibilities. The Member Handbook is also available to Members on the PSCS website. Not less than once a year, PSCS includes an article to remind members of their Responsibilities and where they can obtain a copy.
<table>
<thead>
<tr>
<th>Policy Number: [Policy Number]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective: 3/15/2019</td>
</tr>
<tr>
<td>Next review: 3/15/2020</td>
</tr>
<tr>
<td>Policy type: Government</td>
</tr>
<tr>
<td>Depts:</td>
</tr>
<tr>
<td>Applicable regulation(s): CCO Contract Exhibit B, OAR 410-141-3320</td>
</tr>
<tr>
<td>External entities affected: N/A</td>
</tr>
<tr>
<td>Approved by:</td>
</tr>
</tbody>
</table>
Enterprise Policy

PacificSource has adopted the 15 national Culturally and Linguistically Appropriate Services Standards (CLAS) as a guiding framework to ensure that all services and communications are provided in a culturally sensitive manner and are accessible to all members, including those with limited English proficiency, reading skills, hearing incapacity, diverse racial and ethnic groups, people of all ages, and people with disabilities. In doing so, we are committed to “providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs” (Principle CLAS Standard).

Procedures

PacificSource implements the following procedures to ensure services are provided in a culturally and linguistically appropriate manner, in alignment with CLAS Standards:

- Works to improve the completeness and accuracy of the information on members’ race, culture, ethnicity, language spoken, and geographic location, in order to understand and respond to the diversity in our membership
- Analyzes available data including CAHPS® data and other sources as appropriate, to identify gaps in access, quality of care and health outcomes based on culture, race, ethnicity, language spoken, age and other characteristics
- Partners with the community to assess community health assets, needs and disparities and plans accordingly to implement services that respond to the cultural and linguistic diversity of populations in the service area
- Offers language assistance at no-cost to members
- Monitors cultural and language assessments from federal, state, census and other sources of data
- Assesses the language spoken by our network practitioners and internal staff that interact with Members, to identify and address any gaps related to the language needs of our membership;
- Monitors the competence of internal staff or sub-contractors providing language assistance telephonically or in person; ensures that the use of untrained individuals and/or minors as interpreters is avoided
- Notifies Members, through a variety of modalities and at least annually, of their right to oral interpretation or translation of written materials in their preferred language or mode (e.g. large print, etc.)
- Assesses the geographic adequacy of our practitioner network for groups who speak languages other than English
- Adjusts the practitioner network to ensure it has the types and numbers of practitioners necessary to meet the cultural and/or linguistic needs of our members within their defined geographical areas
Includes Member representation of the diversity of our membership’s culture and language in all advisory committees when possible and ad hoc work groups to help ensure that all Members’ needs are being considered.

Encourages Members to use effective wellness and prevention resources and to make healthy lifestyle choices, in a manner that is culturally and linguistically appropriate.

Utilizes best practice standards, developed by state (Oregon Health Authority) and federal authorities (CMS) to outreach to culturally specific populations experiencing gaps in care.

Develops member materials that are targeted to best-practice reading level and the languages preferred by our members.

Supplies customized member materials to members in non-English languages when requested by large employer groups.

Fosters organizational-wide commitment to diversity of staff and management through recruitment, training, retention, and promotional efforts.

Maintains enterprise training programs on topics of health equity, cultural responsivity, diversity and inclusion.

Maintains and updates annually a Language Access Plan to ensure members are receiving high quality communication services for their health plan navigation and clinical care needs.

Creates conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

Provide education and tools for Providers to use to assist in the culturally and linguistically appropriate education of Members about care coordination, and the responsibilities of both Providers and Members in assuring effective communication.

Data and Information Sources:

- CAHPS® Survey data reported annually
- Complaint data from internal call tracking system monitored monthly, including quality monitoring of telephonic interpretation
- Self-reported member data from enrollment applications, REAL+D data (Medicaid) and reported annually

Appendix

Policy Number: N/A

Effective: 11/30/2018  Next review: 11/30/2019

Policy Type:

Author(s):

Depts: Health Services

Applicable regulation(s): NCQA QI 1A Factor 8 Program Structure, QI 4 Member Experience, NET 1A Availability of Practitioners, PHM 2B-C Population Identification. OAR 410-141-(0220, 3015, 3160, 3220, and 3300). Exhibit N, Coordinated Care Organization Contract.

External entities affected: [External Entities Affected]

Approved by: Senior Vice President and CI
Applicants must provide a detailed plan for community engagement according to the required components in the RFA Community Engagement Plan Reference Document, including identified gaps and plans to address gaps. Applicant’s Community Engagement Plan must be no more than 4 pages (according to the RFA spacing and font restrictions), excluding tables. Tables should be completed in the format provided below and submitted with Applicant’s Community Engagement Plan (narrative).

<table>
<thead>
<tr>
<th>Table 1: Stakeholders to be included in the engagement process</th>
</tr>
</thead>
<tbody>
<tr>
<td>All applicants must complete this full table. Applicants may add rows as needed.</td>
</tr>
</tbody>
</table>

**Part 1a.** List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health (“SDOH-HE”), providers, including culturally specific providers as available (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, and local school districts.

**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.

**Part 1b.** Describe why each listed agency, organization and individual was included.

**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
<table>
<thead>
<tr>
<th>OHP consumers (list in first column below)</th>
<th>OHP consumers</th>
<th>Community Advisory Council (CAC) member consumer representatives</th>
<th>Our Community Governance model utilizes the CAC as a forum for OHP Consumer Representatives to have a voice in decision-making for the CCO.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OHP consumers</td>
<td>Community partner enrollment assisters</td>
<td>Enrollment assisters are key community partners who have an acute awareness of barriers that OHP members may be experiencing in the community.</td>
<td>Maintain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strengthen</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Develop
We currently and will continue to rely on the CAC consumer membership to advise the CCO governing board and engage in shared-decision making around projects including the CHA, CHP, and SDOH-HE spending priorities.

Maintain
We will maintain this relationship by ensuring that consumer members of the CAC actively participate on and provide input to CHP priority workgroups and other subcommittees. We will also have regular CCO representation at each CAC meeting.

Strengthen
We will strengthen relationships by holding member focus groups with consumer members of the CAC to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.
| OHP consumers | Latino Community Association (LCA) | LCA is an essential connection point for our immigrant community to ask questions, assist with translation, and connect to new opportunities. LCA is a trusted partner and our regional subject matter expert on our Latino, migrant, and immigrant population. | Develop
We currently collaborate with LCA to ensure that our Latino membership is equitably and adequately served and represented in our regular operations and in member engagement activities.
Maintain
We will continue to collaborate with LCA as a subject matter expert for our Latino population.
Strengthen
We have new representation from LCA on our CAC. We will hold member focus groups with individuals engaged with LCA to inform the CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |
| --- | --- | --- | --- |
| OHP consumers | Deschutes County Public Health Department | Deschutes County Public Health is an active community partner and our CHA/CHP priorities and strategies are directly aligned with this organization. Deschutes County Public Health has also received community reinvestment funds from the Health | Develop
We have an active provider service agreement with the Deschutes County Public Health Department and collaborate on many community efforts. We also coordinate with Deschutes County Public Health via care management practices and for care coordination across the spectrum of services.
Maintain
We will collaborate with the representatives from this organization on our Board, CAC, Operations Council, and CHP priority workgroups. Deschutes County Public Health has received community reinvestment funds from |
| OHP consumers | Crook County Public Health Department | Crook County Public Health is an active partner and our CHA/CHP priorities and strategies are directly aligned with this organization. | Develop
We have an active provider service agreement with the Crook County Public Health Department and collaborate on many community efforts. We coordinate with Crook County Public Health regularly via care management practices and for care coordination across the spectrum of services. A Crook County Commissioner serves on the Health Council.
Maintain
We will collaborate with the representatives from Crook County Public Health on our Board, CAC, Operations |

Council for prevention and health promotion efforts.

the Health Council for their Perinatal Care Continuum serving our region’s prenatal and postnatal high risk families and additional funds to deploy the CDC’s Diabetes Prevention Programs throughout our region. They have also received Quality Pool funds for a tobacco cessation campaign to encourage utilization of the Tobacco Quit Line, funds for an HIE interface to increase referrals to the Tobacco Quit Line, funds to print 5,000 wallet sized substance use disorder resource cards, and funds to deploy the CDC’s AFIx immunization program throughout the region.

Strengthen
We will evaluate the outcomes of all programs funded by community reinvestment and Quality Pool funds and collaborate on next steps. We will also facilitate member focus groups with individuals engaged with Deschutes County Public Health to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. A Deschutes County Commissioner will hold a seat on our governing board within the next couple of months; turnover has occurred in this seat due to a recent election.
<table>
<thead>
<tr>
<th>OHP consumers</th>
<th>Jefferson County Public Health Department</th>
<th>Jefferson County Public Health is an active partner and our CHA/CHP priorities and strategies are directly aligned with this organization. Jefferson County Public Health has also received community reinvestment funds from the Health Council for prevention and health promotion efforts.</th>
<th>Council, and CHP priority workgroups. Crook County Public Health has received Quality Pool funds for One Key Question provider trainings in their community, to fund a community approach to controlling Type Two Diabetes, and to fund an initiative to increase community awareness about the harms of tobacco and industry tactics targeting youth. <strong>Strengthen</strong> We will evaluate the outcomes of all programs funded by the Quality Pool and collaborate on next steps. We will facilitate member focus groups with individuals engaged with Crook County Public Health to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop</td>
<td>We have an active provider service agreement with the Jefferson County Public Health Department and collaborate on many community efforts. We coordinate with our community’s enrollment assisters regularly via care management practices and for care coordination across the spectrum of services. A Jefferson County Commissioner serves on the Health Council. <strong>Maintain</strong> We will collaborate with the representatives from Jefferson County Public Health on our Board, CAC, Operations Council, and CHP priority workgroups. Jefferson County Public Health has received Quality Pool funds for One Key Question provider trainings in their community. <strong>Strengthen</strong> We will evaluate the outcomes of the Perinatal Care Continuum and collaborate on next steps. We will facilitate member focus groups with individuals engaged</td>
<td></td>
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</tr>
</tbody>
</table>
| OHP consumers | Let’s Talk Diversity | Let’s Talk Diversity works to expand cultural awareness, equity, and inclusion through advocacy, education, and outreach. They are a key CCO partner in Jefferson County and the town of Madras. | Develop
We have collaborated with Let’s Talk Diversity on CHA/CHP-related matters as subject matter experts in Jefferson County and diversity.
Maintain
We will continue to collaborate with this organization on CHA/CHP and other regional projects.
Strengthen
We will facilitate member focus groups with individuals engaged with Let’s Talk Diversity to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP in an attempt to strengthen this relationship. |
| OHP consumers | Homeless Leadership Coalition | The Homeless Leadership Coalition is the regional Coordinated Entry System ensuring that people experiencing homelessness can get help finding stable housing. The Homeless Leadership Coalition is a key CCO partner for our SDOH-HE and CHA/CHP work as well as for the statewide housing priority. | Develop
A PSCS representative served as Chair of the Homeless Leadership Coalition’s Community Action Committee in Bend which created a strong partnership between our organizations.
Maintain
We will continue to engage members of the Homeless Leadership Coalition in community activities including participation on the CHP priority workgroup focused on housing.
Strengthen
We will facilitate member focus groups with individuals engaged with the Homeless Leadership Coalition members to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |
<table>
<thead>
<tr>
<th>OHP consumers</th>
<th>Warm Springs Native Aspirations Prevention Team</th>
<th>The Warm Springs Native Aspirations team focuses on health care and prevention efforts within their tribal community. They are one of the active groups in the Confederated Tribe of Warm Springs that act as our subject matter experts on CCO members that are also part of the tribe.</th>
<th>Develop We have collaborated with representatives from the Warm Springs Native Aspirations Prevention Team and have PSCS staff members that serve as tribal liaisons at these groups regularly. A representative from the Warm Springs Native Aspirations Prevention Team is also on our CHA/CHP Steering Committee. Maintain We will continue to collaborate with the Warm Springs Native Aspirations Prevention Team on CHA/CHP and other regional projects. We will also use this group as our subject matter expert for our tribal member population. Strengthen We will facilitate member focus groups with individuals engaged with the Warm Springs Native Aspirations Prevention Team to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP consumers</td>
<td>La Pine Community Health Center</td>
<td>La Pine Community Health Center is a local FQHC and an engaged partner in our regional work. They serve approximately 7% of our CCO members (predominantly those who reside in rural southern Deschutes and northern Klamath Counties). La Pine Community Health Center has also received Quality Pool funds for...</td>
<td>Develop We have an active provider service agreement with La Pine Community Health Center and collaborate on many community projects. We coordinate with La Pine Community Health Center regularly via care management practices and for care coordination across the spectrum of services. Maintain We will collaborate with representatives from La Pine Community Health Center through their participation on the PSCS Operations Council and CHP priority workgroups. This organization has received Quality Pool funds to provide incentives for adolescent well care visits at their school based health centers, funds to provide parents with diapers and grocery store gift cards when...</td>
</tr>
</tbody>
</table>
| OHP consumers | Central Oregon Council on Aging | The Central Oregon Council on Aging promotes the dignity, wellbeing, security, and independence of older adults in Central Oregon. They are a key stakeholder in our community efforts and provide subject matter expertise on our aging population. | Develop
PCS staff members have attended the Central Oregon Council on Aging community meetings in an advisory and collaborative capacity.  
Maintain
The Council on Aging are active participants in our Community Resource Huddle. PSCS created the Community Resource Huddle, a community gathering that meets quarterly to connect resources within the region. There are close to 500 community partners that attend these huddles. We will continue to collaborate with the Council on Aging on the CHA/CHP and other regional projects.  
Strengthen
We will strengthen our relationship by facilitating member focus groups with individuals engaged with Central Oregon on Aging to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |

- Prevention and health promotion efforts.
- They bring their children in for immunizations, funds for a vital sign standardization program in their clinics, funds for tablets for provider teams to complete SBIRT and ASQ screenings electronically, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program.
| OHP consumers | Central Oregon Veterans Outreach (COVO) | COVO engages in military veteran outreach around housing and referrals to agencies and resources. COVO has been an active partner and is a key stakeholder, providing subject matter expertise on our veteran population. | Develop
We have staff members that attend COVO’s community meetings in an advisory and collaborative capacity. We have also partnered with this organization on community events, such as health and wellness fairs.
Maintain
We will continue to collaborate with this organization on the CHA/CHP and other regional projects.
Representatives from COVO participate in our regional Community Resource Huddle for resource sharing.
Strengthen
We will strengthen our relationship by facilitating member focus groups with individuals engaged with COVO to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.

| OHP consumers | Abilitree | Abilitree provides individuals with disabilities a number of services including job development for employment, Social Security advocacy, community integrated employment, technology assistance, peer support, and support groups. Abilitree has been an active partner and is a key stakeholder, providing subject matter expertise on our population. | Develop
We coordinate with Abilitree regularly via care management practices and for care coordination across the spectrum of services and for many community efforts.
Maintain
We will continue to engage members of this organization in community activities and have representation on the CHP priority workgroups. Representatives from this organization participate in our regional Community Resource Huddle for resource sharing. This organization has received Quality Pool funds for a travel training program which teaches differently-abled individuals how to effectively navigate the public transportation system.
Strengthen
We will strengthen our relationship by facilitating member focus groups with individuals engaged with... |
<table>
<thead>
<tr>
<th>Community-based organizations that address disparities and SDOH-HE (list in first column below)</th>
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<tbody>
<tr>
<td>Community-based organizations that address disparities and SDOH-HE</td>
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</table>

<p>| Community-based organizations that address disparities and SDOH-HE | PacificCrest Affordable Housing | PacificCrest develops affordable housing and is an active and key stakeholder for SDOH-HE efforts. We have collaborated with | Develop | We have an active MOU with PacificCrest Affordable Housing to support and give input on their current and future projects. We coordinate with PacificCrest regularly via care management practices and for care coordination across the spectrum of services. |</p>
<table>
<thead>
<tr>
<th>Community-based organizations that address disparities and SDOH-HE</th>
<th>Housing Works</th>
<th>Housing Works is Central Oregon’s regional housing authority.</th>
<th>Maintain</th>
<th>Representatives from PacificCrest are currently and will continue to be engaged in our regional Community Resource Huddle for resource sharing. PacificCrest has received community reinvestment funds from the Health Council to support their operations of a 50-unit affordable housing unit that is focused on health improvement and access to health care. <strong>Strengthen</strong> We will evaluate the outcomes of the programs funded by the community reinvestments and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based organizations that address disparities and SDOH-HE</td>
<td>Shepherd’s House</td>
<td>Shepherd’s House is a local homeless shelter.</td>
<td>Develop</td>
<td>We coordinate with Housing Works regularly via care management practices and for care coordination across the spectrum of services. <strong>Maintain</strong> We will continue to engage representatives from Housing Works in community activities and in the CHP priority workgroup focused on housing. Representatives from Housing Works are currently and will continue to be engaged in our regional Community Resource Huddle for resource sharing. <strong>Strengthen</strong> We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td>Community-based organizations that address disparities and SDOH-HE</td>
<td>J Bar J</td>
<td>J Bar J is a residential facility serving young offenders, ages 13-18, in need of court ordered rehabilitation services.</td>
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<td><strong>Develop</strong>&lt;br&gt; We coordinate with J Bar J regularly via care management practices and for care coordination across the spectrum of services.</td>
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<td><strong>Maintain</strong>&lt;br&gt; We will continue to engage representatives from J Bar J in community activities. Representatives from J Bar J participate on our regional Community Resource Huddle for resource sharing.</td>
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<td><strong>Strengthen</strong>&lt;br&gt; We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
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<table>
<thead>
<tr>
<th>Community-based organizations that address disparities and SDOH-HE</th>
<th>Bend Parks and Recreation</th>
<th>Bend Parks and Recreation maintains and operates recreational programs and fitness and senior centers in town. Bend Parks and Recreation has received HRS funds for prevention and health promotion efforts.</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td><strong>Develop</strong>&lt;br&gt; We have an active agreement with Bend Parks and Recreation for HRS. The agreement allows members, who have been referred by their primary care physician to improve or prevent a health condition, to utilize their local swim and fitness center. We coordinate with Bend Parks and Recreation regularly via care management practices and for care coordination across the spectrum of services and for many community projects.</td>
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<td></td>
<td></td>
<td><strong>Maintain</strong>&lt;br&gt; We will continue to engage representatives from Bend Parks and Recreation in community activities. Representatives from Bend Parks and Recreation are currently and will continue to be engaged in our regional</td>
</tr>
<tr>
<td>Community-based organizations that address disparities and SDOH-HE</td>
<td>Full Access High Desert</td>
<td>Full Access High Desert provides support services to individuals with intellectual and developmental disabilities. Our CAC membership includes a representative from Full Access High Desert.</td>
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<td>We coordinate with Full Access High Desert regularly via care management practices and for care coordination across the spectrum of service and for many community projects. We also have representation from Full Access High Desert on our CAC.</td>
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<td>Maintain</td>
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<tr>
<td></td>
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<td>We will continue to engage representatives from Full Access High Desert in community activities and have representation on the CHP priority workgroups. Representatives from Full Access High Desert are currently and will continue to be engaged in our regional Community Resource Huddle for resource sharing.</td>
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<td></td>
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<td>Strengthen</td>
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<td></td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td>Community-based organizations that address disparities and SDOH-HE</td>
<td>Neighbor Impact</td>
<td>Neighbor Impact provides community services for food and shelter, provides access to increased education and skills, and assists individuals to become more independent and self-sufficient throughout their lives. Neighbor Impact has also received</td>
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<td>Develop</td>
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<td></td>
<td>We coordinate with Neighbor Impact regularly via care management practices and for care coordination across the spectrum of service and for many community projects.</td>
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<td>Maintain</td>
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</table>
|  |  | We will continue to engage representatives from Neighbor Impact in community activities and have representation on the CHP priority workgroups. Representatives from Neighbor Impact participate on our regional Community Resource Huddle for resource sharing. Neighbor Impact has received community reinvestment funds from the Health Council for mental health support services within
| Community-based organizations that address disparities and SDOH-HE | Better Together | Better Together is a regional cross sector partnership working collectively to improve education outcomes for children and youth from cradle to career. Better Together has also received community reinvestment funds from the Health Council for prevention and health promotion efforts. | Develop  
We coordinate with Better Together regularly via care management practices and for care coordination across the spectrum of service and for many community projects.  
Maintain  
We will continue to engage with representatives from Better Together in community activities and have representation on the CHP priority workgroups.  
Representatives from Better Together participate on our regional Community Resource Huddle for resource sharing. Better Together has received community reinvestment funds from the Health Council for parent led early Spanish literacy program.  
Strengthen  
We will evaluate the outcomes of the programs funded by the shared savings reinvestments and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Abilitree | Abilitree provides individuals with disabilities a number of services including job development for employment, Social Security advocacy, community integrated employment, technology | Develop  
We coordinate with Abilitree regularly via care management practices and for care coordination across the spectrum of services and for many community efforts.  
Maintain  
We will continue to engage members of this organization in community activities and have representation on the CHP priority workgroups. Representatives from this organization participate in our regional Community Resource Huddle for resource sharing.  
Strengthen  
We will evaluate the outcomes of the programs funded by the shared savings reinvestments and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
Community-based organizations that address disparities and SDOH-HE

| MountainStar Family Relief Nursery (MountainStar) | MountainStar is a regional relief nursery. MountainStar has also received community reinvestment funds from the Health Council for prevention and health promotion efforts. | Develop
We coordinate with MountainStar regularly via care management practices and for care coordination across the spectrum of services and for many community efforts. The PSCS Medicaid Contract Manager also serves on the MountainStar Board of Directors.

Maintain
We will continue to engage representatives from MountainStar in community activities and have representation on the CHP priority workgroups. Representatives from MountainStar participate on our regional Community Resource Huddle for resource sharing. MountainStar has received community reinvestment funds from the Health Council to help at risk 3-4 year old children in Bend prepare physically, socially, emotionally, and cognitively for kindergarten through a therapeutic preschool classroom for three years.

Strengthen
We will evaluate the outcomes of the programs funded by the shared savings reinvestments and collaborate on next steps.

| Assistance, peer support, and support groups. Abilitree has been an active partner and is a key stakeholder, providing subject matter expertise on our differently-abled population. Abilitree has also received Quality Pool funding for prevention and health promotion efforts. | Resource Huddle for resource sharing. This organization has received Quality Pool funds for a travel training program which teaches differently-abled individuals how to effectively navigate the public transportation system. Strengthen
We will extend invitations for continued and active involvement in the 2020-2023 CHP. We will also evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. |
### Community-based organizations that address disparities and SDOH-HE

<table>
<thead>
<tr>
<th>Family Access Network</th>
<th>Family Access Network is located in Deschutes and Crook County schools connecting children and families to resources such as food, clothing, and shelter.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop</strong></td>
<td>We coordinate with Family Access Network regularly via care management practices and for care coordination across the spectrum of services and for many community efforts.</td>
</tr>
<tr>
<td><strong>Maintain</strong></td>
<td>We will continue to engage members of Family Access Network in community activities and have representation on the CHP priority workgroups. Representatives from Family Access Network participate in our regional Community Resource Huddle for resource sharing.</td>
</tr>
<tr>
<td><strong>Strengthen</strong></td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP. Family Access Network is also our 2019 Charity of Choice and PSCS employees will spend the year fundraising and volunteering to assist the work at Family Access Network does in our communities.</td>
</tr>
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</thead>
<tbody>
<tr>
<td><strong>Develop</strong></td>
<td>We coordinate with Council on Aging of Central Oregon regularly via care management practices and for care coordination across the spectrum of services and for many community efforts.</td>
</tr>
<tr>
<td><strong>Maintain</strong></td>
<td>PSCS staff members have attended the Central Oregon Council on Aging community meetings in an advisory and collaborative capacity.</td>
</tr>
<tr>
<td><strong>Strengthen</strong></td>
<td>We will continue to engage members of the Council on Aging of Central Oregon in community activities. Representatives from Council on Aging of Central Oregon participate in our regional Community Resource Huddle.</td>
</tr>
</tbody>
</table>
| Community-based organizations that address disparities and SDOH-HE | KIDS Center | KIDS Center is a regional child abuse intervention center. | **Develop**  
We coordinate with KIDS Center regularly via care management practices and for care coordination across the spectrum of services and for many community efforts. The Central Oregon CCO Director also serves on their Board of Directors.  
**Maintain**  
We will continue to engage members of KIDS Center in community activities. Representatives from KIDS Center participate in our regional Community Resource Huddle for resource sharing.  
**Strengthen**  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |

| Providers, physical health, including culturally specific providers as available (list in first column below) |
|---|---|---|
| Providers, physical health | Deschutes County Public Health | Deschutes County Public Health is an active community partner and our CHA/CHP priorities and strategies are directly aligned with this organization. Deschutes County Public Health has also received community reinvestment funds from the Health Council for prevention and health promotion | **Develop**  
We have an active provider service agreement with the Deschutes County Public Health Department and collaborate on many community efforts. We also coordinate with Deschutes County Public Health via care management practices and for care coordination across the spectrum of services.  
**Maintain**  
We will collaborate with the representatives from this organization on our Board, CAC, Operations Council, and CHP priority workgroups. Deschutes County Public Health has received community reinvestment funds from the Health Council for their Perinatal Care Continuum serving our region’s prenatal and postnatal high risk... |
| Providers, physical health | Jefferson County Public Health | Jefferson County Public Health is an active partner and our CHA/CHP priorities and strategies are directly aligned with this organization. Jefferson County Public Health has also received community reinvestment funds from the Health Council for prevention and health promotion | families and additional funds to deploy the CDC’s Diabetes Prevention Programs throughout our region. They have also received Quality Pool funds for a tobacco cessation campaign to encourage utilization of the Tobacco Quit Line, funds for an HIE interface to increase referrals to the Tobacco Quit Line, funds to print 5,000 wallet sized substance use disorder resource cards, and funds to deploy the CDC’s AFIX immunization program throughout the region. **Strengthen** We will evaluate the outcomes of all programs funded by community reinvestment and Quality Pool funds and collaborate on next steps. We will also facilitate member focus groups with individuals engaged with Deschutes County Public Health to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. A Deschutes County Commissioner will hold a seat on our governing board within the next couple of months; turnover has occurred in this seat due to a recent election. | **Develop** We have an active provider service agreement with the Jefferson County Public Health Department and collaborate on many community efforts. We coordinate with our community’s enrollment assisters regularly via care management practices and for care coordination across the spectrum of services. A Jefferson County Commissioner serves on the Health Council. **Maintain** We will collaborate with the representatives from Jefferson County Public Health on our Board, CAC, Operations Council, and CHP priority workgroups. Jefferson County Public Health has received Quality Pool funds |
| Provider, physical health | Crook County Public Health | Crook County Public Health is an active partner and our CHA/CHP priorities and strategies are directly aligned with this organization. Crook County Public Health has also received community reinvestment funds from the Health Council for prevention and health promotion efforts. | Develop
We have an active provider service agreement with the Crook County Public Health Department and collaborate on many community efforts. We coordinate with Crook County Public Health regularly via care management practices and for care coordination across the spectrum of services. A Crook County Commissioner serves on the Health Council.

Maintain
We will collaborate with the representatives from Crook County Public Health on our Board, CAC, Operations Council, and CHP priority workgroups. Crook County Public Health has received Quality Pool funds for One Key Question provider trainings in their community, to fund a community approach to controlling Type Two Diabetes, and to fund an initiative to increase community awareness about the harms of tobacco and industry tactics targeting youth.

Strengthen
We will evaluate the outcomes of all programs funded by the Quality Pool and collaborate on next steps. We will facilitate member focus groups with individuals engaged with Crook County Public Health to inform the next CHA/CHP. We will also extend invitations for continued active involvement in the 2020-2023 CHP. |
<table>
<thead>
<tr>
<th>Providers, physical health</th>
<th>Mosaic Medical</th>
<th>Mosaic Medical is a local FQHC and an engaged partner in our regional work. They serve approximately 30% of our CCO members. Mosaic Medical has also received Quality Pool and community reinvestment funds from the Health Council for prevention and health promotion efforts.</th>
</tr>
</thead>
</table>
|                           |               | Develop
We have an active provider service agreement with Mosaic Medical and collaborate on many community efforts. We coordinate with Mosaic Medical regularly via care management practices and for care coordination across the spectrum of services. The CEO of Mosaic Medical serves on the Health Council and is the co-chair of the Finance Committee.

Maintain
We will collaborate with the representatives from Mosaic Medical on our Board, CAC, Operations Council, and CHP priority workgroups. We also meet with leadership from Mosaic Medical on a regular cadence at the CAP Steering Committee to collaborate on ways to manage the risk arrangement, monitor quality metrics, develop Value-Based Payment (VBP) models, and discuss other community strategies. Mosaic Medical has received community reinvestment funds from the Health Council to provide prescriptions for youth physical activity opportunities, funds to support timely dental access for pediatric patients and pregnant women, and funds to provide mentorship, education, and financial support for patients with diabetes. Mosaic Medical has also received Quality Pool funds for staff SBIRT training, funds to pilot a diabetes training program, funds to administer a CAHPS survey to help bridge barriers to communication and cultural differences, funds for an adolescent well care outreach and incentive program, funds for a One Key Question initiative within their organization, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program. |
| Providers, physical health | St. Charles Health System | Strengthen  
We will evaluate the outcomes of all programs funded by the community reinvestment funds and the Quality Pool funds and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.  
Develop  
We have an active provider service agreement with St. Charles Health System and collaborate on many community efforts. We coordinate with St. Charles Health System regularly via care management practices and for care coordination across the spectrum of services. Representatives of the St. Charles Health System serve on the Health Council and as co-chair of the Finance Committee.  
Maintain  
We will collaborate with the representatives from St. Charles Health System on our Board, CAP, CAC, Finance Committee, Operations Council, and CHP priority workgroups. We also meet with representatives from St. Charles Health System on a regular cadence at the CAP Steering Committee to collaborate on ways to manage the risk arrangement, monitor quality metrics, develop Value-Based Payment (VBP) models, and discuss other community strategies. We also meet with representatives from St. Charles Health System on a regular cadence at the Joint Operating Committee with the regional Independent Practice Association. St. Charles Health System has received community reinvestment funds from the Health Council for a mobile care clinic to provide ongoing support for patients with poor control of diabetes to help improve self-management skills. They have also received Quality Pool funds to shore up their... |
immunization program, funds for a community paramedicine program to decrease emergency department utilization, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program.

**Strengthen**
We will evaluate the outcomes of all programs funded by the community reinvestment funds and from the Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.

**Develop**
We have an active provider service agreement with La Pine Community Health Center and collaborate on many community projects. We coordinate with La Pine Community Health Center regularly via care management practices and for care coordination across the spectrum of services.

**Maintain**
We will collaborate with representatives from La Pine Community Health Center through their participation on the PSCS Operations Council and CHP priority workgroups. This organization has received Quality Pool funds to provide incentives for adolescent well care visits at their school based health centers, funds to provide parents with diapers and grocery store gift cards when they bring their children in for immunizations, funds for a vital sign standardization program in their clinics, funds for tablets for provider teams to complete SBIRT and ASQ screenings electronically, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program.

| Providers, physical health | La Pine Community Health Center | La Pine Community Health Center is a local FQHC and an engaged partner in our regional work. They serve approximately 7% of our CCO members (predominantly those who reside in rural southern Deschutes and northern Klamath Counties). La Pine Community Health Center has also received Quality Pool funds for prevention and health promotion efforts. | We will evaluate the outcomes of all programs funded by the community reinvestment funds and from the Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Providers, physical health | High Lakes Healthcare | **Strengthen**
We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. We will also strengthen this relationship by facilitating member focus groups with individuals engaged with La Pine Community Health Center to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |
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<tr>
<td>High Lakes Healthcare is a primary care organization and an engaged partner in our regional work. They serve approximately 3% of our CCO membership. High Lakes Healthcare has also received Quality Pool funds for prevention and health promotion efforts.</td>
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</tbody>
</table>
| **Develop**
We have an active provider service agreement with High Lake Healthcare and collaborate on many community projects. We coordinate with High Lakes Healthcare regularly via care management practices and for care coordination across the spectrum of services. |
| **Maintain**
We will collaborate with the representatives from High Lakes Healthcare on the CAP, Operations Council, and CHP priority workgroups. High Lakes Healthcare has received Quality Pool funds to implement and EMR solution for documentation standardization and reporting, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program. |
| **Strengthen**
We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Providers, physical health | Weeks Family Medicine | **Develop**
We have an active provider service agreement with Weeks Family Medicine and collaborate on many community projects. We coordinate with Weeks Family Medicine regularly via care management practices and for |
| Weeks Family Medicine is a primary care organization and an engaged partner in our regional work. They |

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**Attachment 10-RFA Community Engagement Plan Required Tables**

Page 23 of 66
<table>
<thead>
<tr>
<th>Providers, physical health</th>
<th>Summit Bend Memorial Clinic</th>
<th>Summit Bend Memorial Clinic is a primary care organization and an engaged partner in our regional work. They serve approximately 7% of our CCO membership. Summit Bend Memorial Clinic has also received</th>
<th>We have an active provider service agreement with Summit Bend Memorial Clinic and collaborate on many community projects. We coordinate with Summit Bend Memorial Clinic regularly via care management practices and for care coordination across the spectrum of services. A representative from Summit Bend Memorial Clinic serves on the Health Council.</th>
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<td></td>
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<td>care coordination across the spectrum of services.</td>
<td>Maintain We will collaborate with the representatives from Weeks Family Medicine on the Operations Council and CHP priority workgroups. Weeks Family Medicine has received community reinvestment funds from the Health Council to implement dental services into their primary care office, specifically targeting children and pregnant women. Weeks Family Medicine has also received Quality Pool funds for patient education materials and training for One Key Question, funds for staff training on adolescent well care visits, developmental screenings, and SBIRT, funds for adolescent well care engagement efforts, funds for resourcing expanded clinic hours, funds for two portable blood pressure monitors that interface with their EMR, and funds for increasing PCPCH tiers including behavioral health integration.</td>
</tr>
<tr>
<td></td>
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<td>Maintain We will collaborate with the representatives from this</td>
<td>Strengthen We will evaluate the outcomes of the programs funded by the community reinvestment funds and Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td>Providers, physical health</td>
<td>Central Oregon Pediatric Associates</td>
<td>Central Oregon Pediatric Associates is a primary care organization and an engaged partner in our regional work. They serve approximately 19% of our CCO members. Central Oregon Pediatric Associates has also received Quality Pool funds for prevention and health promotion efforts.</td>
<td>Quality Pool funds for prevention and health promotion efforts. Organization on the Board, Operations Council, and CHP priority workgroups. This organization has received Quality Pool funds for increasing PCPCH tiers including behavioral health integration and funds to support their internal quality management program. <strong>Strengthen</strong> We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td>Providers, physical health</td>
<td>East Cascades Women’s Group</td>
<td>East Cascades Women’s Group is the largest obstetrics and gynecological clinic in Central Oregon and is an engaged partner in regional work.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Develop</td>
<td>We have an active provider service agreement with East Cascades Women’s Group and collaborate on many community projects. We coordinate with East Cascades Women’s Group regularly via care management practices and for care coordination across the spectrum of services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain</td>
<td>We will collaborate with the representatives from East Cascades Women’s Group on the Operations Council and CHP priority workgroups.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen</td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
<td></td>
</tr>
<tr>
<td>Providers, physical health</td>
<td>Partners in Care</td>
<td>Partners in Care is a regional home health and hospice care organization.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop</td>
<td>We have an active provider service agreement with Partners in Care and collaborate on many community projects. We coordinate with Partners in Care regularly via care management practices and for care coordination across the spectrum of services. The President and CEO of Partners in Care serves on the Health Council.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain</td>
<td>We will collaborate with the representative from Partners in Care on the Health Council.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen</td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
<td></td>
</tr>
<tr>
<td>Providers, behavioral health, including culturally specific providers as available (list in first column below)</td>
<td>Deschutes County Behavioral Health</td>
<td>Deschutes County Behavioral Health is the Community Mental Health Program (CMHP) for Deschutes County.</td>
<td></td>
</tr>
<tr>
<td>Providers, behavioral health</td>
<td>Develop</td>
<td>We have an active provider service agreement with Deschutes County Behavioral Health and collaborate on many community projects. We coordinate with Deschutes County Behavioral Health regularly via care management practices and for care coordination across the spectrum of services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain</td>
<td>We will collaborate with the representative from Deschutes County Behavioral Health on the Operational Council and CHP priority workgroups.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen</td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
<td></td>
</tr>
<tr>
<td>Providers, behavioral health</td>
<td>BestCare Treatment Services</td>
<td>BestCare Treatment Services is the Community Mental Health Program (CMHP) for Jefferson County and an adult SUD Residential and Detox provider.</td>
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</tbody>
</table>
|                             |                            | Develop  
We have active provider service agreements with BestCare Treatment Services and collaborate on many community projects. We coordinate with BestCare Treatment Services regularly via care management practices and for care coordination across the spectrum of services. The Executive Director from BestCare Treatment Services also serves on the Health Council. |
|                             |                            | Maintain  
We will collaborate with the representatives from BestCare Treatment Services on the Health Council Board, Finance Committee, Operations Council, and CHP priority workgroups. We also meet with representatives from BestCare Treatment Services on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies. BestCare Treatment Services has received community reinvestment funds. |
from the Health Council to embed two full time substance use clinicians in the St. Charles Bend hospital. BestCare Treatment Services has also received Quality Pool funds to implement Mothers Outreach and Mentoring Services for pregnant women needing substance use disorder treatment. **Strengthen**

We will evaluate the outcomes of the programs funded by the community reinvestment funds and the Quality Pool and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP.

<table>
<thead>
<tr>
<th>Providers, behavioral health</th>
<th>Lutheran Community Services, Northwest</th>
<th>Lutheran Community Services, Northwest is the Community Mental Health Program (CMHP) for Crook County.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We have an active provider service agreement with Lutheran Community Services, Northwest and collaborate on many community projects. We coordinate with Lutheran Community Services, Northwest regularly via care management practices and for care coordination across the spectrum of services.</td>
<td></td>
</tr>
</tbody>
</table>
|                             |                                       | **Maintain**
|                             |                                       | We will collaborate with the representatives from Lutheran Community Services, Northwest on the Operations Council and CHP priority workgroups. We also meet with representatives from Lutheran Community Services, Northwest on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies. |        |
|                             |                                       | **Strengthen**
|                             |                                       | We will extend invitations for continued and active involvement in the 2020-2023 CHP. |        |

<table>
<thead>
<tr>
<th>Providers, behavioral health</th>
<th>Rimrock Trails</th>
<th>Rimrock Trails is a regional youth SUD Residential and</th>
<th>Develop</th>
</tr>
</thead>
</table>
|                             |                | **Develop**
|                             |                | We have an active provider service agreement with Rimrock Trails and collaborate on many community |        |
|                             |                | **Maintain**
<p>|                             |                | We will extend invitations for continued and active involvement in the 2020-2023 CHP. |        |</p>
<table>
<thead>
<tr>
<th>Providers, behavioral health</th>
<th>Youth Villages</th>
<th>Youth Villages is an intensive outpatient and ED diversion program.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maintain. We coordinate with Rimrock Trails regularly via care management practices and for care coordination across the spectrum of services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong>. We will collaborate with the representatives from Rimrock Trails on the CHP priority workgroups. We also meet with representatives from Rimrock Trails on a regular cadence to discuss ongoing quality improvement strategies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Strengthen</strong>. We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop. We have an active provider service agreement with Youth Villages and collaborate on many community projects. We coordinate with Youth Villages regularly via care management practices and for care coordination across the spectrum of services. We invested in Youth Villages to build capacity and access in the region to support our young members and their families with behavioral health issues.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong>. We will meet with representatives from Youth Villages on a regular cadence to discuss ongoing quality improvement strategies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Strengthen</strong>. We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td>Providers, oral health</td>
<td>Advantage Dental Services</td>
<td>Develop</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>Advantage Dental Services is a Dental Care Organization and an engaged partner in our regional work. They serve a significant portion of our CCO membership.</td>
<td>We have an active provider service agreement with Advantage Dental Services and collaborate on many community projects. We coordinate with Advantage Dental Services regularly via care management practices and for care coordination across the spectrum of services. The CEO of Advantage Dental Services serves on the Health Council.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We will collaborate with the representatives from Advantage Dental Services on the Health Council Board, Finance Committee, CAP, Operations Council, and CHP priority workgroups. Advantage Dental Services has received community reinvestment funds from the Health Council to administer point of care testing in the dental office for diabetic patients and refer to primary care as applicable. Advantage Dental Services has also received Quality Pool funds to develop a system within their EMR for member outreach efforts including texting and appointment reminder calls, funds to purchase a mobile dental unit with equipment to perform on-site dental sealants and preventive services at K-8 Crook County school, and funds to support their internal quality management program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strengthen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We will evaluate the outcomes of the programs funded by the community reinvestment funds and the Quality Pool and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. Advantage Dental Services also has a downstream provider agreement with Mosaic Medical to offer co-located, comprehensive dental services and improve</td>
</tr>
</tbody>
</table>
| Providers, oral health | Capitol Dental | Capitol Dental is a Dental Care Organization, and Capitol serves a significant portion of our CCO membership. | Develop
We have an active provider service agreement with Capitol Dental and collaborate on many community projects. We coordinate with Capitol Dental regularly via care management practices and for care coordination across the spectrum of services. Maintain
We will collaborate with the representatives from Capitol Dental on the CHP priority workgroups and other community groups. Capitol Dental has received Quality Pool funds to provide enhanced preventive dental care services to members in non-traditional settings. Strengthen
We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. Capitol Dental also has a downstream provider agreement with Mosaic Medical to offer co-located, comprehensive dental services and improve dental access within the region; this work will continue to evolve over time with plans for expansion. |
| Providers, oral health | Oregon Dental Service | Oregon Dental Service is a Dental Care Organization that serves a significant portion of our CCO membership. | Develop  
We have an active provider service agreement with Oregon Dental Service and collaborate on many community projects. We coordinate with Oregon Dental Service regularly via care management practices and for care coordination across the spectrum of services.  
Maintain  
We will collaborate with the representatives from Oregon Dental Service on the CHP priority workgroups and other community groups.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. Oregon Dental Service also has a downstream provider agreement with Mosaic Medical to offer co-located, comprehensive dental services and improve dental access within the region; this work will continue to evolve over time with plans for expansion. |
|-----------------------|----------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Providers, oral health | Willamette Dental    | Willamette Dental is a Dental Care Organization that serves a significant portion of our CCO membership. | Develop  
We have an active provider service agreement with Willamette Dental and collaborate on many community projects. We coordinate with Willamette Dental regularly via care management practices and for care coordination across the spectrum of services.  
Maintain  
We will collaborate with the representatives from Willamette Dental on the CHP priority workgroups and other community groups.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Providers, oral health | Kemple Memorial Children’s Dental Clinic | Kemple Memorial Children’s Dental Clinic provides preventative, educational, and dental treatment services for children in non-traditional settings. | Develop
We have an active provider service agreement with Kemple Memorial Children’s Dental Clinic and collaborate on many community projects. We coordinate with Kemple Memorial Children’s Dental Clinic regularly via care management practices and for care coordination across the spectrum of services.
Maintain
We will collaborate with representatives from Kemple Memorial Children’s Dental Clinic on the CHP priority workgroups and other community groups. Kemple Memorial Children’s Dental Clinic has received community reinvestment funds from the Health Council to support their “Screen and Seal” program.
Strengthen
We will evaluate the outcomes of the programs funded by community reinvestment funds and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. |

| Providers, long term services and supports including culturally specific providers as available (list in first column below) | District 10 APD | District 10 APD is our regional APD office that we partner with on shared members who need long term services and supports and/or other resourcing needs. | Develop
We have an active MOU with District 10 APD around coordination and care management for shared members.
Maintain
We will continue to engage with our partners at APD by meeting in person quarterly.
Strengthen
At our quarterly meetings we will solicit feedback and identify community needs or gaps. |

| Providers, traditional health workers including culturally specific providers as available (list in first column below) | Mosaic Medical | Mosaic Medical is a local FQHC that | Develop
We have an active provider service agreement with |
| employs Traditional Health Workers (THWs). | Mosaic Medical and collaborate on many community efforts. We coordinate with Mosaic Medical regularly via care management practices and for care coordination across the spectrum of services. The CEO of Mosaic Medical serves on the Health Council and is the co-chair of the Finance Committee. Maintain We will collaborate with the representatives from Mosaic Medical on our Board, CAC, Operations Council, and CHP priority workgroups. We also meet with leadership from Mosaic Medical on a regular cadence at the CAP Steering Committee to collaborate on ways to manage the risk arrangement, monitor quality metrics, develop Value-Based Payment (VBP) models, and discuss other community strategies. Mosaic Medical has received community reinvestment funds from the Health Council to provide prescriptions for youth physical activity opportunities, funds to support timely dental access for pediatric patients and pregnant women, and funds to provide mentorship, education, and financial support for patients with diabetes. Mosaic Medical has also received Quality Pool funds for staff SBIRT training, funds to pilot a diabetes training program, funds to administer a CAHPS survey to help bridge barriers to communication and cultural differences, funds for an adolescent well care outreach and incentive program, funds for a One Key Question initiative within their organization, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program. Strengthen We will evaluate the outcomes of all programs funded by the community reinvestment funds and the Quality Pool. |
| Providers, traditional health workers | East Cascades Women’s Group | East Cascades Women’s Group is the largest obstetrics and gynecological clinic in Central Oregon and has an embedded THW that is employed by Deschutes County Health Services. | Develop  
We have an active provider service agreement with East Cascades Women’s Group and collaborate on many community projects. We coordinate with East Cascades Women’s Group regularly via care management practices and for care coordination across the spectrum of services.  
Maintain  
We will collaborate with the representatives from East Cascades Women’s Group on the Operations Council and CHP priority workgroups.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
|-------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Providers, traditional health workers | BestCare Treatment Services | BestCare Treatment Services is the Community Mental Health Program (CMHP) for Jefferson County and a Substance Use Disorder program and employs THWs. | Develop  
We have active provider service agreements with BestCare Treatment Services and collaborate on many community projects. We coordinate with BestCare Treatment Services regularly via care management practices and for care coordination across the spectrum of services.  
The Executive Director from BestCare Treatment Services also serves on the Health Council.  
Maintain  
We will collaborate with the representatives from BestCare Treatment Services on the Health Council Board, Finance Committee, Operations Council, and CHP priority workgroups. We also meet with representatives from BestCare Treatment Services on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies. BestCare Treatment Services also serves on the Health Council Board, Finance Committee, Operations Council, and CHP priority workgroups. We also meet with representatives from BestCare Treatment Services on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Providers, traditional health workers | Lutheran Community Services, Northwest | Lutheran Community Services, Northwest is the Community Mental Health Program (CMHP) for Crook County and employs THWs. |

| | | Services has received community reinvestment funds from the Health Council to embed two full time substance use clinicians in the St. Charles Bend hospital. BestCare Treatment Services has also received Quality Pool funds to implement Mothers Outreach and Mentoring Services for pregnant women needing substance use disorder treatment. **Strengthen** We will evaluate the outcomes of the programs funded by the community reinvestment funds and the Quality Pool and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP. |

| | | Develop We have an active provider service agreement with Lutheran Community Services, Northwest and collaborate on many community projects. We coordinate with Lutheran Community Services, Northwest regularly via care management practices and for care coordination across the spectrum of services. **Maintain** We will collaborate with the representatives from Lutheran Community Services, Northwest on the Operations Council and CHP priority workgroups. We also meet with representatives from Lutheran Community Services, Northwest on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies. **Strengthen** We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
Providers, traditional health workers

### Deschutes County Behavioral Health

**Deschutes County Behavioral Health** is the Community Mental Health Program (CMHP) for Deschutes County and employs THWs.

**Develop**
We have an active provider service agreement with Deschutes County Behavioral Health and collaborate on many community projects. We coordinate with Deschutes County Behavioral Health regularly via care management practices and for care coordination across the spectrum of services.

**Maintain**
We will collaborate with the representatives from Deschutes County Behavioral Health on the Operations Council and CHP priority workgroups. We also meet with representatives from Deschutes County Behavioral Health on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies.

**Strengthen**
We will extend invitations for continued and active involvement in the 2020-2023 CHP. A Deschutes County Commissioner will hold a seat on our governing board within the next couple of months; turnover has occurred in this seat due to a recent election.

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Providers, traditional health workers

### Pfeifer and Associates

**Pfeifer and Associates** is a local Substance Use Disorder provider and employs THWs.

**Develop**
We have an active provider service agreement with Pfeifer and Associates and collaborate on many community projects. We coordinate with Pfeifer and Associates regularly via care management practices and for care coordination across the spectrum of services.

**Maintain**
Pfeifer and Associates has received community reinvestment funds from the Health Council for sober housing operations in multiple towns. We will collaborate with the representatives from Pfeifer and Associates on the CHP priority workgroups and other community...
<table>
<thead>
<tr>
<th>Providers, traditional health workers</th>
<th>Serenity Lane</th>
<th>Serenity Lane is a local Substance Use Disorder provider and employs THWs.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengthen</strong></td>
<td></td>
<td>We will evaluate the outcomes of the programs funded by the community reinvestment funds and collaborate on next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
<tr>
<td><strong>Develop</strong></td>
<td></td>
<td>We have an active provider service agreement with Serenity Lane and collaborate on many community projects. We coordinate with Serenity Lane regularly via care management practices and for care coordination across the spectrum of services.</td>
</tr>
<tr>
<td><strong>Maintain</strong></td>
<td></td>
<td>We will collaborate with representatives from Serenity Lane on the CHP priority workgroups and other community groups.</td>
</tr>
<tr>
<td><strong>Strengthen</strong></td>
<td></td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
</tr>
</tbody>
</table>

**Providers, health care interpreters (list in first column below)**

<table>
<thead>
<tr>
<th>Providers, health care interpreters</th>
<th>Mosaic Medical</th>
<th>Mosaic Medical is a local FQHC that employs certified or qualified interpreters.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop</strong></td>
<td></td>
<td>We have an active provider service agreement with Mosaic Medical and collaborate on care management practices and many community efforts. A representative from Mosaic Medical serves on the Health Council.</td>
</tr>
</tbody>
</table>
| **Maintain**                        |               | We will collaborate with the representatives from this organization on our Board, CAC, Operations Council, and CHP priority workgroups. We also meet with this organization on a regular cadence at the CAP Steering Committee to collaborate on ways to manage the risk arrangement, monitor quality metrics, develop Value-Based Payment (VBP) models, and discuss other
community strategies. This organization has received community reinvestment funds from the Health Council to provide prescriptions for youth physical activity opportunities, funds to support timely dental access for pediatric patients and pregnant women, and funds to provide mentorship, education, and financial support for patients with diabetes. This organization has also received Quality Pool funds for staff SBIRT training, funds to pilot a diabetes training program, funds to administer a CAHPS survey to help bridge barriers to communication and cultural differences, funds for an adolescent well care outreach and incentive program, funds for a One Key Question initiative within their organization, funds for increasing PCPCH tiers including behavioral health integration, and funds to support their internal quality management program.

**Strengthen**

We will evaluate the outcomes of all programs funded by the community reinvestment funds and the Quality Pool funds and collaborate on next steps. Invitations for continued involvement in the 2020-2023 CHP will be extended on a collaborative and reoccurring basis.

<table>
<thead>
<tr>
<th>Providers, health care interpreters</th>
<th>Central Oregon Pediatric Associates</th>
<th>Central Oregon Pediatric Associates is a group of primary care providers that employs certified or qualified interpreters.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Develop</strong></td>
<td></td>
<td>We have an active provider service agreement with Central Oregon Pediatric Associates and collaborate on many community projects. We coordinate with Central Oregon Pediatric Associates regularly via care management practices and for care coordination across the spectrum of services.</td>
</tr>
<tr>
<td><strong>Maintain</strong></td>
<td></td>
<td>We will collaborate with the representatives from Central Oregon Pediatric Associates on the CAP, Operations Council, and CHP priority workgroups. We also meet</td>
</tr>
</tbody>
</table>
with representatives from Central Oregon Pediatric Associates on a regular cadence to discuss quality improvement strategies. Central Oregon Pediatric Associates has received Quality Pool funds for SBIRT training, funds for implementation of a pediatric CAHPS survey, and funds for increasing PCPCH tiers including behavioral health integration and funds to support their internal quality management program.

**Strengthen**
We will evaluate the outcomes of the programs funded by the Quality Pool and collaborate on next steps. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.

<table>
<thead>
<tr>
<th>Providers, health care interpreters</th>
<th>Certified Languages</th>
<th>Certified Languages offers phone interpreting services to our providers and members.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We have an active agreement with Certified Languages to provide interpretation services for our providers and members.</td>
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<td></td>
<td></td>
<td>Maintain</td>
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<tr>
<td></td>
<td></td>
<td>We will continue to contract with and offer Certified Languages’ services to our providers and members.</td>
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<td></td>
<td><strong>Strengthen</strong></td>
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<tr>
<td></td>
<td></td>
<td>We will coordinate with Certified Languages on CLAS and health equity planning efforts.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers, health care interpreters</th>
<th>Passport to Languages</th>
<th>Passport to Languages offers phone, on-site, and video interpreter services to our providers and members.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We have an active agreement with Passport to Languages to provide interpretation services for our providers and members.</td>
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<td></td>
<td></td>
<td>Maintain</td>
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<tr>
<td></td>
<td></td>
<td>We will continue to contract with and offer Passport to Languages’ services to our providers and members.</td>
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<td></td>
<td></td>
<td><strong>Strengthen</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>We will coordinate with Passport to Languages on CLAS and health equity planning efforts.</td>
<td></td>
</tr>
</tbody>
</table>
| providers, health care interpreters | Bridges to Communications | Bridges to Communications offers on-site interpreter services to our providers and members. 
Develop | We have an active agreement with Bridges to Communications to provide interpretation services for our providers and members. 
Maintain | We will continue to contract with and offer Bridges to Communications’ services to our providers and members. 
Strengthen | We will coordinate with Bridges to Communications on CLAS and health equity planning efforts. |
| early learning hubs (list in first column below) | Early Learning Hub of Central Oregon | The Early Learning Hub of Central Oregon is an active partner that offers a voice for young children and families and their education readiness. 
Develop | We collaborate with the Early Learning Hub of Central Oregon on CHA, CHP, and other community efforts. PSCS representatives serve on the Early Learning Hub of Central Oregon’s Leadership Council. 
Maintain | We will collaborate with the representatives from the Early Learning Hub of Central Oregon on our CHP priority workgroups. 
Strengthen | We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| local public health authorities (list in first column below) | Deschutes County | Deschutes County is an engaged partner offering a variety of public health services in our communities. 
Develop | We have an active provider service agreement with the Deschutes County Public Health Department and collaborate on many community efforts. We also coordinate with Deschutes County Public Health via care management practices and for care coordination across the spectrum of services. 
Maintain | We will collaborate with the representatives from this |
organization on our Board, CAC, Operations Council, and CHP priority workgroups. Deschutes County Public Health has received community reinvestment funds from the Health Council for their Perinatal Care Continuum serving our region’s prenatal and postnatal high risk families and funds to deploy the CDC’s Diabetes Prevention Programs throughout our region. They have also received Quality Pool funds for a tobacco cessation campaign to encourage utilization of the Tobacco Quit Line, funds for an HIE interface to increase referrals to the Tobacco Quit Line, funds to print 5,000 wallet sized substance use disorder resource cards, and funds to deploy the CDC’s AFIX immunization program throughout the region.

**Strengthen**

We will evaluate the outcomes of all programs funded by community reinvestment and Quality Pool funds and collaborate on next steps. We will also facilitate member focus groups with individuals engaged with Deschutes County Public Health to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP. A Deschutes County Commissioner will hold a seat on our governing board within the next couple of months; turnover has occurred in this seat due to a recent election.

| Local public health authorities | Crook County | Crook County is an engaged partner offering a variety of public health services in our communities. | Develop

We have an active provider service agreement with the Crook County Public Health Department and collaborate on many community efforts. We coordinate with Crook County Public Health regularly via care management practices and for care coordination across the spectrum of services. A Crook County Commissioner serves on the Health Council. |
| Local public health authorities | Jefferson County | Jefferson County is an engaged partner offering a variety of public health services in our communities. | Develop We have an active provider service agreement with the Jefferson County Public Health Department and collaborate on many community efforts. We coordinate with our community’s enrollment assisters regularly via care management practices and for care coordination across the spectrum of services. A Jefferson County Commissioner serves on the Health Council. Maintain We will collaborate with the representatives from Jefferson County Public Health on our Board, CAC, Operations Council, and CHP priority workgroups. Jefferson County Public Health has received Quality Pool funds for One Key Question provider trainings in their community. Strengthen |
We will evaluate the outcomes of the Perinatal Care Continuum and collaborate on next steps. We will facilitate member focus groups with individuals engaged with Jefferson County Public Health to inform the next CHA/CHP. We will also extend invitations for continued and active involvement in the 2020-2023 CHP.

<table>
<thead>
<tr>
<th>Local mental health authorities (list in the first column below)</th>
<th>Develop</th>
<th>Maintain</th>
<th>Strengthen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local mental authority</td>
<td>Deschutes County LMHA is an engaged behavioral health partner.</td>
<td>We have an active provider service agreement with Deschutes County Behavioral Health and collaborate on many community projects. We coordinate with Deschutes County Behavioral Health regularly via care management practices and for care coordination across the spectrum of services.</td>
<td>We will collaborate with the representatives from Deschutes County Behavioral Health on the Operations Council and CHP priority workgroups. We also meet with representatives from Deschutes County Behavioral Health on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies.</td>
</tr>
<tr>
<td>Local mental authority</td>
<td>Crook County LMHA is an engaged behavioral health partner.</td>
<td>We have an active MOU with Crook County LMHA indicating our commitment to work together to support and improve health through shared behavioral health system planning and provision of clinical services. A Deschutes County Commissioner will hold a seat on our governing board within the next couple of months; turnover has occurred in this seat due to a recent election.</td>
<td></td>
</tr>
<tr>
<td>Local mental authority</td>
<td>Jefferson County</td>
<td>Jefferson County LMHA is an engaged behavioral health partner.</td>
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<td></td>
<td></td>
<td>Crook County Commissioner serves on the Health Council.</td>
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<td></td>
<td></td>
<td><strong>Maintain</strong></td>
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<tr>
<td></td>
<td></td>
<td>We will collaborate with Crook County LMHA and representatives from their CMHP, Lutheran Community Services, Northwest, on the Operations Council and CHP priority workgroups. We also meet with representatives from Lutheran Community Services, Northwest on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies.</td>
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<td></td>
<td></td>
<td><strong>Strengthen</strong></td>
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<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
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<td><strong>Develop</strong></td>
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<td></td>
<td></td>
<td>We have an active MOU with Jefferson County LMHA indicating our commitment to work together to support and improve health through shared behavioral health system planning and provision of clinical services. A Jefferson County Commissioner serves on the Health Council.</td>
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<td><strong>Maintain</strong></td>
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<td>We will collaborate with Jefferson County LMHA and representatives from their CMHP, BestCare Treatment Services, on the Health Council Board, Finance Committee, Operations Council, and CHP priority workgroups. We also meet with representatives from BestCare Treatment Services on a regular cadence to discuss the behavioral health system of care and ongoing quality improvement strategies.</td>
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<td></td>
<td></td>
<td><strong>Strengthen</strong></td>
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<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
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<tr>
<td>Other Local Government</td>
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<tr>
<td>Deschutes County</td>
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<td>Commissioners</td>
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<td>A Deschutes County</td>
<td>A Jefferson County</td>
<td>A Crook County</td>
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<td>Commissioner will hold</td>
<td>Commissioner holds a</td>
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<td>a seat on our governing</td>
<td>seat on the Health</td>
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<td>board within the next</td>
<td>Council governance</td>
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<td>couple of months;</td>
<td>Board.</td>
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<td>turnover has occurred</td>
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<td>in this seat due to a</td>
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<td>recent election.</td>
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<td><strong>Develop</strong></td>
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<tr>
<td>We have an active MOU</td>
<td>We have an active MOU</td>
<td>We have an active MOU</td>
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<td>with Deschutes County</td>
<td>with Jefferson County</td>
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<td>LPHA and LMHA indicating</td>
<td>LPHA and LMHA indicating</td>
<td>LPHA and LMHA indicating</td>
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<td>our commitment to work</td>
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<td>together to support</td>
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<td>system planning, health</td>
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<td>promotion activities,</td>
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<td>and provision of</td>
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<td>clinical services.</td>
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<td><strong>Maintain</strong></td>
<td><strong>Maintain</strong></td>
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<td>We will collaborate</td>
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<td>with the county</td>
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<td>commissioners regarding</td>
<td>commissioners regarding</td>
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<td>CHA, CHP, and other CCO</td>
<td>CHA, CHP, and other CCO</td>
<td>CHA, CHP, and other CCO</td>
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<td>and community activities.</td>
<td>and community activities.</td>
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<td><strong>Strengthen</strong></td>
<td><strong>Strengthen</strong></td>
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<td>We will solicit</td>
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<td>feedback from the</td>
<td>feedback from the</td>
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<td>regarding the shared</td>
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<td>agreements in our MOU.</td>
<td>agreements in our MOU.</td>
<td>agreements in our MOU.</td>
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</tr>
</tbody>
</table>
| Other Local Government | Bend City Council | Board. | health system planning, health promotion activities, and provision of clinical services.  
  
  **Maintain**  
  We will collaborate with the county commissioners regarding CHA, CHP, and other CCO and community activities.  
  
  **Strengthen**  
  We will solicit feedback from the county commissioners regarding the shared agreements in our MOU |
|---|---|---|---|
| City of Bend Planning Commission | PacificSource has a staff member that sits on the City of Bend Planning Commission and the Transportation Steering Committee, which is developing the next transportation plan for the region. | Develop  
  A PSCS staff member serves on the City of Bend Planning Commission and who is also a member of the Health Council’s Finance Committee.  
  
  **Maintain**  
  We will collaborate with the representatives from the City of Bend Planning Commission on the CHA, CHP, and other community activities.  
  
  **Strengthen**  
  We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
### Tribes, if present in the service area (list in first column below)

<table>
<thead>
<tr>
<th>Tribes</th>
<th>Confederated Tribes of Warm Springs</th>
<th>The Confederated Tribes of Warm Springs has representation on our CHA/CHP Steering Committee.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Confederated Tribes of Warm Springs</td>
<td></td>
<td>We have representatives from the Confederated Tribes of Warm Springs on our CHA/CHP Steering Committee.</td>
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<tr>
<td></td>
<td></td>
<td>PSCS also participates in the Warm Springs Native Aspirations community group.</td>
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<td></td>
<td></td>
<td>Maintain</td>
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<td></td>
<td></td>
<td>We will collaborate with the representatives from this organization on the CHA, CHP, and other community activities.</td>
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<td></td>
<td>Strengthen</td>
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<tr>
<td></td>
<td></td>
<td>We will extend invitations for continued and active involvement in the 2020-2023 CHP.</td>
<td></td>
</tr>
</tbody>
</table>

### Regional Health Equity Coalitions, if present in the service area (list in first column below)

<table>
<thead>
<tr>
<th>Regional Health Equity Coalitions</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>N/A</td>
<td>N/A</td>
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</tbody>
</table>

### Health Services in an Educational Setting (list in first column below)

<table>
<thead>
<tr>
<th>Health Services in an Educational Setting</th>
<th>High Desert Education Service District</th>
<th>High Desert Education Service District is a regional support system that links school districts in Central Oregon to state and national education resources.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Representatives from the High Desert Education Service District serve on the Health Council and the CHP priority workgroups.</td>
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<td></td>
<td></td>
<td>Maintain</td>
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<tr>
<td></td>
<td></td>
<td>High Desert Education Service District has received community reinvestment funds from the Health Council to train over 3,000 educators in our region on trauma-informed care practices. We will collaborate with the representatives from High Desert Education Service District on the CHA, CHP, and other community activities.</td>
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<td></td>
<td></td>
<td>Strengthen</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>We will evaluate the outcomes of the programs funded by the community reinvestment funds and collaborate on next steps. We will extend invitations for continued and</td>
<td></td>
</tr>
</tbody>
</table>
| Health Services in an Educational Setting | Bend-La Pine School District | This is the local school district serving students in Bend and La Pine geographical areas. | Develop  
We have representatives from the Bend-La Pine School District on the CAC and the CHP priority workgroups.  
Maintain  
We will collaborate with the representatives from Bend-La Pine School District on the CHA, CHP, and other community activities.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Health Services in an Educational Setting | School-Based Health Centers | We have nine School Based Health Centers throughout our region. | Develop  
We have representatives from regional School-Based Health Centers on the CHP priority workgroups.  
Maintain  
We will collaborate with the representatives from the regional School-Based Health Centers on the CHA, CHP, and other community activities.  
Strengthen  
We will extend invitations for continued and active involvement in the 2020-2023 CHP. |
| Health Services in an Educational Setting | OSU-Cascades | OSU-Cascades is the only university in our region that offers both baccalaureate and graduate programs. | Develop  
We have representatives from OSU-Cascades on the CHP priority workgroups.  
Maintain  
OSU-Cascades has received community reinvestment funds from the Health Council to implement health and wellness education and outreach opportunities. We will collaborate with the representatives from OSU-Cascades on the CHA, CHP, and other community activities.  
Strengthen  
We will evaluate the outcomes of the programs funded by the community reinvestment funds and collaborate on |
next steps. We will extend invitations for continued and active involvement in the 2020-2023 CHP.

| ORS 190 organizations (list in first column below) | COIC provides regional services in employment and training, alternative high school education, business loans, transportation, and community and economic development. | Develop
We have an active provider service agreement with COIC as our NEMT brokerage. The Executive Director of COIC is the chair of the Health Council. Maintain
COIC has received Quality Pool funds for a travel training program which teaches differently-abled individuals how to effectively navigate the public transportation system. We also meet with COIC on a regular cadence to discuss quality improvement strategies. We will collaborate with representatives from COIC on the Health Council Board, CHA, CHP, and other community activities. Strengthen
We will evaluate the outcomes of the programs funded by the Quality Pool funds and collaborate on next steps. Invitations for continued involvement in the 2020-2023 CHP will be extended on a collaborative and reoccurring basis. |

ORS 190 organization | Central Oregon Intergovernmental Council (COIC) | |
### Table 2: Major activities and deliverables for which the CCO will engage the community

All applicants must complete this full table.

<table>
<thead>
<tr>
<th>Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.</th>
<th>Part 2b. Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHA</td>
<td>5) Shared decision-making, 4) Collaborate.</td>
</tr>
<tr>
<td>CHP</td>
<td>5) Shared decision-making, 4) Collaborate.</td>
</tr>
<tr>
<td>SDOH spending priorities</td>
<td>5) Shared decision-making, 4) Collaborate.</td>
</tr>
<tr>
<td>Health Related Services spending</td>
<td>5) Shared decision-making, 4) Collaborate.</td>
</tr>
<tr>
<td>TQS</td>
<td>3) Involve, 2) Consult.</td>
</tr>
<tr>
<td>Member engagement strategies</td>
<td>4) Collaborate.</td>
</tr>
<tr>
<td>Policy development</td>
<td>3) Involve, 2) Consult.</td>
</tr>
<tr>
<td>Setting priorities for health care</td>
<td>4) Collaborate.</td>
</tr>
</tbody>
</table>

*  
1) **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.  
2) **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.  
3) **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.  
4) **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.  
5) **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.
Table 3: Engagement with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans

All applicants must complete this full table. Applicants may add rows as needed.

<table>
<thead>
<tr>
<th>Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 2.</strong> List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.</td>
</tr>
<tr>
<td><strong>Part 3.</strong> The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers* must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**</td>
</tr>
<tr>
<td><strong>Part 4.</strong> For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.**</td>
</tr>
<tr>
<td><strong>Part 5.</strong> For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization (s), including gaps.</td>
</tr>
<tr>
<td><strong>Part 6.</strong> For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates.</td>
</tr>
</tbody>
</table>
| **Part 7.** Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations.
Local public health authorities (list in this column below)


Non-profit hospitals (list in this column below)
<table>
<thead>
<tr>
<th>St. Charles Health System</th>
<th>Collaboration</th>
<th>Behavioral Health: Identification/Awareness</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

**Current coordinated care organizations, as of 2019 (list in this column below)**

| PacificSource Community Solutions | Collaboration | 1. Behavioral Health (Identification/Awareness and Substance Use/Chronic Pain)  
2. Reproductive and Maternal/Child Health  
3. Cardiovascular Disease  
4. Diabetes  
5. Oral Health  
6. Social Determinants of Health (Housing and Kindergarten Readiness) | N/A | N/A | N/A |

**Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)**

| Confederated Tribes of Warm Springs | Competition and Cooperation | N/A | The Confederated Tribes of Warm Springs did not engage in our previous CHA/CHP activities but is now represented on our current CHA/CHP Steering Committee and is an active partner. | The Confederated Tribes of Warm Springs has representation has been engaged on the CHA/CHP Steering Committee since 2018 and will continue to collaborate on the 2019 CHA and 2020-2023 CHP activities. | N/A |

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* a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows;
independent goals; adapting to each other or accommodating others’ actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.

b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.

c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.

d) Not applicable

**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).**

***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP***
<table>
<thead>
<tr>
<th>All applicants must</th>
<th>Applicants with an existing CHA and CHP must complete Parts 2, 3 and 4. Applicants that intend to change their service area must also complete Parts 2, 3, and 4.</th>
<th>Applicants without an existing CHA and CHP or that intend to change their service area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1.</strong> List of organizations that address the social determinants of health and health equity in the applicant’s service area. Add additional rows as needed.</td>
<td><strong>Part 2.</strong> Applicants with an existing CHA and CHP will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.</td>
<td><strong>Part 2a.</strong> Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one CHA and CHP, b) the applicant did not have a relationship with the organization, c) the applicant is working with the organization to address gaps in existing relationships.</td>
</tr>
<tr>
<td><strong>Part 3.</strong> Applicants with an existing CHA and CHP will describe gaps in existing relationships with identified organizations.</td>
<td><strong>Part 4.</strong> Applicants with an existing CHA and CHP will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**</td>
<td><strong>Part 4a.</strong> Applicants without an existing CHA and CHP or that intend to change their service area will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure funding for engagement.**</td>
</tr>
</tbody>
</table>
All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.

<table>
<thead>
<tr>
<th>Tribe Name</th>
<th>Description</th>
<th>Notes</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Confederated Tribes of Warm Springs</td>
<td>We continue to work on partnerships within The Confederated Tribes of Warm Springs and collaborate with them whenever possible. We have had a presence on their local radio station, via health promotion interviews and ads, and participated in their health fair activities. Representatives from Warm Springs did not engage in our current CHA/CHP activities.</td>
<td>A representative from The Confederated Tribes of Warm Springs sits on the CHA/CHP Steering Committee, which is currently meeting at least monthly for the 2019 CHA and 2020-2024 CHP development and implementation.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.

<table>
<thead>
<tr>
<th>RHEC Name</th>
<th>Description</th>
<th>Notes</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no RHECs in the service area.</td>
<td></td>
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</tbody>
</table>

Local government, including counties

<table>
<thead>
<tr>
<th>County Name</th>
<th>Description</th>
<th>The Health Council’s CHA/CHP engagement assessment identified no gaps.</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deschutes County</td>
<td>Deschutes County is an active and engaged partner in CCO and community activities. They actively collaborated in our current CHA/CHP and have adopted all priorities and strategies for their own internal improvement plans.</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crook County</td>
<td>Crook County is an active and engaged partner in CCO and community activities. They actively collaborated in our current CHA/CHP and have adopted all priorities and strategies for their own internal improvement plans.</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Health Council’s CHA/CHP Engagement Assessment</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
<tr>
<td>Jefferson County</td>
<td>Jefferson County is an active and engaged partner in CCO and community activities. They actively collaborated in our current CHA/CHP and have adopted all priorities and strategies for their own internal improvement plans.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Organizations that address the four key domains of social determinants of health* (list in this column below).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bethlehem Inn</td>
<td>We have an active MOU with the Bethlehem Inn for HRS to show specific outcomes for members who seek their services. Representatives from Bethlehem Inn are active participants in the CHP workgroup focused on SDOH: Housing.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>High Desert Education Service District</td>
<td>The Health Council has reinvested shared savings into a trauma informed “culture of care” program that the High Desert Education Service District will implement over the next two years. Representatives from High Desert Education Service District collaborated on the development of the current CHA/CHP and are also active on the SDOH: Kindergarten Readiness CHP workgroup.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Bend-La Pine School District</td>
<td>We have representatives from the Bend-La Pine School District on the CAC and the CHP priority workgroups.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>United Way</td>
<td>The Health Council has reinvested shared savings into a community movement called “Trauma, Resilience, and Adverse Childhood Experiences” that will be implemented over the next two years. Representatives from United Way serve on our CAC and collaborated on the development of the current CHA/CHP.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Neighbor Impact</td>
<td>The Health Council has reinvested shared savings into Neighbor Impact’s Head Start mental health support services. Representatives from Neighbor Impact served on our CAC and collaborated on the development of the current CHA/CHP.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Family Resource Center</td>
<td>Family Resource Center teaches parenting skills throughout the region and had representation on our CAC when the current CHA/CHP process was underway</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Engagement Assessment</td>
<td>Notes</td>
<td></td>
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<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Full Access High Desert</td>
<td>Full Access High Desert provides support services to individuals with intellectual and developmental disabilities. Our CAC membership has included a Full Access High Desert employee during the current CHA/CHP process when priorities were adopted and will continue through the next CHA/CHP process and prioritization.</td>
<td>The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Homeless Leadership Coalition</td>
<td>The Homeless Leadership Coalition engages the region through education, advocacy, planning, prioritization, and accountability for services to persons experiencing homelessness. This organization has representatives on our CAC and CHP priority workgroups. They are actively collaborating in our next CHA/CHP.</td>
<td>During the development and implementation of the 2015 CHA and 2016-2019 CHP the Homeless Leadership Coalition did not have the resources and community engagement that they have now. They are now active partners who will be engaged in the next iteration of the CHA/CHP.</td>
<td>We will extend invitations for continued and active involvement in the 2019 CHA and 2020-2023 CHP no later than 11/1/19.</td>
<td></td>
</tr>
<tr>
<td>Central Oregon Veterans Outreach</td>
<td>The Central Oregon Veterans Outreach</td>
<td>During the development and implementation of</td>
<td>We will extend invitations for continued</td>
<td></td>
</tr>
</tbody>
</table>

|                      |                                                                 |                       | Notes                                  |
| Outreach | Supports veterans and their families by providing a variety of housing alternatives, as well as job search preparedness and placement assistance. They are actively collaborating in our next CHA/CHP. | the 2015 CHA and 2016-2019 CHP the Central Oregon Veterans Ranch did not have the resources and community engagement that they have now. They are now active partners who will be engaged in the next iteration of the CHA/CHP. | and active involvement in the 2019 CHA and 2020-2023 CHP no later than 11/1/19. |  |

<table>
<thead>
<tr>
<th><strong>Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mosaic Medical</td>
<td>Mosaic Medical is an active and engaged partner in CCO and community activities. Representatives from Mosaic Medical sit on the Health Council governing board, Community Advisory Council, Clinical Advisory Panel, Finance Committee, Operations Council, and multiple CHP workgroups. They also actively collaborated in our current CHA/CHP. The Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
</tr>
<tr>
<td>BestCare Treatment Services</td>
<td>BestCare is an active and engaged partner in CCO and community activities. Representatives from BestCare sit on the Health Council’s CHA/CHP engagement assessment identified no gaps.</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Health Council governing board,</td>
<td></td>
</tr>
<tr>
<td>Finance Committee, Operations</td>
<td></td>
</tr>
<tr>
<td>Council, and multiple CHP workgroups. They also actively collaborated in our current CHA/CHP.</td>
<td></td>
</tr>
<tr>
<td>Deschutes County Health Services</td>
<td>Deschutes County is an active and engaged partner in CCO and community activities. Representatives from Deschutes County sit on the Health Council governing board, Community Advisory Council, Operations Council, and multiple CHP workgroups. They also actively collaborated in our current CHA/CHP.</td>
</tr>
<tr>
<td>Lutheran Community Services,</td>
<td>Lutheran is an active and engaged partner in CCO and community activities. Representatives from Lutheran sit on the Operations Council and multiple CHP workgroups. They also actively collaborated in our current CHA/CHP.</td>
</tr>
<tr>
<td>Northwest</td>
<td></td>
</tr>
<tr>
<td>Pfeifer and Associates</td>
<td>Pfeifer and Associates is an active and engaged</td>
</tr>
</tbody>
</table>
partner in CCO and community activities. Representatives from Pfeifer actively collaborate in our CHP workgroups.

Serenity Lane is an active and engaged partner in CCO and community activities. Representatives from Serenity Lane actively collaborate in our CHP workgroups.

The Health Council’s CHA/CHP engagement assessment identified no gaps.

**Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Engagement Details</th>
<th>Actions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino Community Association</td>
<td>The Latino Community Association is an engaged partner and their Executive Director holds a seat on our CAC. Representatives from the Latino Community Association did not engage in our current CHA/CHP development.</td>
<td>We extended invitations to the Latino Community Association to attend community meetings and feedback sessions for collaboration on the current CHA/CHP priorities.</td>
<td>N/A</td>
</tr>
<tr>
<td>Let’s Talk Diversity</td>
<td>Let’s Talk Diversity is an engaged partner but did not engage in our current CHA/CHP development.</td>
<td>We extended invitations to Let’s Talk Diversity to attend community meetings and feedback sessions for collaboration on the current CHA/CHP priorities</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment,*

Attachment 10-RFA Community Engagement Plan Required Tables  Page 63 of 66
Engagement activities **must** begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.
Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants

<table>
<thead>
<tr>
<th>Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.</th>
<th>Part 1a. Source for priority (i.e. which CHP it came from).</th>
<th>Part 1b. Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) or priority populations (i.e. addressing early childhood education for children as a priority population) or other.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>2016-2019</td>
<td>Other: increasing affordable and alternative housing opportunities</td>
</tr>
</tbody>
</table>

**Part 2. Description of process through which the applicant will identify and vet SDOH-HE priorities** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority.
- Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities.
- If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.

**Timelines**
We will align SDOH-HE spending priorities with CHP priorities (selected at the end of 2019 and vetted by the CAC and community partners listed in Table B, Part 1) by February 2020. The 2020-2023 CHP will include SDOH-HE components as selected by the prioritization process described below. The prioritization process will occur at the end of 2019. We will determine and approve SDOH-HE spending priorities by the end of January 2020 and by the end of November preceding any subsequent contract year.

**Milestones**
During development of the CHA, an epidemiologist from Deschutes County Health Services analyzes data to identify health trends and themes from the CHA. Workgroups prioritize trends and themes by impact, preventability/controllability, and
feasibility. The CAC will determine 2-4 SDOH-HE priorities and infrastructure needs/gaps for the implementation plan based on the CCO Contract criteria. Priorities will align with the CHP and TQS and fall in one of the four SDOH-HE domains. SDOH-HE priorities will also include the OHA-identified statewide priority, which for 2020-2021, is housing-related services and supports (including supported housing).

Methods
Central Oregon health system and community partners created the current CHA and CHP and are now working on the next iteration of the CHA and CHP, with leadership from the Health Council. The Operations Council of the Health Council used a planning process called Mobilizing for Action through Planning and Partnership (MAPP) to guide the creation of the CHA. They use data, input, and information from a wide variety of health and community-based organizations, stakeholders, and community members to develop the CHA. The Community Advisory Council, individuals from a number of health-related advisory boards and groups, and individuals from community meetings in Crook, Deschutes, and Jefferson Counties also provide input to develop the CHA. Information from these community meetings not only informs development of the CHA, but that information is also used to develop priority health issues in the CHP. This is a system and process that we have used previously, and we have evaluated it to ensure that we are maximizing community engagement and member voice. The current 2016-2019 CHP includes two SDOH-HE components: housing and milestones to health and education. After the CAC and community members establish 2020-2024 CHP priorities, the CAC will determine the SDOH-HE priorities that align.

* Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).

** The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.
1. General Component (Narrative and Tables 1 and 2)

1. Identify Stakeholders.
   Please see attached in Table 1.
   2. Community Engagement in Major Projects, Programs, and Decisions.
   3. Process to Provide Input.
4. **Elevate Member Voice.**

5. **Barriers and Resolution.**
   a. We have identified the following potential barriers to community engagement:
   - 
   b. We propose to address barriers using the following strategies.

2. CAC Component (Narrative)
   1. Community Advisory Council:
      a. Formation Strategies.
      This Section is not applicable. Please see below.
      b. Existing CAC.
3. Meaningful Engagement

c. Meaningful Engagement.

d. Collaboration Strategies.

3. CHA/CHP Component (Narrative and Tables 3, 4, and 5)

5. Linking Health-Related Services Community Benefit Initiatives with the CHP.
Attachment 10 – Social Determinants of Health and Health Equity Questionnaire

Attachment 10, Section A.1.a: Did Applicant obtain Community involvement in the development of the Application?
Yes, PSCS involved the community in the development of the application. We met with many providers and community stakeholders as part of the community governance structure and specifically to discuss plans for 2020-2024, unmet needs, community opportunities, and strategic plans. We specifically discussed our proposed approach and made changes in response to community input.

Attachment 10, Section A.1.b: Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies. Please see attached.

Attachment 10, Section B.1.a: Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.
Yes, PSCS holds many agreements and MOUs with entities that meet the definition of SDOH-HE partners, including housing partners. The CCO’s governing body, the Central Oregon Health Council (Health Council), also has agreements and MOUs to invest CCO shared savings with multiple SDOH-HE partners and programs. The Health Council is a body of community stakeholders. It consists of a Board of Directors, staff, and legislatively required or ad-hoc committees, that together, function as the governing body of the CCO. The Health Council selects SDOH-HE partners by CHP priorities and forms workgroups focused on programming and regional work plans. Workgroups are open to the public and the Health Council shares quarterly updates of all workgroup processes, work plans, and investments transparently in public meeting packets. Here are examples:

Housing. PSCS has an MOU with Pacific Crest Affordable Housing where we act in an advisory capacity for their initiatives to support health and housing. We also have an MOU with a regional homeless shelter, Bethlehem Inn, which supports our members with funding for Health Related Services. Bethlehem Inn is collecting outcome data on members receiving services through this funding. The first year of the pilot demonstrated improvements in more stable housing, income, employment, mental health, safety, and overall well-being. The Health Council has an agreement with DAWNS House and invests shared savings in their programs. DAWNS House provides a safe and compassionate living option for homeless, newly sober women seeking long-term recovery.

SDOH-HE. The Health Council has an agreement with the local United Way to support the Trauma, Resiliency, and Adverse Childhood Experiences (TRACES) movement dedicated to making Central Oregon a region where every individual has the strengths, social connectedness, and community resources they need to thrive. Using CCO shared savings, TRACES will identify...
a high-risk population (kids experiencing foster care), study the total possible spectrum of children’s needs (health, development, education, social connectedness, etc.), and assess a defined population to identify ‘how much’ is needed. Once this work is completed, TRACES and partners will work to attract and direct (potentially significant) resources to agencies that can fulfill the identified needs. PSCS committed significant financial, staff and analytic resources to TRACES.

**Education.** In partnerships with our six regional school districts, early learning providers, institutions of higher education, and TRACES, Better Together is launching an initiative to ensure cultures of care exist across education systems. The Health Council is investing shared savings in this work, which includes training over 3,000 educators in trauma-informed care and practices, ensuring trauma-informed policies and procedures are in place, and increasing capacity for coaching in trauma-informed practices through our local Education Service Districts. The ultimate aim of this initiative is to close disparities in critical outcomes.

**Attachment 10, Section B.1.b: Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.**

Yes, PSCS has performance milestones and metrics in place related to SDOH-HE. These milestones and metrics are incorporated into multiple provider and community partner agreements and MOUs. For example, PSCS has a program agreement with a regional homeless shelter, Bethlehem Inn, which supports our members and Bethlehem Inn’s programs through Health-Related Services funding. Performance milestones in the program agreement include obligations for the Bethlehem Inn to provide shelter and case management services to CCO members that are residents, establish workable self-sufficiency action plans, and have those residents select and establish a relationship with a Primary Care Provider within the first 30 days of residency. Additional agreement milestones include the Bethlehem Inn referring CCO members to behavioral health specialists and making specialists available on-site for ease of access. The outcomes from the first year of the pilot demonstrated improvements in more stable housing, income, employment, mental health, safety, and overall well-being. We have an evaluation plan in place related to year-two milestones and metrics. All SDOH-HE partners and programs listed in **Section B.1.a, above, also have agreements and MOUs with the Health Council that include specific milestones or metrics. Recipients of CCO shared savings report their outcomes after one year of implementation and each program has a formal evaluation plan.**

In addition, PSCS is participating in the Oregon Accountable Health Communities (AHC) project. The AHC project is designed to help better understand and address the impact of SDOH on the needs of Medicare and Medicaid members in our CCO region. Under the Oregon Rural Practice-Based Research Network, a consortium of health and social service organizations in four regions of the state were recently awarded the five-year, $4.5M AHC grant by the Centers for Medicare and Medicaid Innovation. Central Oregon is one of the four CCO regions involved in the project. The purpose of the grant is to identify health-related social needs within participating communities and create community-wide support for the highest need residents by implementing screening of Medicaid and Medicare members, including: housing, food, utilities, transportation, connecting patients to community services, and developing a tailored referral and care plan for a subset of high risk patients. The study primarily seeks to determine if screening
for social needs plus tailored navigation to health and social services leads to improved outcomes and reduced costs of care. The AHC project is part of our 2019 Transformation and Quality Strategy (TQS) and includes a suite of metrics.

Attachment 10, Section B.1.c: Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.

Yes, please see the attached policy titled “Social Determinants of Health and Health Equity, Quality Pool, and Community Benefit Initiative Spending” (the “Spending Policy”).

Attachment 10, Section B.1.d: Please describe how Applicant intends to award funding for SDOH-HE projects, including: (1) How Applicant will guard against potential conflicts of interest.

PSCS will work in partnership with the Health Council to establish a structure for awarding funds for SDOH-HE activities. In our process of awarding funding, we will adhere to the conflict of interest policy details and how they will be enforced, and will communicate in written form, post on PSCS and Health Council websites and through SDOH-HE funding opportunity webinars. Consistent with these policies, individuals from organizations that may benefit monetarily from a proposed project will be required to recuse themselves from the process of reviewing and voting on funding decisions. In addition, as described in Section B.1.d of this attachment, final decisions will be made in meetings that are open to the public, using explicit criteria and the results of structured scoring in the decision making process.

Attachment 10, Section B.1.d: Please describe how Applicant intends to award funding for SDOH-HE projects, including: (2) How Applicant will ensure a transparent and equitable process.

SDOH-HE spending decisions will be made through a transparent and equitable process that includes the following: a public process by the CAC to determine spending priorities, explicit criteria for projects, explicit criteria for organizations eligible to receive funding, public notice of funding opportunities and timelines, and a structured review process that includes compliance screening and use of a scoring rubric. We will use written decision-making processes, approved by the Health Council, and we will follow them in evaluating applicants. We will publicly announce the projects that are funded, including amounts awarded and planned work.

Attachment 10, Section B.1.d: Please describe how Applicant intends to award funding for SDOH-HE projects, including: (3) How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.

Eligible SDOH-HE partners will submit proposals that include an evaluation plan, expected outcomes, and budget. The CAC, in collaboration with Health Council and CCO staff, will review and select proposals that are sufficiently aligned with the selected SDOH-HE priorities. The CAC, in collaboration with Health Council and CCO staff, will direct and track SDOH-HE spending and will review project evaluations and outcomes at least annually. We will publicly share a description of funded projects. After the projects have been implemented for at least one year, we will request evaluations and share outcomes publicly.
Attachment 10, Section B.1.e: For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area. We think it is wise to use a blend of process and outcome metrics. Specific to outcome metrics, we propose the following: 1) increase over baseline the number of low-income families or individuals that transition into stable housing (including families or individuals exiting out of sober living, transitional housing, shelters, hotels, or motels, or those defined as precariously housed); and 2) increase over baseline the percent of members who receive support for utilities to remain housed if they are paying rent above 30% of the Area Median Income.

Attachment 10, Section B.2.a: Please describe the criteria Applicant will apply when selecting SDOH-HE partners. The CAC will determine the qualifications of SDOH-HE partners to be eligible for funding based on their subject matter expertise in the approved priorities and their current engagement in community efforts that align with CHP and TQS priorities. Eligible SDOH-HE partners will be invited to submit proposals. We will have a structured and open application process that would welcome any eligible participant. We will select SDOH-HE partners that are in good standing and actively involved in community efforts that align with CHP and TQS priorities. We will apply the Spending Policy in a transparent and equitable manner.

Attachment 10, Section B.2.b: Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process. The CAC will determine two to four priorities and infrastructure needs/gaps for the SDOH-HE spending implementation plan based on the CCO contract criteria. The CAC will determine the qualifications of SDOH-HE partners to be eligible for funding based on their subject matter expertise in the approved priorities and their engagement in community efforts that align with CHP and TQS priorities. Eligible partners will be invited to submit proposals that include an evaluation plan, expected outcomes, and budget. The CAC, in collaboration with Health Council and CCO staff, will review and select proposals that are sufficiently aligned with the selected SDOH-HE priorities. These processes and discussions will occur at public CAC meetings. Milestones will be shared publicly with the Health Council, CAP, CAC, and other workgroups. We will collaborate on and share the Spending Policy with the Health Council, CAP, CAC, CHP workgroups, and other subcommittees. The Spending Policy includes details regarding how spending priorities will be chosen and the project selection process. PSCS and the Health Council will broadly communicate the availability of funds and the process for applying via public meetings, email distribution lists, websites, newsletters, webinars, and other forums as appropriate. We will operate the SDOH-HE spending plan in a transparent and equitable manner.

Attachment 10, Section B.2.c: Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection. Applicants will submit SDOH-HE proposals electronically in the Health Council’s grant management system. That system will track and report SDOH-HE expenses. The grant management system has the technological capacity to collect proposal data and run financial reports. Eligible SDOH-HE partners will submit proposals that include an evaluation plan and
expected outcomes. Outcomes collection and evaluation plans may include the SDOH-HE partner completing these tasks themselves with their own technological capacity or using a third party. These plans will be confirmed between the applicant and the review committee. The CAC, in collaboration with Health Council and CCO staff, will direct and track SDOH-HE spending and will review project evaluations and outcomes at least annually. We will publicly share a description of funded projects once they are approved. After the projects have been implemented for at least one year an evaluation report will be requested from the project owners and a summary of outcomes will be shared publicly. This information will be shared transparently via Health Council and CAC public meetings, email distribution lists, websites, newsletters, and other community forums as appropriate.

Attachment 10, Section B.2.d: Applicant will submit a plan for selection Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in Section A. The Spending Policy outlines the process for selecting spending priorities. The CAC will determine two to four priorities and infrastructure needs/gaps for the implementation plan based on the CCO contract criteria by the end of January 2020 and the end of November preceding any subsequent contract year. Priorities will be aligned with the CHP and TQS and also fall in one of the four SDOH-HE domains. Priorities will also include the OHA-identified priority, housing-related services and supports, including supported housing. SDOH-HE spending priorities will be vetted by the CAC, Health Council, and community partners listed in Table B, Part 1 of the Community Engagement Plan Tables. The Health Council shall approve or reject the CAC’s recommendation within 30 days based on its evaluation against the stated process.

Attachment 10, Section C.1.a: Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities. The regional CHP will be the foundational document for setting spending priorities for the Community Benefit Initiatives (CBI), one of several funding streams to address SDOH-HE needs. Aligning spending with CHP priorities is an established and effective practice in our experience as a CCO, and that experience informs plans for SDOH-HE spending across multiple funding streams in 2020 and beyond. In an effort to create overall alignment between CBI spending and the SDOH-HE, funds coming from the State Quality Pool and from CCO net margin, a similar prioritization will be used across these funding streams, with differentiation in process based on the requirements particular to each stream.

Community Benefit Initiatives will be funded using 1/10 of the 1% of net revenue that is designated for SDOH-HE spending by the Health Council, equaling 0.1% of CCO revenue. Because Health Related Services have more clearly defined parameters than other types of SDOH-HE spending, every proposed CBI will need to meet at least one of the criteria as outlined in the “Health-Related Services FAQ” produced by the OHA.

Consistent with the SDOH-HE spending requirements, each year the CAC will use the CHP, the
state SDOH-HE domains, and the OHA-designated statewide priority to establish priority areas for spending. For CBI, the planned spending model is a single annual cycle of three to five grants per CCO. In addition, because of the requirements particular to CBI, PSCS will assist the CAC in identifying registries of evidence-based and promising practices to be funded, including those published by the Social Interventions Research and Evaluation Network, Centers for Disease Control, University of California, San Francisco Social Interventions Research & Evaluation Network, and others. The CAC will determine the criteria for partners who will be eligible to receive funding, including their experience in priority areas and their history of engagement and performance in similar community efforts. A request for proposals process will be conducted, including a preliminary Letter of Interest screening to assist agencies in determining if they meet criteria for receiving funding. Organizations invited to submit proposals will need to include an evaluation plan, expected outcomes, and budget as well as documentation of how their proposed intervention addresses a priority area, meets the Health Related Services criteria listed above, and draws on information in an approved registry. PSCS will pre-screen applications for compliance with Medicaid and other required elements. The CAC or a designated subgroup will then review and select proposals that are aligned with the selected CBI priorities.

Attachment 10, Section D.1.a: Community Advisory Council membership and role - Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant’s Service Area

Attachment 10, Section D.2.a: Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix.

Please see the attached Community Engagement Plan narrative and required tables.

Attachment 10, Section E.1.a: Please briefly describe the Applicant’s current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity. Organizational Staff (Employed and Contracted Workforce). PSCS currently develops, administers, and monitors completion of training material. Our systems are scalable. For example, we currently use our web-based Learning Management System (LMS) to ensure staff are up-to-date on training, including required trainings such as fraud, waste, and abuse, HIPAA,
and privacy/security. We can tailor the LMS as needed based on the requirements of each functional area where training needs may vary. PSCS leadership has committed to training our employee base on topics related to diversity, health, and health equity. Subject matter experts oversee the development of this training curriculum, including the development and implementation of a cultural responsivity training plan for CCO staff and leadership. The team’s managing director and training lead have completed the Developing Leadership through Training and Action program. We integrate these trainings into a continuum of learning and growth programming including new employee orientations and leadership development programs. In 2019, PSCS will launch training developed by Quality Interactions, Inc., an OHA-approved cultural competency continuing education vendor as a complement to in-person trainings and as a key element of our cultural competency continuing education plan. This will introduce a menu of cultural responsiveness topics, including a mandatory module focused on implicit bias. We will integrate this to administer and monitor the training for all employees. In addition, PSCS will make the training modules available to Health Council staff and other community partners.

Providers and Subcontractors. Our Provider Network Department has infrastructure, policies, and processes in place to develop, administer, and monitor completion of provider and subcontractor trainings on a variety of topics. For example, we maintain a compliance program that utilizes a provider-facing website with information on topics such as provider training and education, examples of compliance and FWA issues, and reporting of these issues. Providers are also able to access CMS approved training modules from this site and are required to report completion using a training attendance log. To fulfill OHA requirements, we are considering making key training activities available to our network of CCO providers and subcontractors who do not have access to such tools, leveraging this and other existing platforms. Our Provider Network Department also conducts annual site visits to monitor provider and subcontractor compliance with required trainings. We monitor provider completion of cultural competency training and update this information regularly in our records. PSCS does not explicitly require providers or subcontractors to complete training topics on diversity, health, and health equity at this time. As discussed above, and in advance of CCO 2.0 requirements, we are developing plans to extend training resources related to health and health equity to illustrate our commitment to this. We also continue to work diligently to advance the National Culturally and Linguistically Appropriate Services (CLAS) Standards as part of our Transformation and Quality Strategy (TQS). We developed trainings related to CLAS and offered these in a variety of modalities. We introduced CLAS Standards language into our provider contracts. As part of our quality strategy and long-term roadmap, PSCS will introduce a system to monitor which providers are complying with CLAS Standards, specifically tracking policies for cultural competency/responsiveness, continuing education, and language access plans and policies that ensure use of qualified or certified medical interpreter services.

Attachment 10, Section E.1.b: Please describe Applicant’s capacity to collect and analyze REAL+D data.

PSCS has significant experience and capacity to collect and analyze REAL+D data. PSCS is committed to embodying the national CLAS Standards. Consistent with Standard 11, our Analytics, Business Intelligence, IT, and Community Engagement Departments work together as one team to continually improve our capacity to use data to ensure our services are culturally responsive and effective at engaging populations that experience health disparities or unmet
Our teams are staffed with subject matter experts who have MPH and PhD credentials, as well as other degrees and certifications focused explicitly on the reduction of health disparities. Three team members have graduated from the Developing Equity Leadership through Training and Action program and, collectively, we are focused on transforming, joining, and storing a variety of demographic data sources for analytical purposes, including REAL+D data received from OHA. We produce reports accessible to our quality and population health teams, and our team of analysts and IT professionals have the skill sets necessary to identify meaningful patterns, differences, and areas of interest using demographic information. Our teams also have the capacity to train and educate others and we also built a roadmap to expand our capacity in years 2021 through 2024.

Attachment 10, Section E.2.a: Please provide a general description of the Applicant’s organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.

PSCS is committed to the Culturally and Linguistically Appropriate Services (CLAS) Standards. Since 2012, we have built internal capacity to operationalize CLAS Standards and have conducted assessments to build strategies to advance CLAS throughout our networks. By way of summary, please see our key organizational practices, below:

**Communication.** PSCS annually updates a Language Access Plan that ensures that all member-facing materials and encounters take into account members’ cultural, literacy, and linguistic needs. All materials in English are written at a sixth-grade reading level and all materials translated into Spanish are translated at the appropriate, best practice, reading level. We have a policy in place titled “Accessibility for Limited English Proficiency (LEP) and Hearing Impaired” and update it annually to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, vision impairments, hearing impairments, as well as members with diverse cultural and linguistic needs. In compliance with state and federal law, we provide interpreter services at no cost to all non-English speaking, limited English proficient members. Any member can request these services.

**Workforce.** PSCS recognizes and values the importance of recruiting diverse personnel and leadership that is representative of the demographic characteristics of our service areas. We recruit and support a bi-lingual and bi-cultural workforce. Members with limited English proficiency have access to on-site bi-lingual customer service representatives. We use qualified or certified medical interpreters to deliver case management and clinical services.

**Data Collection Procedures and a Data-Informed Approach.** PSCS has a robust Analytics Department that utilizes demographic data from 834 files and REAL+D to build member reports. For example, we analyze member enrollment, claims, health factors, chronic condition flags, and demographic data at a member or population level. We also use REAL+D data in numerous ways for reports and analyses. PSCS is using the TQS framework to improve data collection practices with respect to REAL+D and other demographic sources that would inform the provision of culturally, linguistically and socially responsive services. In 2019, we will be collecting data from the Oregon Pediatric Improvement Project’s (OPIP) Pediatric Health Complexity initiative as well as data shared by OHSU’s Accountable Health Communities.
RFA OHA-4690-19-PacificSource Community Solutions-Central Oregon

initiative. Each of these sources offer the ability to filter by race, ethnicity, and language. We will integrate data to give us a well-rounded view into a member’s cultural, linguistic, and health-related social needs. This practice informs our development of risk models and stratification. Our teams will also collaborate and utilize data and analytic models to inform planning and development of community-based interventions for populations that require community services outside of clinical care. For example, we will partner with the Early Learning Hub to leverage the OPIP Health Complexity data to inform community-based wraparound services for children with medical complexity and/or social complexity.

Attachment 10, Section E.2.b: Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.

PSCS recognizes and values the importance of recruiting diverse personnel and leadership, representative of the demographic characteristics of our service areas. PSCS will continuously develop and deploy strategies that engage our employees who reflect the communities we serve.

To ensure the highest quality customer service, PSCS uses a blended staffing model with staff located at our corporate headquarters in Oregon and distributed locally in each CCO region. We think this is critical to promote scalability and integration in the communities we serve. As a result, we have standard corporate policies as well as locally oriented recruitment efforts in place to ensure our staff represent the demographic characteristics of each respective service area. Our leadership has the expectation that all hiring managers use a lens of “cultural contribution” versus “cultural fit” as they evaluate prospective applicants—valuing different perspectives and world-views as an asset to our company’s long-term growth and sustainability. We support and disseminate affirmative action policies among hiring managers and through recruitment efforts.

Given the diversity of our members, including a growing population of Latinx members, PSCS prioritized recruitment of a Spanish bi-lingual and bi-cultural workforce and developed strategies that leverage community partners to address system-level workforce development. Our team collaborates with local organizations to develop community-based pipeline programs that actively recruit a diverse health system workforce and empower growth for those just entering the health care field. For example, we partnered with a local community college Latino Club to cultivate interest among Latinx students in joining our company. We partnered with hospital systems to convene community discussion about workforce diversity. For example, we supported efforts by the Columbia Gorge Health Council to provide a local, 60-hr training for health care interpreters to achieve qualification or certification status. We are also working in partnership with local high schools to support internship programs, including a new program for high school students with a focus on health care workforce opportunities. In Central Oregon and the Columbia Gorge, we partner with the East Cascades Workforce Investment Board. This work has evolved into a community-supported health care workforce diversity initiative, called Central Oregon Cares (www.cocares.org). We plan to continue to invest time and collaboration in these types of community-based initiatives that address workforce diversity at a system level.

PSCS is committed to maintaining high rates of employee satisfaction. We administer an annual employee satisfaction survey. We share results broadly and use responses to inform our continuous improvement strategies. In 2019, we will introduce mandatory diversity, equity and
inclusion training, including training on cultural responsiveness. We will require this training for all staff, and are committed to expanding training opportunities to fulfill the OHA requirements for CCO 2.0. We expect this additional training will strengthen retention and inclusionary practices within our organization, creating a welcoming environment for all employees, and particularly those from diverse backgrounds. To ensure equitable access to development and promotion opportunities, PSCS offers a robust suite of benefits and other opportunities for all employees—including entry-level employees. We offer tuition reimbursement as a benefit for employees who wish to seek training or higher education. In addition, we offer numerous internal opportunities for employees to expand their skills and pursue personal or professional areas of interest. All of these strategies support our employee retention efforts.

We promote from within our current employee base on average forty percent of the time. We offer a continuum of robust learning opportunities for all staff and encourage both leaders and entry-level employees to participate as a pathway for professional growth and promotion. PacificSource University is our umbrella strategy for a variety of learning and development programs, including Leadership Education and Development (LEAD), a 9-month cohort program for managers and directors and Leadership Connections, a two-day program focusing on critical skills, knowledge, and best practices that support participants who are looking to become future leaders. We provide trainings on topics related to health equity, diversity, and inclusion. We believe our rate of internal promotion, combined with our efforts to recruit and retain a diverse workforce, will result in continued growth in diversity across our workforce, including among our managers and leaders.

**Attachment 10, Section E.2.c:** Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.

PSCS will ensure that members, staff, and providers can access linguistically appropriate services. Specifically, we will use the following strategies to ensure we provide linguistically appropriate services to members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternative formats, and to measure and evaluate the quality of language services:

**Policies and Procedures.** PSCS takes reasonable steps to ensure that persons with Limited English Proficiency (LEP) and/or those who are deaf or hard of hearing have meaningful access and an equal opportunity to participate in our services, activities, programs, and other benefits. The “Accessibility for LEP and Hearing Impaired Policy” was designed to ensure meaningful communication with this population of members or their authorized representative. This Policy provides for communication of information contained in vital documents, including, but not limited to, Member Handbook, Benefit Materials, information pertaining to Member Rights and Responsibilities, educational materials, website and all written correspondence. PSCS will provide certified or qualified health care interpreter services free of charge to any member or potential member. This service will apply to all non-English languages. PSCS has a toll-free TTY line available to accommodate any caller that may need this service. We provide this
through State relay services. All Customer Service staff receive training so that they can efficiently connect members to an external interpreter or the use of TTY services.

Organizational Staff, including Bilingual Personnel. PSCS will provide language assistance through the use of competent bilingual staff, contract or formal arrangements with local organizations providing interpretation or translation services, or telephonic interpretation services. Trained staff will monitor internal telephone calls to evaluate the quality of the interpreter service provided.

Qualified and Certified Interpreter Services. We will make interpreter services available to members via embedded providers in participating clinic locations as well as through contracted vendors. PSCS has contracts with three interpretation vendors. We will deploy surveys for members who receive outside interpreter services to determine the quality of the service provided. In addition, we will support any member who contacts PSCS with a complaint by offering them the grievance process. In turn, PSCS will investigate the details of the grievance and take appropriate action.

Translation of Notices and Alternate Formats. PSCS utilizes a variety of tools to identify and incorporate the needs of linguistically and culturally diverse populations within our regions. We identify and record needs in our systems; if we identify a need for alternative formatting, the system will flag our staff to provide all future communications in the format requested. PSCS contracts with a full-service language services provider to adapt communication materials into most languages, large print, and braille, as needed. PSCS sends the communication to the vendor who translates the document or formats it into the alternative format requested by the member. The vendor sends the materials to the member. We track and monitor all requests. We also translate all documents regularly used in the course of business so they are available upon request. PSCS will also conduct a regular review of the language access needs of our members, as well as update and monitor the implementation of our Accessibility for LEP and Hearing Impaired Policy. PSCS will utilize the data provided by the OHA in the 834 files, as well as REAL+D, to measure any meaningful changes to the population we serve. PSCS also prints and mails all material with references that members can ask PSCS to provide documents in alternative formats.

Additional Monitoring and Evaluation. PSCS works closely with contracted providers to ensure that they are developing capacities to provide culturally and linguistically appropriate care and meeting the needs of the population they serve. PSCS ensures that all members are assigned to PCPs and receive specialty or facility care from providers who are well suited to meet their needs. PSCS generates a Member Insight report for providers to communicate information about Special Healthcare Needs, Health Risk Factors, and Cultural and Linguistic needs. We also produce analytics dashboards to monitor factors related to health equity. These dashboards monitor utilization, health screenings, disease rates, and access factors. We use this information to develop projects to improve quality and access.

Service Access. PSCS ensures access to bilingual personnel, qualified and certified interpreter services, translation of notices in languages, and use of alternate formats by informing members, providers, and staff of the methods of communication to access these services. There are various
routes through which these services can be accessed, such as: Customer Service call center, through a member’s PCP, specialist, or other providers, by accessing the PSCS website where materials can be immediately translated or provided in Spanish, and by visiting a local PSCS office.

Attachment 10, Section E.2.d: Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

PSCS ensures members or potential members have access to auxiliary aids and services at no cost, using education, staff training, monitoring, and corrective action strategies. Auxiliary aids and services commonly include alternative formats and sign language interpreters.

We educate members in a variety of ways. PSCS mails new members their member handbook within 14 days of enrollment. The handbook includes information on interpreter services. In addition, because we serve members on a walk-in basis, all PSCS lobbies have this information posted in a prominent location. All written materials we distribute to members explain how to obtain the information in an alternative format using required taglines and disclaimers. In addition, we conduct welcome calls to all new members. These calls are intensive sessions where we answer member questions, explain benefits and rights, and take follow-up action to ensure we meet members’ needs.

We clearly outline that auxiliary aids and services must be available to members, at no cost to the member, in our provider materials, including the PSCS provider manual and provider contracts. We provide tools for providers to use to assist in educating members about care coordination and the responsibilities of both providers and members in assuring effective communication.

PSCS trains staff on how to provide assistance to members who need interpreter services for telephonic communications, face to face encounters, or require the use other auxiliary aids, such as TTY and sign language services. To monitor the quality of the services provided by PSCS, we review internal calls for quality and survey members who have received interpreter services from PSCS or a vendor. We take follow up action and ensure that services rendered meet our standards for quality customer service.

PSCS monitors contracted providers and subcontractors by reviewing claims data, surveying members and providers, monitoring grievances and appeals, and by completing site visits. Our Provider Service Representatives complete these annual site visits using a standard site visit questionnaire. This standardized approach allows us to score and compare the overall condition of our contracted providers and their offices, physical accessibility, adherence to ADA requirements, physical appearance, adequacy of waiting and examination room space, and adequacy of record keeping. In 2018, we expanded our site visits to assess understanding and compliance with the CLAS Standards. These face-to-face visits also allow us to answer questions and provide targeted education and follow-up. If the provider fails the site visit, the Credentialing Department sets up a follow-up visit with the provider. We will also issue corrective action requirements and monitor completion of corrective action plans. In addition, if the Credentialing
Department receives a complaint, PSCS representatives will conduct an additional site visit to evaluate and monitor steps in compliance with our internal policies. We may take additional steps and escalate a lack of provider compliance to ensure our members have access to appropriate services. We monitor grievance and appeals data, which allows PSCS to determine if there are providers that are not complying with the requirements for providing auxiliary aides and services to members. If services are not being provided appropriately, we will follow up appropriately.

Attachment 10, Section F.1.a: Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant’s workforce.
Attachment 10, Section F.1.b: If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

Attachment 10, Section F.2.a: Please submit a THW Integration and Utilization Plan. Please see the attached THW Integration and Utilization Plan.

Attachment 10, Section G.1.a: Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant’s strategies for engaging its Community Advisory Council, its process for developing and conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant’s strategy for health-related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities. Please see attached our RFA Community Engagement Plan with narrative and required tables.
Attachment 10 - THW Integration and Utilization Plan

This THW Integration and Utilization Plan (Plan) addresses our role in supporting the integration and utilization of Traditional Health Workers (THWs) in service to members in their community, including the enrolled Oregon Health Plan beneficiaries in a PacificSource Community Solutions (PSCS) Coordinated Care Organization (CCO). We recognize our role in supporting a robust THW workforce in health care settings and community based organizations. We used several outreach methods to build a THW research compendium and to shape this Plan, including initiating a series of state-wide interviews with key informants to discuss employment and payment practices, unmet needs, existing programs and pilots, and areas of opportunity. We also participated in forums where THWs shared feedback on their experiences and gave input on strategies to support the THW workforce. We drew on our experience in funding THWs in a variety of settings. We also reviewed encounter data reports and provider rosters, and we researched published best practices on THW work.

PSCS is committed to providing high-quality care and care coordination to all members, including Culturally and Linguistically Appropriate Services (CLAS). The work THWs do with our provider partners and community-based organizations is essential in this regard. As an experienced CCO, we are familiar with more and less successful THW models and are committed to continuing to improve the quality of structure, support, and evaluation for the work. Prior pilot programs inform this Plan and our future work. PSCS has historically funded THWs in health care using robust primary care value-based payment arrangements that support non-encounterable, team-based care.

In further investigating options for the future, we found that the regional THW and Non-Certified Workforce is strong, but many individuals are not certified or eligible to encounter services. Many of the organizations interviewed had little interest in obtaining certification from the OHA for their Non-Certified Workforce, billing for THW services or tracking metrics.

This Plan describes a plan of action for PSCS, our provider network, and our community partners starting in 2019 and extending through 2020, at which point additional strategies will be identified and a revised Plan created. Through the end of 2020, PSCS will address the following challenges and opportunities that we identified during our review:

1. **Certification and Grandfathering.** PSCS will support increased opportunities for THW certification in the communities we serve and also foster dialog between THWs, Non-Certified Workforce members, employers, and statewide leadership to better align local interests with state-level expectations in regards to moving to a certified THW workforce. Our goals in this process include increasing the overall size of the workforce, the stability of employment, and the number of certified THWs serving the community.

2. **Performance Measurement and Evaluation.** Organizations reported that they use a wide variety of metrics to evaluate THW performance and track outcomes, including THW-to-member ratios, percentage of time spent in the “field” versus in the office, completed pathways, and job satisfaction. Because we did not observe any natural alignment, PSCS will invite providers and community partners to collaborate to build successful performance measurement and outcome benchmarks.
3. **Flexible Payment Strategies.** Best practices suggest there is no “one size fits all” THW payment model that will meet the needs of all providers, community-based organizations, and members. PSCS will offer a variety of funding options to meet the various THW and employer needs. At a minimum, we will continue to offer fee-for-service payment, value-based payment models, and direct employment, with ongoing evaluation and refinement.

**THW Integration Plan**

PSCS will integrate THWs at two levels, both as staff at the health plan level and through the expansion and continued engagement of THWs employed in our communities. PSCS does not currently employ THWs and has instead focused on supporting THWs to be successful in the community. However, PSCS employs Member Support Specialists (MSS), who perform work similar to Personal Health Navigators, in that they help members understand their plan, connect members with PCPs and specialists, coordinate care, assess unmet social needs, and connect members with community resources. During 2019, we will modify the MSS role and recruit Personal Health Navigators (PHN) for these positions. We will also offer certification and training opportunities for existing staff and evaluate our recruitment strategy. We believe it is imperative that the MSS and PHN workforce mirror the demographics of our membership to support cultural sensitivity, build trust, and reduce health disparities.

Based on our key informant organizational interviews, we identified that the ratio of the THW workforce to Non-Certified Workforce is approximately 1:4. Given this and other findings, we believe the THW workforce must expand to promote effective integration, so we propose the following three-prong strategy:

1. **Organizational Capacity Interviews and Assessments.** PSCS will conduct additional interviews and work with our provider network and community-based organizations to evaluate opportunities to expand the workforce and cascade THW integration to multiple sites of service. This will include an assessment of the breadth of THW roles and functions, challenges and opportunities that may need to be addressed to ensure optimal leverage of the workforce to support CLAS, patient safety, and positive health outcomes.

2. **Education and Promotion.** We will meet with colleges and universities to explore offering THW certification programs in all regions. We will identify and share opportunities regarding THW services and certification with the provider network and community-based organizations. We see this as an ongoing dialogue. We have experience using fidelity models to evaluate integration and propose to deploy a similar approach to support THW integration in care teams.

3. **Capacity Funding.** We propose to work with the community governance model and draw on organizational and community resources to expand capacity funding for integration in various sites of service. We have paid for certification trainings in the past and will continue to do so. We are exploring new partnerships with educational organizations (including a community college) to expand the availability of trainings.

**Member THW Communication Plan**

In order to communicate with members about the availability and benefit of THW services, PSCS employees, staff of provider organizations, and community partners need to have accurate information and consistent messaging. We recognize that community-based organizations and health care staff may be the most effective advocates for members accessing THW services. As a
result, we propose to deploy a three-part plan with assistance from our communication
department. The THW Liaison will play a key role in executing this plan and identifying areas
for future improvement:

1. **CCO Communication.** PSCS will convene facilitated community discussions during summer
2019 to evaluate how our member materials should be revised to better represent THW
services. We will incorporate information about the benefits and availability of THW
services and members’ rights to access them in our New Member Welcome calls. We will
also engage with the Community Advisory Council (CAC) and Provider Engagement Panel
(CAP) in facilitated discussions about how best to communicate about THW services in
clinical and community-based settings.

2. **Community-Based Communication.** PSCS will seek opportunities to collaborate on
communication and educational efforts with community-based organizations, particularly
those engaged in the CHA and CHP process. PSCS will work in partnership with the Health
Council to include THWs in the CHA and CHP process and to contribute to community-
based resource guides. Because we already provide funds to support THW programs and
because we already participate in community forums where THWs gather to address best
practices, we plan to capitalize on those connections during summer 2019 to refine
community-specific THW messages.

3. **Provider Communication.** We will provide resource guides and materials to support
providers in communicating with members about the availability and benefits of THW
services. We will ask for input on the effectiveness of the provider communication plan
through the CAPs and PSCS provider service site visits.

**Increase THW Utilization**
In order to increase THW utilization, PSCS proposes to deploy the following strategies and
evaluate the impacts over time:

1. **Expand and Develop the THW Workforce.** PSCS will complete an assessment of the existing
THW and Non-Certified Workforce. Working in collaboration with existing Capacitation
Centers, community-based training programs, and certified THW trainers, we will discern
needs and appropriate solutions to secure adequate funding and systems to provide initial
training and continuing education for the region’s THWs.

2. **Expand Awareness and Understanding.** Per the Commission’s best practices, we will support
increased utilization through community engagement, outreach and relationship building, and
sharing knowledge of community resources. We believe the Health Council community
governance model creates an ideal platform for collective impact, or leveraging partnerships
to establish a common agenda for addressing community needs that span sectors.

3. **Reduce Billing and System Barriers.** We will reduce billing barriers by employing a
standardized menu of payment options for health care providers and social service
organizations, coupled with implementation support to reduce confusion and remove barriers.
At a minimum, we will develop and offer fee-for-service payments, value-based payment
models and direct employment.

**THW Commission Best Practices**
PSCS intends to implement the Commission best practices in the following ways:

1. **Support and Supervision.** PSCS understands the demands and turnover challenges of a front
line, community health workforce and is committed to offering technical assistance and
providing education about best practices for THW supervision, such as sharing requirements and qualifications and illustrating key attributes of effective THW supervisory practices.

2. **Billing.** PSCS will share materials produced by the Commission and by PSCS to help reduce confusion about billing requirements. PSCS will also develop options for payment models to use with provider partners and community-based organizations and offer regular trainings.

3. **Provider Enrollment.** The PSCS Provider Service Team will offer trainings and collaborate with the THW Liaison to share information about how to enroll and bill for services. We will also schedule informational sessions in existing THW forums.

4. **Scope of Practice.** PSCS will use information produced by the Office of Equity and Inclusion (OEI) and the Commission to share standards of excellent practice with providers and community partners. PSCS will provide oversight and monitoring for scope of practice. We are most interested in expanding the workforce and building trust before engaging in monitoring, since our interviews revealed challenges with meeting administrative requirements. Many THWs bring valuable and unique perspectives based on life experience as members of communities that are commonly affected by inequities, and may be new to the norms and expectations of positions within community-based organizations and health systems. We intend to approach this work in a trauma-informed manner.

**Measuring Utilization and Performance**

Published THW reports emphasize the importance of employing simple data collection techniques and using existing data tracking mechanisms. While PSCS will comply with any mandatory metric established by the OHA, we see value in using a combination of individual encounter forms, group education session documentation, clinic reports, case management reports, and member surveys. We propose using a series of process indicators and then transition to outcome and impact indicators over time. Based on our key informant interviews, many providers and organizations expressed skepticism about the value of extensive data collection (versus time spent with members in the field). We propose to explore whether the community would be willing to adopt a standard survey collection instrument to use pre and post THW intervention, which would also address member satisfaction. We will also partner with providers and community-based organizations to develop a shared tracking tool for engagements, THW demographic information, and counts of employed THWs.

After we complete the organizational capacity interviews and assessments set forth above, we will refine our strategies and metrics. Our initial proposal is to track the rate of THWs per 1,000 members, the utilization of THW services on a per-member per-month basis, and the number of surveys deployed and collected. In subsequent measurement periods, we anticipate a higher ratio of members served, increased utilization, and a higher deployment and return rate. We would also welcome the opportunity to partner with other CCOs in developing shared metric strategies across the state.

**THW Liaison**

PSCS commits to creating a full-time position to serve as the THW Liaison (Liaison). Depending on member enrollment and the outcome of strategies set forth above to expand the workforce and increase utilization, additional Liaison positions may be necessary. The Liaison’s work will be focused on improving member access to THWs, executing on strategic plans and work plans that embrace the strategies and commitments set forth above, and increasing recruitment and
retention of THWs throughout the provider network and community-based organizations. For each strategy set forth below, consistent with the Commission’s best practices, PSCS intends to offer clear, supportive supervision to the Liaison and make education and promotion opportunities available in a transparent manner. PSCS expects to use the following strategies to maximize effectiveness and community impact consistent with best practices:

1. **CCO Workforce.** The Liaison will collaborate with community partners to build shared annual work plans, deploy trainings, and facilitate community coordination that is responsive to stakeholder needs. We view this as a collective effort to grow and support the THW workforce available to the CCO. The Liaison will also collaborate with our OHA Regional Outreach Coordinators and at Community Partner Collaborative meetings to leverage the Community Partners who are or who plan to become certified THWs.

2. **THW Integration and Utilization Plans.** As discussed above, after PSCS gathers additional baseline data and executes on educational strategies, the Liaison will collaborate with PSCS leadership and community partners to refine plans for 2021-2024. We expect to connect this work with the Health Council community governance model and engage the CAP and the CAC in designing ongoing plan development. We also intend to engage in development strategies and coordinate such strategies with CHA and CHP activities.

3. **Technical Assistance.** Based on the best practices published by the Commission, we know that THWs and associated provider and community-based organizations may face unique challenges in navigating Medicaid provider enrollment. The Liaison will work with THW Community of Practice groups to provide technical assistance and coordinate with staff doing site visits and provider training to offer individual and group-based technical assistance.

4. **Coaching for THW Workforce and Members.** PSCS will support the Liaison spending time in the community to help THWs and members navigate the CCO and related systems of care. The Liaison will work with local partners to maximize opportunities for shared learning. The Liaison will also gather information from coaching sessions to communicate with the CAC about how we may work together to reduce barriers for THWs and members.

5. **THW Payments and Rates, Utilization, Service Delivery, Supervision, Scope of Practice, Accessibility.** The Liaison will be a key subject matter expert in efforts to build systems that provide livable wages to THWs and promote THW utilization in a variety of settings. Because the Commission’s best practices indicate that flexibility is key and no one method will serve members best, the Liaison will take steps to expand on existing relationships, gather information about unmet needs, and build a feedback loop with the CCO and the Health Council to inform pilot programs, payment models, and social determinants of health and health equity investments.

**Conclusion**

PSCS is committed to working in collaboration with the THW Commission and the OHA to implement the Commission’s best practices and work in tandem with the OEI to access technical assistance and spread best practices. We would welcome the opportunity to partner with the OHA during 2019 and 2020 to evaluate metrics, data collection methods, and flexible arrangements to best meet the needs of members, providers, and THWs in order to increase integration and utilization of THW services consistent with our shared commitment to health system transformation objectives.
Attachment 11 – Behavioral Health Questionnaire

Attachment 11, Section A.1: How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed?

PSCS plans to ensure that Behavioral Health (BH), oral health, and physical health services are seamlessly integrated so that members are unaware of any differences in how the benefits are managed by integrating our internal operations and our work at the payer-provider interface.

Internal Operations
Our approach fully appreciates the inter-relationship of physical, oral, and behavioral health conditions. We prioritize working with our members from the perspective of “whole person health” and have put in place an organizational design and function to ensure our members have a fully integrated experience.

PSCS will utilize integrated Utilization Management and Care Management teams (“UM Team” and “CM Team,” respectively) using an interdisciplinary approach. Every team has both physical health and BH expertise, as well as a fundamental appreciation for the importance of oral health strengthened by close working relationships with dental care organization (DCO) care management teams, analogous to the integrated, interdisciplinary teams we support in Patient-Centered Primary Care Home (PCPCH) care settings. Each integrated team is under a single line of managerial oversight. We cross train our staff on clinical topics across all care domains to ensure our teams are capable of managing the medical complexity of our members that so often involves BH conditions (mental health disorders and substance use disorders (SUDs)), chronic medical illness, and dental disease. Two BH management positions provide enterprise-wide consultation, subject matter expertise, oversight and accountability: one primarily inward facing to our integrated teams and one primarily outward facing with our integrated providers, community mental health programs (CMHPs), and BH panel providers. In addition, PSCS employs a BH Medical Director who is a board-certified Child Psychiatrist and General Psychiatrist providing clinical leadership across all lines of business. The BH Medical Director works closely with the Medicaid Medical Director, Dental Services Program Manager, and Utilization Management (UM) and Care Management (CM) directors to ensure all services are managed to meet our members’ needs.

Beyond UM and CM, we have also consolidated our operations to support CCO-managed benefits in integrated departments. Our in-house data analytics staff have access to claims and clinical data across care domains, supporting identification of strengths and gaps in providing integrated health plan and clinical services. Their work supports deployment of information exchange tools like PreManage, standardized, self-service reports such as those in our Member and Provider Insight (MiPi) suite, and ad-hoc reports. Our members and providers enjoy a seamless experience because of the work we have done to integrate our operations at the CCO level. Whether it is a question about a provider resource, a member seeking help with case management and care coordination from our call center, or questions about a covered benefit, our internal operations are integrated such that the member can get help from the same team whether it is for a BH, physical health, or oral health condition. Our call center staff conduct new member screenings and outreach calls in an effort to welcome new members, help them understand their
benefits, and identify and address any initial questions or special needs. We also produce and distribute integrated member materials, including member handbooks.

**Payer-Provider Interface**

We are proud to be a leader in innovative clinical and payment models that support sustainable reimbursement of BH integration. One example of this is our work through the Behavioral and Physical Health Integration (BPHI) Alternative Payment Methodology (APM) Grant we received from the OHA in 2016 and 2017. As a result, over 90% of our CCO members in Central Oregon and over 75% of our CCO members in the Columbia Gorge are assigned to PCPCHs with Fidelity integrated BH. This requires the PCPCHs to meet the rigorous Integrated BH Alliance (IBHA) standards, including psychiatric consultations, and having BH Consultants (BHCs) in those clinics that meet a specific percentage of population reach as part of an embedded primary care team. We audit these integrated services annually at the individual clinic level, including a review of policies and procedures, work flows, job descriptions, chart notes, and provider schedules. The result is that our members experience a primary care environment that meets both their physical health and BH needs through the identification of BH conditions, brief interventions, and coordinated referral to specialty services and social supports. We support this work through contractual language and payments designed to sustainably reimburse and incentivize provider behavior that meets the whole-person health needs of our members.

With respect to “reverse” or “bi-directional” integration we have partnered with CMHPs to stand up Comprehensive Community Behavioral Health Centers (CCBHCs) that address the medical needs of our members with Serious and Persistent Mental Illness (SPMI). We also have experience supporting partnerships between CMHP and Federally Qualified Health Center (FQHC) partners to reimburse for integrated services that manage both the chronic medical conditions of our members as well as their severe BH conditions in one location.

We also encourage coordinated delivery of oral health services across care settings, including in behavioral health settings, to better support members in successfully receiving oral care. PSCS partners with DCO that provide services at numerous integrated care settings, and we reimburse for these services. Many local primary care providers have received First Tooth training to enable them to provide oral health assessments, anticipatory guidance and referrals, and fluoride varnish. PSCS reimburses for these services when they are provided in a physical health setting. PSCS also looks for opportunities to align and maximize internal and community resources and priorities to advance oral health care coordination. For example, PSCS proposed an integration concept to secure the partnership of the DentaQuest Institute and the MORE Care model. PSCS participated in a workgroup to develop and deploy an RFA process for region primary care providers and helped recruit three primary care organizations to participate in a two-year project (beginning January 2019) to pilot integration of oral health care in primary care settings, create collaborative care models, and establish inter-professional referral networks using the MORE Care model. We have actively supported this work from concept to launch, including facilitating conversations with DCOs about the project and their role, connecting this project with 2019 Transformation Quality Strategy, and convening multiple stakeholders to learn about Health Information Technology and Electronic Health Record solutions to better enable referrals and care collaboration. We look forward to working across the state to explore these types of innovations.
Attachment 11, Section A.2: How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate? Our vision for optimal patient care within the global budget starts with the goal that the structure use integrated funding rather than budgets that are segregated by care sector. Within an integrated model that includes aligned goals and metrics, providers across all care domains, including physical health and BH, can work together to best meet the needs of the member, promote quality improvement, manage costs, and improve health outcomes.

PSCS has designed and is implementing a global budget model that does not put a pre-defined limit, cap, or ceiling on BH spending. PSCS does not create carve outs, delegate, or outsource BH benefit decisions to external entities. We believe that any models that pre-define spending with a cap, limit, or ceiling would have a detrimental effect on patient care, could lead to rationing of care, and are contrary to effective population health. Providers across care domains should have incentives to work together to meet the care needs of the population and meet quality objectives that represent indicators of high-quality care.

In our existing CCOs, we have already taken steps to fully integrate the financing of physical health and BH, and we will complete this process well in advance of the January 2020 start date for this contract. This is also the model that we will implement at startup of new CCOs in the state. Through work extending back to 2016, we identified the importance of bringing payment streams together, out of the same pool of money, to align incentives across sectors and not predetermine the portion of spending that was appropriate to meet known and emerging needs across domains of care. In addition, our work to integrate behavioral, oral, and physical health services within shared teams and single institutions helped us (and our partners) understand the artificial and arbitrary nature of determining what payments get charged to which budget. While PSCS tracks spending in various domains, these are targets used for planning and in no way create a cap on spending. Sound financial management means that we evaluate spending carefully using a variety of indicators across care domains.

While we have executed VBP arrangements that involve risk sharing, we structure these arrangements for providers to share in the financial performance of the CCO through a shared savings mechanism from a pool of funds over which PSCS maintains responsibility. PSCS also makes UM decisions, processes claims and payments, negotiates payment arrangements with providers, and bears full responsibility for ensuring that our members receive medically appropriate and necessary covered services, while working with our providers to minimize low-value care and encourage use of preventive and evidence-based services.

In addition to the foundational elements discussed above, PSCS manages the global budget in a fully integrated manner through the following strategies:

- **Collaboration.** We have a long history of bringing physical and BH care providers together to discuss needs of the community, opportunities for improvement, and common goal setting.
- **Shared Investments.** We work collaboratively across care domains and through integrated discussions to identify where health care delivery system investments are needed.
Integrated care approaches often require seed funding to jump start programs, which in turn often leads to other innovations that make a positive impact on quality and cost effectiveness. Our model enables such investments through either grant funding, PCPCH supports, or other established models supported through community governance.

- Community Governance. We operate under a community-based governing model where the Health Council provides a forum for transparent dialogue to benefit our members. Participants include providers, PSCS, community members, and other organizations. The Health Council and its subcommittees have the authority to approve annual budgets and funding of initiatives that benefit members. Because of this background, PSCS has experience working in community governance settings to support full integration and believes this governance structure is key to promote health system transformation and drive success in CCO 2.0.

Attachment 11, Section A.3: How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

PSCS complies with the Mental Health Parity and Addiction Equity Act of 2008 in managing the CCO global budget and in contracting, payment, and authorization of services. PSCS complies with parity standards in funding and does not discriminate based on service type or diagnosis. While the CCO global budget process will continue to include budgeted expenditures for various types of services, these are projections that set goals to manage overall spending. They do not define the maximum amount that will be spent on behavioral or physical health services.

In setting payment levels, our contracting and actuarial departments collaborate with subject matter experts within PSCS to develop contracts and rates for primary care, specialty medical, hospital, oral health, and BH. These functions are carried out by the same teams for Commercial, Medicare, and Medicaid lines of business and use similar methodologies across sectors of care. These centralized functions help PSCS ensure our contracting and rate-setting methodology is consistent with the Mental Health Parity and Addiction Equity Act of 2008 and other relevant regulatory requirements.

In managing service delivery at the member level, PSCS is scrupulous in using Utilization Management processes like prior authorization only in areas where we feel it yields important benefit in managing costs. Utilization Management is conducted in accord with written policies and procedures that apply comparable levels of scrutiny and review parameters to both behavioral and physical health services. We also ensure that medically necessary services are delivered in a manner that is no more restrictive than that used in the OHP fee-for-service system, including quantitative and non-quantitative treatment limits. Our commitment is evidenced by our strong Mental Health Parity Assessment results finalized by the OHA in December 2018.

Attachment 11, Section A.4: How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?

Monitor Need
PSCS is accountable for meeting the BH needs of our members as outlined in the OHPB Policy #17. We are aware that multiple national reports indicate the prevalence of BH conditions in the
general population is between 20-22%. Our data indicates the most common chronic health condition among our members, across all lines of business, is depression. It is also well documented in multiple studies that identifying and treating mental health and SUDs leads to avoidance of other health care costs such as emergency department visits and repeat hospital inpatient admissions for medical reasons. PSCS is committed to increasing our capabilities to provide screening, identification, and access to BH treatments. Our data shows we have increased the percentage of members who receive a BH service, yet we recognize the need to continue this trend. PSCS maintains an open provider panel, coordinates information across departments and within the provider network, and regularly reviews data on access, utilization, and costs across all services.

Our Provider Service Representatives monitor access and availability of physical health services and BH services. In addition, our integrated Care Management Team (the “CM Team”) contacts providers monthly to assess access by documenting the next available appointment to better position our staff to assist members getting the right care at the right time. Our Analytics Department has developed a variety of reports and works closely with the leadership to adapt and refine available data to meet a wide range of requests. One type of reporting available to us to assess unmet need is a user-customizable template that displays the co-occurrence of depression with other chronic medical conditions. This has helped us work with integrated service sites to focus on increased care management at the primary care clinic for members with both diabetes and depression, tracking both HbA1c and PHQ scores. We have found that the majority of members with high HbA1c scores have undiagnosed or under-treated depression or anxiety or a history of psychological trauma. This is an example of working closely with our provider partners to develop strategies to increase the identification and awareness of BH conditions and the role treating those conditions can play in decreased physical health costs, along with improved quality of life.

PSCS has revised the data system we use to document care management contacts, assessments, and care plans to include assessment screening tools such as PHQ-2 and -9, history of BH concerns or treatments, and presence of Social Determinants of Health (SDOH). This helps our Teams assess BH needs and work with members to address previously undiagnosed BH conditions.

**Fund BH to Address Prevalence**
PSCS is actively working to partner with more providers to deliver more BH services to members at the right time and at the right place. We are aware of national prevalence data. We believe it is a safe assumption that we should build systems and payment models to address at least a 20% prevalence rate of BH conditions, and we are actively taking steps to build these systems and models. While we make projections of expected expenditures, we do not set budget limits on BH benefits. We conduct monthly multi-disciplinary meetings of PSCS staff to screen new BH provider applications for inclusion on our provider panel. These meetings allow us to outreach to applicants and learn more about their experience with specialty populations. We also screen for bilingual and bi-cultural providers and those interested in working with members who live in geographically isolated areas. This process has helped us onboard new BH providers, and, as a result, we are implementing a coordinated onboarding process. By expanding our network in a strategic way, we can expand funding for BH to address prevalence. We also use a variety of
financing methodologies for a wide array of providers. We build VBP arrangements (without caps on spending for BH) based on our actuarial analysis of underlying need and risk. These strategies are critical to funding BH services to address prevalence and manage an integrated global budget.

Monitor Cost and Utilization
PSCS monitors cost and utilization of BH services (and all other services funded through the global budget) and examines that data in a variety of forums. We present a BH quality and utilization work plan every other month to our BH Clinical Quality and Utilization Review Management Committee (CQUM), made up of clinicians from many of the communities we serve, who provide advice across all lines of business. We review a suite of reporting to address potential over and underutilization, across all benefits and all lines of business. We share dashboards on utilization and access for members across all care domains, internally and externally. We present access and utilization data for a wide range of services and work with the community to build transparent annual budgets. In this process, we strive to meet community needs in a way that addresses underlying prevalence, not historical trend.

Attachment 11, Section A.5: How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure Providers integrate Behavioral Health services and physical health services?
PSCS will leverage its experience contracting for BH services in primary care service delivery locations and physical health services in BH care service delivery locations, reimbursing providers for the complete BH benefit package, and ensuring providers integrate BH and physical health services. We plan to build on that experience to promote health system transformation in CCO 2.0.

In 2016, PSCS began including BH integration language and payments into contracts for primary care as part of our support for PCPCHs. We also built performance incentives for completing readiness assessments for CCBHC state grant applications into agreements with CMHPs. In subsequent years, we have refined and improved our contractual commitment to integration through contract language, terms, and performance incentives that address BH services in physical health settings and physical health services in BH settings. Contracts that do not specifically require integrated services set forth our minimum expectations for coordinated care. Going forward, we will continue to ensure that contracts with physical health providers include incentives and opportunities to provide and be paid for integrated BH, and contracts with BH providers include opportunities to integrate and be paid for physical health services.

PSCS uses a combination of aligned VBP methodologies to finance integrated medical and BH services, and we are committed to expanding our financing model. In 2016, we made changes to ensure that providers who offer integrated care could receive reimbursement for all outpatient services available in the BH benefit and use a modifier to bypass prior authorization requirements. These services are available on the same day our members receive medical services in a primary care setting. PSCS also provides reimbursement for the CPT codes specifically associated with the Collaborative Care Model of psychiatric consultation to primary care across our lines of business. Together, these payments provide a foundation that allowed
PCPCHs to expand the availability of BHCs in integrated primary care settings. We have also used grants and capacity-building payments to support services that are not encounterable in traditional rate-setting models. Given the challenges associated with grant-based reimbursement, we have started offering VBP arrangements that provide tiered PMPMs for an array of integrated BH services (“PCPCH-BHI”). All of our reimbursements for BH integration are tied to specific quality criteria that ensures fidelity to the IBHA standards. We use a combination of site visits and reporting to make payments by tier. We also endorsed the PCPCH Payment Reform Collaborative recommendations and are working actively to implement these recommendations across all lines of business.

PSCS has invested in integration of BH into medical settings beyond primary care. We offer integration payments to women’s health clinics and other specialty medical clinics that meet the fidelity criteria. We have experience working to establish embedded providers on medical-surgical units. This dyad offers SUD assessments and brief interventions to medical inpatients and then coordinates warm handoffs to specialty SUD providers at discharge.

With respect to “reverse” or “bi-directional” integration of medical services into specialty BH settings, we reimburse for these services and work closely with our provider partners to sustain and expand access. We have successfully supported CMHPs to apply and receive funding to establish CCBHCs, which provide a fidelity level of medical screening and physical health services to members in specialty BH settings.

PSCS also uses a variety of methods to ensure the integration that is required or encouraged through contracting and payment methodologies actually occurs. Our Analytics Department produces reports on a variety of metrics related to utilization of BH services in primary care. We find sharing this data with providers and other community stakeholders increases the enthusiasm for this work. We use provider site visits to review adherence to specifically referenced fidelity standards and to examine providers’ work flows. We routinely meet with providers to review integrated services that are being implemented as the result of performance incentives. In addition, we arrange opportunities for providers to present their experiences with various models of integrated care in a wide range of settings. This helps keep the community informed and creates an environment that supports transparency and continuous quality improvement.

Attachment 11, Section A.6: How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant’s Service Area?

PSCS has adopted three primary strategies to ensure the full BH benefit is available to all members in our service area: integration, contracting, and oversight and access management. PSCS has developed PCPCH-BHI business model and contracts for a broad range of specialty services, mostly within the service area and when necessary, with specialty providers outside the service area. PSCS staff routinely monitor access and availability. The integrated CM Team assists members with access to intensive, highly specialized and out-of-area services, and ensures a smooth transition back to their home community with the supports they need to be successful. Our experience with multiple lines of business and as a Choice Model Services contractor provides us a network of experienced providers for consultation and specialized services. We have also collaborated with other CCOs when arranging specialized services or transitions for
members. We will use these strategies in CCO 2.0 to ensure the full BH benefit is available to all members.

Integration. As discussed above, PSCS has adopted multiple strategies to integrate BH into a variety of medical settings and medical services into a variety of BH settings. A subset of this strategy, PCPCH-BHI, is proving to be a successful means of increasing the rates of members receiving BH services, through routine screenings using evidence-based tools like PHQ-2 and -9, identification of BH conditions through other means, initiation of low intensity treatment, and facilitated referral to specialty BH providers when needed. While members are able to seek BH services from panel providers without a referral from primary care or a CMHP, the PCPCH-BHI framework has improved communication across primary care and specialty BH settings, and the BH clinicians who are based in primary care clinics help members identify community BH providers, provide smooth transitions, and promote continuity of care.

Contracting. PSCS contracts with a panel of BH providers to assure member choice and ensure access to the full continuum of covered BH services. Our provider panel is open to new providers, and we screen applicants to identify those with special expertise, such as experience serving LGBTQ individuals, trauma informed care, and treatment of co-occurring mental health and SUDs. We also contract with CMHPs and through our oversight of those specialized providers, ensure access to outpatient treatment of mental health and SUDs, and a broad range of higher intensity BH services such as Mobile Crisis, Assertive Community Treatment (ACT), Supported Employment, Supported Housing, Youth Wraparound Services, and Intensive Treatment Services and Intensive Outpatient Services and Supports, as well as peer and family-delivered services.

PSCS also contracts for specialized services such as Withdrawal Management, Residential Treatment of SUDs, Residential Treatment of SUDs for adult Spanish-speaking members, Co-Occurring Residential Treatment of SUD/MH for Adolescents, Psychiatric Residential Treatment Services for youth, Sub-Acute for youth, and Psychiatric Inpatient Hospital for youth and adults. When available, these services are provided within the member’s home community, but, in serving communities where population density does not support these programs, they are provided outside the CCO region, but as close as possible to member’s home community. We will continue to leverage this strategy to ensure members can access the full BH benefit.

Oversight and Access Management. Please see our response to Section A.4, which describes our approach to oversight and access management.

Attachment 11, Section A.7: How will Applicant ensure timely access to all Behavioral Health services for all Members?
PSCS will ensure timely access to all BH services for all members through supportive access models, contracting, PSCS policies and procedures, oversight, and care coordination support. The contracted BH professionals, working within primary care settings, serve as knowledgeable liaisons to specialty BH providers in the community when more than brief treatment is needed, and coordinate referrals and transitions. We participate regularly in community workgroups to develop community standards for referrals from primary care settings to specialty behavioral health, and for transitions back to primary care. This work helps develop a network of providers.
that work together as a system. In addition, we use an open access model for members to self-refer to any BH provider on our panel without required screening or referral from primary care. We also track, report, and monitor performance on quality metrics related to meeting routine, urgent, and emergent referrals.

PSCS collects data related to access, develops reports to aid in analysis, and works directly with CMHP staff or providers to ensure they meet timeliness requirements set forth in OARs, the CCO contract, and PSCS policies and procedures. We report this information to CQUM for transparency. We also conduct monthly reviews of specialty BH providers to ensure we direct members to providers that can see them timely. We also coordinate access to appropriate covered services for all members, especially members with Special Health Care Needs and those eligible for Intensive Care Coordination (ICC) services. Our integrated CM Team provides care coordination and a Care Transitions Program (a specialized case management program) for members that require specialized or facility-based services outside of the service area, to ensure timely access to appropriate services as well as smooth and timely transition back to their home community with necessary supports.

Attachment 11, Section A.8: How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?

PSCS has centralized the responsibility to ensure members who require treatment out of the service area continue to have access to the full range of benefits. For members who require services that are not available within our service area, the integrated CM Team works with the member, current providers, and prospective out-of-area providers to develop a plan that is both medically appropriate and agreeable to the member. As part of arranging for out of area care, PSCS puts authorization in place for payment, assists the provider in enrolling as an Oregon Medicaid provider if they are not enrolled, and pays claims directly from an integrated global budget that does not place an arbitrary cap on BH spending. When specialized services are needed that are not available within the service area, the CM Team works with the Member and/or their representative to ensure access to all necessary services. When these types of arrangements are necessary, the CM Team establishes a community team of all the interested and involved parties, including parents if the member is a youth, and holds regular conference calls to share information and establish the supports needed for transition back to the service area.

For members placed out of the CCO service area, the CM Team continues to work with the member to facilitate a smooth transition back home with appropriate follow up care. When an allied agency is involved, such as DHS Child Welfare, we also use the CM Team to communicate with the case worker and the DHS placement. The CM Team can also help out of area providers navigate any prior authorization or billing requirements. We have experience managing and paying for out-of-area care and will bring this experience in CCO 2.0 to ensure that members can receive services out of area, as needed, and that PSCS will remain responsible for arranging and paying for such care.

We also have experience as a Choice Model Services contractor for Central Oregon and the Columbia River Gorge. Due to the responsibilities in that scope of work, we employ staff who are experienced with coordinating care and helping individuals who require temporary treatment.
at the Oregon State Hospital (OSH) or in an OHA Certified Secure Residential Treatment Facility (SRTF). We support our members in remaining connected to their chosen home community, and in residing in these out-of-area placements only as long as is needed to be stabilized. The CM Team also coordinates care for these individuals through contracts with CMHPs, to ensure transitional independent living and other critical non-treatment supports are available.

Our integrated CM Team has an established an e-mail address that we provide to the OHA, Health Systems Division, and out-of-area residential programs such as Adult Mental Health Residential and Behavior Rehabilitation Services settings for youth involved with Child Welfare or Oregon Youth Authority. This e-mail inbox creates a queue that the CM Team works on a daily basis. The CM Team also ensures that members, who are temporarily out of the area for treatment purposes, have access to all needed primary care, specialty physical health, oral health, and BH services.

Attachment 11, Section A.9: How will Applicant ensure Applicant’s physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools?

We have supported CMHPs in becoming CCBHCs and will continue to do so. These programs have increased the use of evidence-based screening tools and data collection. PSCS has learned much from each CMHP’s experience and will use this knowledge to increase medical screenings in BH settings, especially settings that specialize in serving members with SPMI. PSCS completes annual site reviews of these providers, including reviewing a sample of medical records. We also obtain copies of CCBHC reviews. As discussed above, we have also used a variety of methods to support clinics in seeking PCPCH recognition and to integrate BH services. This has helped clinics move from universal screening using SBIRT and either PHQ-2 or PHQ-9, to targeted use of additional evidence-based screening tools such as the GAD 7, DAST, Columbia Suicide Severity Rating Scale, Life Event Checklist (screening for presence of psycho-social trauma), and others. Going forward, we will continue to support the use of these tools and conduct clinical review to ensure their appropriate use.

PSCS has also made use of community provider work groups that consist of PSCS staff, representatives from primary care, and specialty BH providers to develop technical assistance tools on the recommended use of screening tools, criteria for transition of members from primary to specialty BH and back, and shared care. We plan to use consensus documents from these groups to establish community standards in important areas of coordinated care. Our model of promoting PCPCH-BHI includes regular technical assistance, learning collaborative sessions, and site visits, all of which are useful in promoting and assessing the use of standardized screening tools. The site visits provide an opportunity to verify clinics are using the evidence-based screening tools.

PSCS looks for opportunities to promote adoption of evidence-based, best-practice screening protocols by oral health providers that are emerging as appropriate within the evolving dental scope of practice. For example, PSCS has worked with the Central Oregon Health Council to support DCOs in piloting blood glucose screening in dental offices. We plan to promote system-wide adoption and standardization of this practice and other appropriate screenings (e.g. blood
pressure, depression, and oral cancer screenings) in all dental clinics. Some DCOs have implemented pregnancy intention screenings, such as “One Key Question.” Also, PSCS ensured that DCOs had the opportunity to participate in screening and referral efforts as part of the Accountable Health Communities (AHC) pilot. Doing so positions dental providers to better understand SDOH and immediate care needs, including those that may impact member physical and behavioral health. PSCS will continue to look for opportunities to scale BH and physical health screening elements throughout the oral health delivery system.

Attachment 11, Section A.10: How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309-019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320? PSCS contracts with CMHPs to deliver Mobile Crisis Services for all members to promote stabilization in a community. Each CMHP Mobile Crisis Service provider has active and ongoing working relationships with local law enforcement (city and county), county jails, emergency departments, and hospitals. PSCS conducts on-site reviews of compliance with administrative rules as well as annual audits of delegated duties. PSCS has worked closely with Mobile Crisis Service providers to improve the specificity of calculating and reporting crisis services. We will continue to monitor and improve oversight in this area by reviewing Mobile Crisis Services in compliance with the OARs cited above.

Attachment 11, Section A.11: Describe how Applicant will utilize Peers in the Behavioral Health system.

PSCS believes that Peers, with their lived-experience, are an essential part of an overall strategy to engage our members with BH services. Our provider partners already use Peers extensively throughout the BH system. Peers are an integral part of CMHP treatment teams, providing Peer-Delivered Services as part of ACT teams, supported employment programs, supported housing programs, in Wraparound, at drop-in centers, and in outpatient SUD programs as Recovery Mentors. We have supported these roles historically and intend to continue to do so going forward. BestCare has a Recovery Mentor as part of an SUD consult team embedded in the medical-surgical inpatient unit of St Charles-Bend hospital. More recently, BestCare has also placed Recovery Mentors in the Madras and Prineville St. Charles emergency departments in an effort to reduce re-admissions to the emergency department and hospital by members with SUD. These embedded Recovery Mentors also provide warm handoffs to specialty SUD programs, which increases engagement and leads to improved outcomes.

We intend to expand the use of Peers embedded in Mobile Crisis teams as well. We also see an opportunity to develop Peer involvement in Young Adults in Transition (YAT) and other intensive youth services teams and teams, with a focus on serving older adults with BH conditions. As we further integrate BH into medical settings, we also plan to support expanding the use of Peers working in PCPCHs, especially in FQHCs that provide primary care for a disproportional amount of the SPMI and SUD population.
Attachment 11, Section A.12: How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals’ integration into the community, and ensure all Members access to Peer services and networks.

PSCS is committed to effectively addressing SDOH-HE needs for our members through a variety of integrated community supports, ensuring increased community integration, and for members with SPMI, ensuring access to Peer services. There are many examples of how we do this work in the communities we serve. For more information about our commitment to educate our staff and community partners about the National Standards for Culturally and Linguistically Appropriate Services, please see our responses to Attachment 10.

Community Integration
We contract with the BestCare Residential SUD program, which is specifically staffed by Spanish-speaking providers who bring cultural responsiveness to their work. This is the only program of its kind in the state, and it serves individuals that meet the clinical criteria statewide. We provide support, and expansion when indicated, of specific evidence-based practices, such as ACT, Supported Housing, Wraparound, Care Coordination and Peer Delivered Serviced, which provide individualized community based supports in order to ensure members with SPMI are supported to live independently and be integrated in the community of their choice.

Access to Peer Services
We have partnered with the Latino Community Association (LCA) to address health disparities with our Latino membership. We have worked with the LCA on a Latino Emotional Workgroup to expand access to Spanish-speaking providers. We have drafted a strategic plan and began to execute on that plan. In addition, the Health Council is also working to address SDOH-HE, particularly for our members with significant BH conditions. The Advancing Integrated Care (AIC) workgroup, chartered by the Health Council is charged with increasing use of Traditional Health Workers (THWs), including Peers, with members struggling with BH conditions, in an effort to decrease health disparities. The AIC consultant has met with the Confederated Tribes of Warm Springs to learn more about their specific needs for integration and to offer technical assistance. Another Health Council workgroup is addressing homelessness and housing issues, which disproportionately affect those with SPMI and or SUD. Members of this workgroup have substantially increased the availability of sober housing in the community as a result. Finally, another workgroup is focused on SDOH-HE in early childhood and is developing strategies to address Adverse Childhood Experiences (ACEs) through resiliency building, literacy building, kindergarten readiness, and pathways to appropriate services for those who have developmental delays.

Some of the resources described above are available to all PSCS members statewide and some examples have been specifically crafted by and for members of the region. We will continue to support these and similar initiatives directly and through our Health Council governance model to help communities develop services and supports that are crafted to meet the needs of specific groups. The aim is to increase the capability of each community we serve to embrace and support member access to Peer services and supports.
Attachment 11, Section B.1: Please describe Applicant’s process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.

**Warm Handoffs and Documentation**

Warm Handoffs may occur in a variety of settings and are characterized by face-to-face meetings to transition care from one provider to another. Barriers can arise as a result of geographical factors, availability of provider time, and/or as a result of billing or reimbursement models. PSCS has deployed strategies to address these barriers in order to ensure members experience warm handoffs between primary care and BH providers, as described below.

PSCS requires that warm handoffs and any barriers be documented in the medical record. In addition, we provide case management support to members who are transitioning from facility-based services to community based follow-up as described below. When these transitions occur within our service area, we expect a face-to-face warm handoff as part of standard practice. When transitions occur outside our service areas, we provide care coordination and utilize telehealth technology when that technology is used by the out-of-area provider. Whether in person or through the use of telehealth technology, when transitions are managed by our CM Team, they document warm handoffs and potential barriers in Dynamo, our software for storing this information.

**Removing Barriers**

We have taken extensive and innovative steps to remove barriers arising from billing and payment structures so that we can reimburse for a wide array of BH services in medical settings. We have developed a claim modifier that our providers can attach to any BH service code we determine eligible for use in a medical setting. Once we authorize the specific clinic to use the modifier, the provider can begin billing for those services. The modifier allows the claim to bypass our UM protocols that we would typically provide in a specialty setting. The standard UM protocols are not compatible with the warm handoffs that frequently occur between a PCP and a BH consultant on same-day visits. Thus, our system for processing claims allows for busy primary care and other medical clinics to be reimbursed for almost any outpatient BH service. This provides a revenue source, along with our PCPCH-BHI payments, which enable our providers based in medical settings to develop additional integrated infrastructure and deploy fully embedded BH consultants as part of their treatment teams. Furthermore, the reimbursement supports other clinical integration activities in medical settings, such as impromptu provider-to-provider consultations, morning huddles, registry maintenance, integrated care management, and psychiatric consultation.

PSCS addresses geographical and time barriers in a variety of ways. For members with SPMI discharging from the one acute psychiatric hospital or transitioning from any setting to specialized services such as ACT, Parent Child Interaction Therapy, Wraparound, Supported Employment, Supported Housing, and Peer Delivered Services, these transitions will be accompanied by a warm handoff. We prioritize face-to-face warm handoffs, either by our staff or by a contracted community provider. When geography is a barrier to in-person hand offs, we plan to utilize telehealth technology. Our staff attends interdisciplinary and inter-agency weekly meetings at St. Charles Sageview’s acute psychiatric unit. CMHP representatives also attend these meetings so that they can connect their existing patients and establish a relationship with
patients discharging to establish or re-establish care. This ensures a smooth and coordinated transition for the member and allows for a single treatment plan that is properly resourced and adjusted for the step down in level of care. For our members psychiatrically hospitalized out of area, we also offer highly coordinated care management from our integrated CM Team. This includes using telehealth in connecting the member and hospital staff with our community-based providers to ensure that the member’s transition is as successful as possible.

Attachment 11, Section B.2: How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the Member’s home) for Members?
PSCS has contracted capacity for in-home services. For example, PSCS currently utilizes in-home services for youth and families that have experienced an emergency department visit, when psychiatric hospitalization was not required and member and family agree.

We would like to provide greater standardization, while continuing to support local flexibility. PSCS intends to conduct a planning process to assess, develop standards, and ensure expanded contracted capacity. We plan to execute on the following timeline:
- **May-June 2019**: Develop details of planning process, topics, sub-topics, and key participants. Conduct initial gap analysis.
- **September-December 2019**: Work with community partners, contracting, internal operations, and leadership to ensure we are prepared to implement the plan or revise as needed to achieve compliance with related requirements.

Attachment 11, Section B.3: Please describe Applicant’s process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient’s care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient’s representative participate in discharge planning activities.

Every member that is admitted to an inpatient psychiatric hospital, sub-acute, or psychiatric residential treatment services is involved in PSCS Care Transitions, a specific type of CM focused on members experiencing a transition from one care setting to another. We work closely with existing community teams, and when one does not exist, we work to establish one.

When admissions occur at a facility within our service area, we are notified within 24 hours of admission and participate in meetings with hospital or residential facility staff and interact with the member. Discharge planning begins at this time, and involves the treatment team, CM Team, and the member (or their representative). Our staff ensure that members with an existing relationship with a community provider are able to meet with their provider prior to discharge in order to ensure a smooth transition to post hospital follow up services and supports. When intensive treatment services occur outside of our service area, our staff have been involved in the search for an appropriate provider, and we stay in close communication with the facility and the member, using a variety of methods, including telehealth if it is available at the facility. Often the community provider is able to visit the member in person, even if the facility is outside our service area.
PSCS staff that provide these CM functions do not have UM responsibilities. This separation of functions allow the care manager to focus exclusively on the member’s needs for services and supports, ensure a smooth transition to treatment in a new setting, and address non-treatment needs related to SDOH.

Attachment 11, Section B.4: Please describe Applicant’s plan to coordinate Behavioral Health care for Fully Dual Eligible Members with Medicare providers and Medicare plans, including ensuring proper billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.

As discussed in Attachment 6, an affiliate of PSCS offers Medicare Advantage (MA) plans throughout Oregon and also offers plans specifically designed for Dual Eligibles. We have experience coordinating BH care for dual eligible members with Medicare providers and plans. We have worked closely with Aging and Peoples with Disabilities (APD) and our providers to ensure smooth transitions during the change to opt-out dual enrollment. We are also prepared to coordinate with other MA plans as well as traditional Medicare coverage and providers, consistent with our current practice.

Our Provider Services Representatives conduct regular provider meetings to review changes from year to year and make sure providers know they have a dedicated liaison to answer questions and help them with any challenges. PSCS has also worked for years to make sure that Medicare-eligible providers (especially those employed by a CMHP that see a high proportion of dual eligible individuals) have the Medicare provider number they need to bill MA plans. The OHA-funded Older Adult BH Initiative staff, who also address the needs of younger disabled adults, have been helpful coordinating educational forums, disseminating information, and helping to connect payer, providers, and advocates. We will continue to educate specialty BH providers about Medicare coverage, eligibility, enrollment, and billing.

One of the barriers to dual-eligible members receiving BH services is the comparatively limited types of BH providers that are eligible to receive Medicare reimbursement. In order to expand access to BH services, we expanded our MA benefit to cover Licensed Professional Counselors and Licensed Marriage and Family Therapists. We are not allowed to submit these claims to CMS, but we are committed to ensuring that members have access to BH services. Dually eligible members will benefit similarly. PSCS will continue to work closely with all providers, including BH providers, to reduce barriers to effective coordination of benefits and to resolve any issues that come to light. We will also collaborate with Medicare providers and other MA plans to promote coordination of benefits. Please review our responses to Attachment 6 for more information.

Attachment 11, Section C.1: Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant’s Service Area. Please include dates, milestones, and Community partners.

PSCS will coordinate with each Local Mental Health Authority (LMHA) and designated CMHP on the development of a comprehensive BH Plan (“Plan”) for the Central Oregon region. The Plan will include goals to improve health outcomes and increase access to services in the region.
We propose that the Plan include the following components, but we also recognize that this list could grow, given the multi-stakeholder nature of this work:

- Identification of priority actions, accountable parties for those actions, and timeline for action and assessment;
- Structures for communication across systems, coordination of services to individuals, and feedback processes to improve functioning of BH system;
- Prioritization of best-practice and evidence-based strategies where available;
- Use of a community-based, multisystem approach; and
- Utilize data from a population-based needs assessment, using the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP), as applicable, including ethnic, age, cultural, and diversity needs of the population.

We propose to address the following objectives in the Plan:

- Improve health in region through access improvement and system redesign for BH services;
- Integrate service delivery and improve coordination among service providers;
- Maximize resources for consumers and improve the use of funds other than state general fund and Medicaid payments to support local services;
- Coordinate services among the criminal and juvenile justice systems, adult and juvenile corrections systems, child welfare, schools, and local mental health programs;
- Address local housing needs for persons with mental health disorders; and
- Address local BH workforce needs and training opportunities.

We plan to measure our efforts against the following process steps, milestones, and dates:

- We propose to facilitate this process and secure approval of a written plan and execution of written commitments from participating parties prior to December 31, 2019;
- The process will include periodic meetings, every 1-2 months, with interim work by individuals, groups, and organizations beginning on or before April 1, 2020. PSCS, LMHA representatives, and other participating stakeholders will report to the Health Council quarterly on progress; and
- We will complete the Plan by December 31, 2020.

PSCS will collaborate closely with LMHA and CMHP representatives to extend invitations to the following stakeholders and facilitate their engagement in the process:

- Representatives of CCOs serving counties in or adjoining the PSCS service area;
- System of Care Executive Committee members;
- BH services organizations and professionals;
- Local mental health advisory committee members;
- BH system consumers, advocates, and families;
- Representatives of early childhood and K-12 education;
- Representatives of Oregon Department of Human Services’ child welfare division;
- Members of the local public safety coordinating council, including criminal justice and correctional institutions, law enforcement, and first responders;
- Providers of dental and physical health services, including hospitals and public health; and
- Providers of social supports, including, but not limited to, housing, employment, and transportation.

Attachment 11, Section C.2: Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.

PSCS will collaborate and coordinate with LMHA staff as core participants in the group conducting the regional CHA and CHP. Our experience as a CCO has demonstrated how the overall quality of the CHA/CHP process is improved when multiple organizations contribute expertise, staff time, money, and data to a joint process. In addition, the resulting regional CHP becomes a vehicle to align organizational strategic plans, grant applications, and spending decisions by hospitals, philanthropies, the CCO, and others.

PSCS will invite LMHA representatives to join as core participants in the process and will use the following elements of successful collaboration in convening or co-convening the CHA/CHIP process: inviting a broad range of organizations to participate, creating an explicit structure with written commitments for engagement, conducting a process that meets regulatory requirements for all participating organizations, and utilizing the expertise and leadership capacity in the staff of the participating organizations, including the Health Council.

The next iteration of the CHA launched in June 2018 and is scheduled to be complete in July 2019. Each CMHP is participating and representing their respective LMHA. The CHP will be complete in January 2020. Upon completion, the CHP will become a region-wide structure for collaboration and action. In addition, each participating organization may use the CHP for their own strategic planning and priority setting. Where necessary, organizations can create a supplemental document to articulate additional plans that are regulatory requirements or otherwise important, but too particular to be part of the regional CHP. Using this approach, we hope to make best use of community resources and facilitate the collective impact of aligned planning and investments.

Attachment 11, Section C.3: Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.

PSCS will collaborate with each LMHA as they create their local plan. We plan to provide data from our internal sources as well as use information collected in the CHA process. PSCS has also developed a documented BH continuum, which serves as a helpful guide to support the service planning aspects of the required elements in a local plan. We have purposely designed the process and content of the BH Plan (as described above) so that it will be a useful tool to inform LMHA representatives as they create local plans. We will be readily available to convene with an LMHA to develop a data sharing plan, including data from the CHA, and to establish written agreements as to the responsibilities and engagement of each organization in the creation of the local plan.

Attachment 11, Section C.4: Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.
PSCS does not anticipate challenges or barriers within the organization to executing a written BH Plan. Although it is hard to predict in advance, it is possible that LMHA, CMHP, or other important organizational representatives might become unavailable or decline to participate. In this case, PSCS will make best efforts to bring those entities to the table. If that is not successful, PSCS will pursue alternative processes to obtain organizational input and extend invitations to representatives of other entities who may be able to provide similar perspectives. PSCS also feels confident in its ability to meaningfully contribute to each LMHA’s local plan and to facilitate a regional CHA/CHP that incorporates LMHA representation and largely meets their needs for community level data.

All MOUs have been executed.

Attachment 11, Section D.1: Please provide a report on the Behavioral Health needs in Applicant’s Service Area.

One excellent source of state and sub-state BH prevalence data is Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, and is based on the National Survey of Drug Use and Health (NSDUH), annual surveys from 2012 thru 2014. This data is based on members of the general population that took a national survey, so caution should be used in making direct comparisons to utilization patterns. In general, the Medicaid population has higher needs than the general population. Another source is reporting produced by our Analytics Department on a wide variety of service utilization trends. We use this data for analysis and planning with our provider partners. When reviewing utilization, we use claims data and review the percentage of unique members receiving a BH service each quarter. This data is also broken down and incorporated in reports by age and diagnosis.

For purposes of illustration, we have listed a sample of prevalence data from the SAMHSA report cited above and a sample of our BH utilization data from Central Oregon. These data sets are not directly comparable as they represent different populations, time periods, and age cohorts. However, comparing this data can be useful to illustrate the capability we have to use our claims data, examine patterns and trends, and compare to known estimates of need (i.e. prevalence).

Based on this information, we can make these observations:

- The overall percent of members receiving BH services has steadily increased over the last three years. This is due to our opening of the provider panel, recruiting certain provider types, and expanding bi-directional integration;
- Depression is the single most diagnosed chronic medical condition, and we have begun to focus initiatives on the interaction between depression and diabetes, as an example; and
- Despite significant efforts to increase the availability and intensity of the treatment of SUDs, we must place more emphasis on meeting the demand that is indicated by prevalence data. We have focused on screening in primary care and co-located services in medical settings and schools. We have recently begun training our own CM staff and provider staff within clinics in motivational interviewing. We will continue to focus on these efforts, as evidence related to the medical cost offset from treating SUDs is clear and compelling.
Table 1 contains examples of excerpts from prevalence data from SAMHSA and utilization data from PSCS.

**Table 1 Prevalence Data vs. Utilization Data**

<table>
<thead>
<tr>
<th>SAMHSA NSDUH Data (Central Oregon)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mental Illness in Past Year (age 18 and up)</td>
<td>20.68 – 21.58%</td>
</tr>
<tr>
<td>Major Depressive Episode in the Past Year</td>
<td>7.57 – 7.97%</td>
</tr>
<tr>
<td>Illicit Drug Use in the Past Month</td>
<td>10.24 – 12.75%</td>
</tr>
<tr>
<td>Needing but Not Receiving Treatment for Illicit Drugs or Alcohol</td>
<td>2.19 – 2.50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSCS Utilization Data (Central Oregon)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members w/BH service</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>14%</td>
</tr>
<tr>
<td>2017</td>
<td>18%</td>
</tr>
<tr>
<td>2018</td>
<td>21%</td>
</tr>
<tr>
<td>Percent of Members receiving Treatment for Affective Disorder, by qtr.</td>
<td>2.3 – 2.9%</td>
</tr>
<tr>
<td>Percent of Members receiving Treatment for Substance Use Disorder, by qtr.</td>
<td>2.8 – 3.6%</td>
</tr>
</tbody>
</table>

Table 2 displays a broad range of information about the BH needs in the service area. In this table, we categorized a collection of similar services listed generally by increasing intensity. For instance, screenings are generally less intensive than Inpatient Psychiatric Hospitalization. The Availability/Provider Type fields convey information about the diversity of settings where a particular service may obtained. The Frequency of Need column is based generally on prevalence data, for instance prevention information and intervention ought to be available to all members or targeted to members of sub-groups, while Psychiatric Inpatient Hospital services are only needed by a relatively small percentage of members.

In general, the frequency of need and the intensity of the service are inversely correlated. Services with a high frequency of need are most often of lower intensity, and the higher intensity services are utilized or needed by a smaller percentage of the overall membership. PSCS BH leadership assessed whether a service or need was met using data from multiple sources, including routine reports of access time frames, service utilization data, information from complaints and grievances, anecdotal information from service providers, observations from PSCS staff, key informant interviews, and BH work group sessions.
### Table 2 Behavioral Health Availability and Needs

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Availability / Provider Type</th>
<th>Frequency of Need</th>
<th>Intensity of Service</th>
<th>Need Met</th>
</tr>
</thead>
</table>
| Prevention/Harm Reduction: Examples, Suicide Prevention, Drug and Alcohol Prevention | Community Coalition  
                              Public Health  
                              CMHPs                                                                                     | High              | High                 | Met      |
| Screenings: MH/SUD Psychological Trauma                                      | Primary Care  
                              School Based Health Centers (SBHCs)  
                              CMHPs  
                              Emergency Department  
                              Hospital  
                              CCO Care Management                                                                  | High              | Low                  | Met      |
| Outpatient Mental Health: Adult, Youth, Family                               | Primary Care  
                              SBHCs  
                              Specialty BH Panel  
                              CMHPs                                                                                     | Medium            | Low                  | Met      |
| Outpatient SUD: Adult, Youth, Family                                         | Primary Care  
                              Specialty BH Panel  
                              CMHPs                                                                                     | Medium            | Low                  | Met      |
| Medication Assisted Treatment-Opioid Use                                     | Primary Care-Waiver Providers  
                              MAT Program  
                              CMHP  
                              Adult Residential SUD Provider                                                             | Medium            | Medium               | Met      |
| Youth Intensive Outpatient MH, Day Treatment, Partial Hospitalization        | CMHP Young Children  
                              CMHP EASA                                                                                   | Low               | Medium               | Met      |
| Adult Intensive Outpatient MH, Day Treatment, Partial Hospital               | CMHPs                                                                                       | Low               | Medium               | Met      |
| Intensive Outpatient SUD, Day Treatment, Partial Hospitalization             | Specialty SUD Providers  
                              CMHP                                                                                       | Low               | Medium               | Met      |
| Mobile Crisis                                                                | CMHPs                                                                                       | Medium            | High                 | Met      |
| ACT, Supported Employment, Supported Housing                                 | CMHPs                                                                                       | Low               | High                 | Met      |
Attachment 11, Section D.2: Please provide an analysis of the capacity of Applicant’s workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant’s Service Area.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Availability / Provider Type</th>
<th>Frequency of Need</th>
<th>Intensity of Service</th>
<th>Need Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABA</td>
<td>▪ One Community Provider</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>▪ One National Provider w/Community Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Department Outreach</td>
<td>▪ CMHPs, Specialty BH Provider-Youth</td>
<td>Medium</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Home Based Services</td>
<td>▪ CMHPs, One Youth Oriented Provider</td>
<td>Medium</td>
<td>Medium</td>
<td>Partially Met</td>
</tr>
<tr>
<td>Youth Wraparound</td>
<td>▪ CMHPs</td>
<td>Low</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Youth Treatment Foster Care, Procter Care, Respite</td>
<td>▪ No Provider in Region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Adult Psych Respite</td>
<td>▪ CMHP, one provider in region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Youth Sub-Acute/PRTS</td>
<td>▪ Available by Contracts Outside Region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Adult SUD Res/Detox</td>
<td>▪ Available in Region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Youth SUD Residential</td>
<td>▪ Available in Region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Peer Delivered Services</td>
<td>▪ CMHPs</td>
<td>Medium</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Psych Inpatient Hosp.</td>
<td>Hospital In Region Adult, Youth Out of Region only, also Adult Hosp contracts out of region</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
</tbody>
</table>
Attachment 11, Section D.3: How does Applicant plan to work with Applicant’s local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant’s Members?

PSCS looks forward to working closely with the OHA to address issues of workforce capacity and diversity as outlined in the OHPB Policy #19. Working closely with our providers to utilize federal and state student loan repayment programs has helped the region attract and diversify health care professionals in a competitive employment market. Our experience working with Central Oregon Community College, Oregon State University, Portland State University and the Area Health Education Centers affiliated with Oregon Health Sciences University has made it clear that community-based partnerships will benefit greatly from state-sponsored strategies for measurement of the diversity of the workforce. The OHA’s leadership to develop policy and payment strategies aimed at expanding availability of THWs and Peer Service providers and Healthcare Interpreters has created opportunities to train members of traditionally underserved populations, integrate them into the work force, and narrow workforce diversity gaps.

PSCS has actively participated in workforce development planning forums as a part of CCO 1.0, co-convening health care and education partners to discuss and develop strategies to diversify the workforce to better meet member needs. We have also increased the number and type of internship opportunities available at PacificSource across all lines of business.

Moving forward, PSCS will follow the OHA’s lead in developing strategies for the measurement of the diversity of the workforce and leverage our sophisticated data systems to contribute predictive analytics to help define workforce needs for the future. We will work with state and local educational resources as well as key community stakeholders, including industry leaders, to develop a collaborative action plan to address current gaps in the health care workforce and long-term solutions to address forecasted needs.
Attachment 11, Section D.4: What is Applicant’s strategy to ensure workforce capacity meets the needs of Applicant’s Members and Potential Members?
PSCS will evaluate workforce needs in our service area(s); invest in targeted training to fill urgent gaps in knowledge, skills or attitudes; and participate in regional forums to plan and advocate for long-term solutions.

PSCS will conduct a comparative analysis of regional internal workforce, provider workforce, and member demographic/health care needs. This process may include surveying providers to collect additional workforce demographics, capacities, training needs and interests. We will develop a regional workforce dashboard describing provider characteristics as compared to member needs as a communication tool for our Health Council governing board to track progress.

We will utilize the data gleaned from our workforce analysis to inform annual training plans. PSCS will develop comprehensive training plans that encompass cultural responsiveness, implicit bias, language access, and trauma informed care. These training plans may be augmented to target specific gaps that may be identified in the workforce analysis and prioritized as urgent by our Health Council governing board and/or provider partners.

We will expand staff capacity to engage with K-12, higher education systems, and economic development organizations in our region and in state-wide forums to communicate identified workforce development needs. We will seek opportunities to partner with these entities to develop collaborative strategies. We will commit to implementing identified strategies ourselves or support implementation efforts as appropriate. We will support regional and statewide efforts to measure progress and commit to updating our workforce dashboard at least every two years to track our individual progress.

Attachment 11, Section D.5: What strategies does Applicant plan to use to support the workforce pipeline in Applicant’s area?
PSCS will conduct a comparative analysis of regional workforce needs and leverage the Health Council community governance structure to identify gaps and prioritize needs. We will expand our internal staff capacity to participate in regional forums related to workforce development and conduct outreach to K-12 and higher education to develop or strengthen programming to meet identified needs. As we strengthen our relationship with educational institutions, we will reach out to our provider partners to orchestrate job shadows, mentorships, and internships in alignment with our identified priorities.

Attachment 11, Section D.6: How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?
PSCS reviewed the data collection requirements set forth in Exhibit M of the 2020 CCO Contract. We have experience working with this type of information using our internal Analytics Department. We already collect or use data related to timely transitions out of OSH, percent of individuals transitioned to specific service settings or types, percent of members receiving a variety of specific specialty BH services for either mental health or SUD, referrals to ACT program and ACT denials, numbers of adult members with SPMI admitted to Acute Care
Psychiatric Facilities, and detailed information about discharge disposition. We utilize dashboards to support improvement projects related to data about adult members with SPMI admitted to emergency departments. We will continue to collect this data ourselves and expand our existing partnerships with hospitals and other service providers to capture additional data collection opportunities. This work is underway. We expect that detailed data collection and analysis (using our robust teams and processes) will improve quality of care and health outcomes for members with SPMI.

Compiling this information into a common electronic data set will allow us to risk stratify our population and better correlate members in need with specific service types. We may find trends in length of stay or service intensity that are useful in ensuring members are not receiving too little or too much of a given evidence-based practice. The data points identified in the proposed 2020 CCO Contract related to members with SPMI admitted to an Acute Care Psychiatric Facility and about members with SPMI admitted to an emergency department will provide us with information that we can incorporate into contractual performance incentives that better link Hospitals and CMHPs. We expect to learn that including SDOH-HE data, such as housing, personal safety, and education, will help us identify the non-health care supports that have the most significant contribution to successful community living. Our Analytics Department is experienced in using data from multiple sources to help inform health care decision making. We look forward to applying that experience to improve the health outcomes for members with SPMI, particularly those that require strategic, individualized use of community based supports.

Our multi-disciplinary teams will evaluate how this information can best be used to improve care and the health status of this important group of our members. We plan to refine our routine methods of sharing data trends and summaries with our service delivery partners to improve the quality of service delivery, and, most importantly, the outcomes and health status of the targeted members.

Attachment 11, Section D.7: What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant’s Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?

PSCS works with tribal representatives on an ongoing basis. Tribal members may identify an Indian Health Service (IHS) physician as their Primary Care Provider if they prefer, but they are also welcome to use providers and clinics in the CCO network if that is their preference. PSCS supports the choice of the tribal members and seeks to obtain consent to share Protected Health Information through a Release of Information, so that multiple providers serving the member can provide coordinated care. In addition, our CM Team works with providers and members to facilitate transitions from one treatment setting to another. We regularly have staff associated either with the Tribal CMHP or the IHS clinic attend CCO staff meetings to educate our staff on their work. Our CM Team coordinates with tribal services when developing transitions from hospital or other facility based services to community based after care. PSCS contracts with BestCare Treatment Services, the CMHP for Jefferson County, for crisis services in that community. The BestCare crisis team has frequent contact with both the IHS and Tribal CMHP staff.
PSCS has conducted outreach to, and collaborated with, the Confederated Tribes of Warm Springs for many years. PSCS participates in an annual health fair that draws tribal members from all over the northwest. Over the past several years, one of our staff has been acting as our primary liaison to the Confederated Tribes of Warm Springs in order to build a stronger relationship over time. In addition to the liaison, other staff, including the Manager of our CM Team, attend regular monthly meetings in Warm Springs. The liaison attends regular monthly meetings with IHS and OHP Enrollment Assisters. The liaison has formed a Tribal committee with representatives from several PSCS departments in an effort to gather information relevant to future tribal meetings, and educate staff about issues expressed at tribal meetings that we may be able to examine and problem solve. As a result of our long standing collaboration with the Confederated Tribes of Warm Springs, we are aware that many tribal members seek care from providers outside of the Warm Springs Reservation. The CMHP in Jefferson County has a long history of providing BH services to tribal members and collaborates well with Tribal clinics and officials.

Attachment 11, Section E.1.a: How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services? PSCS provides all levels of SUD services to our members through contracts with our provider partners, monitoring compliance with contract and administrative rule standards, and strategic investments through the Health Council community governance model. Specifically, outpatient SUD services and MAT services are provided by contracted specialty SUD providers, CMHP providers and by many of our contracted PCPCHs. Contracted specialty SUD providers offer intensive outpatient, residential, and detoxification services (outside of the general hospital setting). One example of this is BestCare, which provides the only SUD residential program in the state that is intentionally designed to specifically serve the Latino population and has Spanish-speaking staff fully embedded in the program. Additional examples are set forth below:

Using CCO shared savings, the Health Council has invested in a team of one SUD counselor and one Recovery Mentor to assess patients that have been readmitted to medical floors at St. Charles Medical Center in Bend for the presence of undiagnosed SUDs. The team motivates members to engage in treatment and facilitates transitions. The Health Council has also invested in Recovery Mentors to meet with individuals who make frequent use of the emergency department and have a substance use history in an effort to help them better utilize the appropriate health care providers. We are finalizing contracting that will provide MAT services out of emergency departments in Redmond, Prineville, and Madras. Recovery Mentors and SUD providers embedded in the emergency department will connect members with follow-up MAT services delivered in primary care and SUD specialty programs. In addition, the Health Council has provided grant funding for the Mothers’ Outreach Mentoring Services program (MOMS), which utilizes peer support resources to engage pregnant women with SUD and encourage their entry into treatment.

We have also adopted the National CLAS Standards and have added this language to our contracts with all of our providers, including those delivering SUD services. We routinely audit our providers for compliance. Our full-time Health Equity and Diversity Strategist provides in-
person provider trainings and has hosted a webinar on the CLAS standards. For more information about our commitment to CLAS, please see our responses to Attachment 10.

Attachment 11, Section E.1.b: How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to Members?

PSCS ensures that we provide culturally and linguistically appropriate SUD, including alcohol and tobacco, prevention and educational services for our members through active participation in Health Council workgroups, partnering with public health programs primarily charged to deliver health prevention services, and working with our providers to offer preventative services and education to our members.

We participate in CHP workgroups with specific prevention goals and associated initiatives for substance use, inclusive of alcohol, tobacco and other drugs of abuse. These include a Mind Your Mind campaign, secondary prevention targeted at adolescents at risk for substance use, and engagement tools for providers to address risky drinking. The Health Council has also funded a project expanding Quit Line referrals and a grant aimed at tobacco prevention for teens. Each work group uses CCO shared savings to fund targeted initiatives.

With respect to county-based prevention, we have supported the Deschutes County Public Health Department (DCPHD) in offering a Substance Abuse Prevention Program (inclusive of tobacco prevention) focused on youth and young adults. DCPHD also offers a needle exchange program with staff trained in culturally responsive approaches to educating members about specific risky behaviors while taking a harm-reduction approach. We actively collaborate with the Department on these prevention programs though behavioral health CHP workgroups. We have provided input and have participated in work groups to provide CCO shared savings through the Health Council to support these prevention programs.

We also work across regions to facilitate shared learning. For example, in Central Oregon, we participate in a CHP workgroup that developed a primary care SUD algorithm for addressing risky behaviors prior to the development of an SUD. Providers in Central Oregon shared this document with providers in the Columbia Gorge as well to inform their strategies.

PSCS also supports SBHCs by contracting with their medical sponsors. We reimburse for fidelity BH integration at these SBHCs. BH consultants conduct screenings for SUD risk and provide education and early intervention to reduce the likelihood of developing a SUD.

In addition to the engagement described above, we propose to conduct a careful community-based needs assessment on the following timeline to inform our future strategies:

- **May-June 2019:** Develop details of planning process, including topics, sub-topics, key participants, and an initial gap analysis.
- **July-September 2019:** Develop approaches, policies, and procedures. Finalize the plan.
- **September-December 2019:** Work with community partners and internal departments to ensure we are prepared to implement the plan or revise as needed to achieve compliance with related requirements.
Attachment 11, Section E.1.c: How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?
PSCS provides members with culturally responsive and linguistically appropriate information about available SUD services (including outpatient, IOP, RES, Detox and MAT) and how they can access them. This includes a member-facing electronic and hard copy (upon request) provider directory, member handbook, member newsletter, and specific materials that can be sent either electronically or in the mail from our case management and customer service teams. Our integrated call center is available to assist members by phone. All of these materials are offered in Spanish, as well as several other languages. They are also offered in large print and braille. The reading level required for these materials is such that it is accessible to members with only elementary literacy skills. We ensure that our providers and subcontractors meet these same requirements. We intend to continue these strategies in CCO 2.0. For more information on our strategies to deliver Culturally and Linguistically Appropriate Services, please see our response to Attachment 10 and associated policies and procedures.

Attachment 11, Section E.1.d: In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant’s Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.
PSCS maintains an adequate provider workforce with provider capacity that is focused on treating our members with Opioid Use Disorder (OUD) and helping them recover from this chronic condition that has hit our state and region in epidemic proportions. Our provider contracting department evaluates the adequacy of our contracted workforce specific to provider types and our health services team regularly assesses provider capacity on a monthly basis. We generate regular reporting on access and utilization of SUD services.

Beyond contracting with numerous providers to offer the psychosocial interventions and medication assisted treatment that is necessary to treat OUD effectively, our Medicaid Medical Director and BH Medical Director serve on the Central Oregon Pain Standards Taskforce (COPSTF) that has become a central hub for addressing the opioid epidemic. Despite its name, other regions are invited and participate in many of the COPSTF activities and trainings. We also partner with local community providers who are addressing the opioid issue. In some communities, we will support existing infrastructure to respond to this epidemic. In others, we will extend the expertise of the COPSTF and invite local providers to join that group. In conjunction with the COPSTF, as well as through participation in the state-wide Performance Improvement Project (PIP) on improving Opioid Safety, we have shared the Oregon Pain Guidance Guidelines and the Oregon Opioid Prescribing Guidelines extensively with contracted providers. We are educating providers on the new prescribing guidelines for acute pain and the dangers of co-prescribing benzodiazepines with opioids. We are educating providers on the new prescribing guidelines for acute pain and the dangers of co-prescribing benzodiazepines with opioids. On two different occasions, we have sent provider-specific letters notifying our providers of members who are getting potentially unsafe levels of opioids, or getting opioids and benzodiazepines concurrently. We co-sponsor numerous conferences and learning collaboratives
on pain, appropriate prescribing, and opioid use disorders annually. Through our PIP initiatives and COPSTF efforts, we educate our providers about the importance of using the Prescription Drug Monitoring Program (PDMP) and track its use by our providers. In addition, the COPSTF has employed support personnel that are specifically dedicated to assisting providers with PDMP enrollment. We have successfully increased the number of contracted providers querying their patients’ use of prescribed opiates using the PDMP. We are also educating our providers about the new rule that requires OHP providers to register with the PDMP. We will continue to execute on these strategies in CCO 2.0 and build new strategies as the epidemic and landscape change.

One example of our comprehensive approach to OUD and the opioid crisis is that in Central Oregon, the number of members on a 120mg Morphine Equivalent Dose (MED) or higher has decreased from 115 members in April 2016 to thirty-five members in September 2018. In the Columbia Gorge, the number of members on a 120mg MED or higher dose has decreased from thirty members in April 2016 to three members in September 2018. We have also worked diligently to increase the availability of naloxone as a rescue drug for those members experiencing an opioid overdose. For example, the Health Council made grants available to stock naloxone in first responders’ vehicles and at a needle exchange programs. Many pharmacies stock naloxone and this information is published on the COPSTF web site. Through the Performance Improvement Project (PIP) initiatives and COPSTF efforts, PSCS has also increased the number of waivered providers. Please see Section E.1.e of this Attachment, for more details.

Attachment 11, Section E.1.e: Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

PSCS supports and encourages providers to obtain DATA waivers that allows them to prescribe MAT. For example, using CCO shared savings and administrative dollars from PSCS, COPSTF held a training event in April 2018 that trained 11 providers in MAT, getting them DATA waivered. In an effort to increase provider convenience and uptake, we have advertised a free on-line DATA waiver training that we have made available to our entire network of providers. We plan to continue to execute on this solid foundation as part of CCO 2.0.

As an active participant on the COPSTF and through our PIP initiatives, we have co-sponsored DATA waiver trainings to increase our DATA waived workforce. This includes targeting not just physicians but also nurse practitioners and physician assistants since federal and state requirements have changed to allow these provider types to provide MAT, including buprenorphine. The COPSTF brings together medical providers, CMHPs, and specialty SUD providers to participate in these trainings. MAT providers include BestCare, Bend Treatment Center, and dozens of primary care providers that provide MAT to medically complex members with dual diagnoses, including SPMI. One practitioner in Crook County has obtained a DATA waiver, thirty six practitioners in Deschutes County have obtained DATA waivers, and four practitioners in Jefferson County have obtained a Data waiver through these efforts.
Attachment 11, Section E.1.f: Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.

PSCS ensures that hospitals, emergency departments, law enforcement, EMS, certified peers, housing coordinators and other local partners coordinate a continuum of care for our members and families struggling with OUD. Health Council work groups serve as a forum for coordination between health care providers and others, such as law enforcement and housing. We have also used incentive metrics to encourage collaboration. We plan to build on this successful foundation to expand as part of CCO 2.0.

In 2019, we partnered with the St. Charles Health System to deploy a performance metric to develop MAT capability at multiple emergency departments so that our members who are identified as having an OUD can start induction on buprenorphine. Studies have demonstrated that induction in the emergency department can increase by more than twice the likelihood of engagement in SUD services at thirty days post discharge. In addition, we have worked with BestCare and the Health Council on two projects to embed SUD providers in hospitals. The first project started in 2018 and involves a Certified Alcohol and Drug Counselor (CADC) and a Recovery Mentor on St. Charles medical-surgical units where they assess members with comorbid SUD conditions, including OUD, do brief interventions, and then help them get engaged with specialty SUD providers upon discharge. The second project embedded a CADC and Recovery Mentor in emergency departments in Prineville and Madras to assess for SUD, including OUD, support the MAT initiative described above, and connect and engage members in SUD specialty outpatient or more intensive services.

We have also made connections with the oral health community to support these efforts. The COPSTF includes dentists and extends trainings and guidelines to dental offices. We track opioid prescribing by dentists and outreach to those providers as part of the overall strategy to reduce OUD. In addition, DCOs have adopted their own opioid prescribing guidelines.

Attachment 11, Section E.1.g: Additional efforts to address opioid use disorder and dependency shall also include:

- Implementation of comprehensive treatment and prevention strategies

In addition to the efforts described above, we intend to focus on decreasing opioid use and supply and increasing treatment opportunities. We plan additional investments in provider education, reporting, and treatment. Our current PIP focus is on acute opioid prescribing, and we intend to expand adoption of the Oregon Acute Opioid Prescribing Guidelines and monitor the average days’ supply of initial opioid prescriptions. We are also taking significant steps to address the opioid epidemic by decreasing inappropriate use of opioids for chronic pain, limiting the use of acute opioids, developing and reimbursing effective clinical resources for non-opioid treatment of chronic pain, and integrating SUD treatment, including MAT, into medical settings.

- Care coordination and transitions between levels of care, especially from high levels of care such as hospitalization, withdrawal management and residential

As discussed above, we have a fully integrated case CM Team with BH and physical health clinical expertise that coordinates the care of our members with more intensive SUD or OUD.
We have also helped develop and reimburse for Recovery Mentors to provide warm handoffs to our members between levels of care.

- **Adherence to Treatment Plans**
  Our CM programs support members in understanding their treatment plans, and we coordinate their care with the providers who deliver the services on those plans. We identify barriers such as transportation, housing, or other social determinants and work to find solutions. Philosophically, we do not see a challenge in “adhering to treatment plans” as a failure on the member’s part but as a need for better engagement with the member.

- **Increase rates of identification, initiation and engagement**
  PSCS screens for SUD in all of our CM programs. We have developed screening, brief treatment, and referral workflows and algorithms. All of our staff have been trained in motivational interviewing, which aids in member engagement. We reimburse for screenings.

- **Reduction in overdoses and overdose related deaths**
  Please see our previous responses. We will continue to work actively with our partners with the ultimate aim to reduce overdoses (ODs) and OD-related deaths. We continue to contract with our provider partners to support and reimburse novel, transformative clinical models such as offering MAT in emergency departments in an effort to reduce opioid-related deaths. We will also continue to support the distribution of naloxone and the promotion of safe disposal.

**Attachment 11, Section E.2.a: How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?**

PSCS will use a multi-tier strategy to ensure periodic screening for socio-emotional needs in young children and effective and appropriate responses to areas of concern. We plan to equip providers with screening tools, treatment and referral strategies, adequate referral resources, and performance feedback on the process overall. PSCS is committed to success in this area because identifying problems in our members during childhood will allow us to contribute to kindergarten readiness across the community we serve and improve long-term health outcomes.

We plan to work in partnership with the Health Council community governance structure, including key clinical work groups, to review clinical processes, articulate the benefit of the services, and adopt standards for community practice grounded in evidence and expected benefit. After achieving community support for a process, we then plan to deploy a variety of technical assistance strategies. We expect we will draw on resources, such as the work of the Oregon Pediatric Improvement Partnership (OPIP), around follow-up pathways for developmental screening and PSCS quality improvement staff to meet with practice leadership individually and in groups. We will assist clinics in developing workflows, adopting screening and referral tools, and addressing barriers to implementation.

When it comes to changing health care practices, we know the power of data and performance reporting. Once providers have adopted screening and referral standards, we will use claims data, EHR data, and Health Information Exchange (HIE) referral tracking to monitor processes, identify outliers, and respond to places where clinical processes may be lagging.
As an element of implementation, we have added this screening requirement to our provider contracts. While this is not our lead strategy, it allows us to articulate that the service is a required element of participating in the network. By integrating this requirement in contract language, we can implement clinical quality oversight and performance monitoring, and offer feedback to providers on performance. When necessary, we will use corrective action provisions to communicate and confirm improvement to the required standard.

If a screening detects concerns, providers will have workflows and best practice information available to them to appropriately respond to the diversity of potential issues. The process outlined above will be used during late 2019 to develop workflows for referral that are customized to potential outcomes of screening, best practices for further evaluation, and the availability of local and more distant resources for follow up. We will partner with the Provider Engagement Panel (the local Clinical Advisory Panel) for expertise and shared learning, as well as statewide resources such as the OHA Transformation Center and OPIP. These partnerships will produce documented workflows and service level agreements to facilitate referrals between medical settings and from medical to educational or social service organizations if a child and family’s needs can be best met in those settings.

Attachment 11, Section E.2.b: What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?

PSCS Care Managers are all trained in Motivational Interviewing and trauma-informed practices, and they use these skills to work in tandem with each member to develop an individualized plan of care to support the member in identifying and achieving identified goals. Our CM Team follows the screening process for trauma history programmed in our integrated IT platform for Care Management and Utilization Management (Dynamo), and this includes mandatory screening for ACEs and domestic violence. The ACEs questions are drawn from the original instrument developed by Dr. Vincent Felliti. We use information obtained during interactions with members to assess for resiliency. Current upgrades are in process to Dynamo so that, by the end of 2019, the system will be able to report on outcomes from this process. Complimentary to these technology upgrades, PSCS is developing workflows and best practice processes to respond to the results of these screenings.

Within our provider network, we will partner with the Provider Engagement Panel to evaluate available questionnaires and screening tools, to determine which may be used in clinical practice settings to assess patients for a history of trauma and for resilience. The results may include different processes for the variety of settings and populations in which members are served. Screening for trauma and childhood adversity is an area of emerging practice, and ACEs screening has been more widely used in research settings rather than clinical practice. For this reason, we believe it is essential to use the expertise of our clinical partners to identify a process that is compassionate and practical, to develop workflows for effective responses, and to ensure that the screening takes place in an overall care setting that is trauma-informed. We will use the experience of screening in early-adopter clinics that have implemented trauma-informed practices to model and scale ACEs screenings in additional clinical care settings.
Attachment 11, Section E.2.c: How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?

PSCS proposes to use a multi-tier strategy to ensure universal screening for mental health conditions and substance use disorders in pregnant women at least once during pregnancy and again during the post-partum period. We will equip providers with screening tools, treatment and referral strategies, adequate referral resources, and performance feedback on the process overall. We are committed to success in this area because of the crucial impact that maternal well-being has on the long term health of both women and their children. In addition, we anticipate that implementation of the Postpartum Follow-Up and Care Coordination quality measure (proposed to be adopted by the Health Plan Quality Metrics Committee in 2021) will give us the opportunity to create a VBP model supporting high-quality postpartum care, including monitoring the depression screening and follow-up element as a proxy for use of a more comprehensive mental health and SUD screening process.

As discussed in Section E.2.a, we plan to partner with the Health Council and the Provider Engagement Panel to review recommended or available screening tools and recommend options for clinics. PSCS plans to promote use of the Edinburgh Postnatal Depression Scale, given its strong evidence base, appropriate literacy level, availability in multiple languages, and widespread current use by maternity and public health care providers. We then propose to deploy a variety of technical assistance strategies. We expect to use resources such as the OHA’s Transformation Center programs and our employed quality improvement staff to meet with practice leadership individually and in groups. These interactions will help clinics develop workflows, adopt screening and referral tools, and address barriers to implementation.

When it comes to changing health care practices, we know the power of data and performance reporting. Once the community has adopted screening and referral standards, we will use claims data, EHR data, and HIE referral tracking to do a look-back assessment and establish a performance baseline. Health Council workgroups will be able to monitor performance going forward in 2020 to identify outliers and respond if processes appear to be lagging.

As an element of implementation, we have added this screening requirement to our provider contracts. While this is not our lead strategy, it underscores that the service is a required element of participating in the network. Integrating contract language allows us to implement clinical quality oversight and performance monitoring, and give feedback to providers. When necessary, we will use corrective action provisions to communicate and confirm improvement to the required standard.

Attachment 11, Section E.2.d: How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?

We will ensure that when providers identify post-partum members with BH needs, providers have the information and resources needed to provide follow-up for those patients. PSCS believes that successful execution requires that the providers doing the screening be educated about referral options and that appropriate referral resources exist in the community. During CCO 1.0, PSCS successfully implemented new clinical practices by sharing a combination of
policies developed by Health Council workgroups and written materials developed by PSCS, as well as sharing resources and practices through written communication, education of clinical leaders, and in-person coaching in clinics. PSCS makes our employed medical directors and quality improvement staff available to address problems that clinicians or their staff encounter.

In order to ensure adequate referral resources, PSCS contracts with a diverse panel of BH providers, including those located in CMHPs, hospital systems, and private practices. We survey these providers monthly to determine capacity for new patients and maintain information about areas of specialty and culturally specific attributes of their care. Providers or members seeking BH services may use the lists that we distribute to referral coordinators, or they may contact our CM Team for assistance in securing care that meets their needs. We have removed pre-authorization requirements for outpatient BH services, and members may self-refer to any network provider or access our staff for support in accessing care. In order for primary care and OB-Gyn providers to support access to BH services for post-partum members, we have implemented Reliance eHealth Collaborative (HIE). This system allows providers to enter referral requests and receive closed-loop feedback on the outcomes of their referrals.

PSCS will continue to evaluate augmenting the range of BH care models available in response to needs identified in the population and strategies for effectively meeting these needs, including BH specialty consultation to front line and primary care providers and home visiting models. To create better systems to support this care, we use our employed Provider Service Representatives, who make site visits to all network providers, and we partner with the Health Council community governance to establish community standards for screening, referral, and treatment and ensure that communication is clear with front line clinicians and their staff. In order to ensure functioning of this system, we act on member feedback that we collect through our BH Plan access monitoring plans, and CHA to improve members’ experience with care, access to care, and health outcomes.

Attachment 11, Section E.2.e: How will evidence based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?

PSCS recognizes the importance of natural supports and healthy attachment in recovery from mental health and emotional or behavioral dysregulation in children. We define dyadic treatment in this setting as therapeutic interventions that include both the child, whose condition has been identified, and at least one parent or similar significant person in the child’s life. We support Parent Child Interaction Therapy and Child Parent Psychotherapy as dyadic treatments with a strong base of evidence for effectiveness. We ensure dyadic therapies are available for younger children. We will continue to contract for these services in the scope of work for contracted providers and explore additional models, such as the Parent Management Training Oregon model, as additional therapeutic strategies. Through community forums such as the System of Care, Clinical Advisory Panel, and Community of Practice for THWs, we will ensure that a broad range of providers serving families are aware of these services and know how to support clients to access them. As with other intensive outpatient treatments, we require no health plan involvement prior to initial assessment for services. When requested by the patient or a provider, we facilitate connecting families with services appropriate to their needs.
Attachment 11, Section E.2.f: How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

PSCS will use a multi-tier strategy to ensure that members undergo screening and to create effective responses to identified needs. We will equip providers with screening tools, treatment and referral strategies, referral resources, and performance feedback on the process overall. We are committed to success in this area because unmet basic needs can be a significant barrier to achieving good health and can constrain the effectiveness of treatment.

We intend to partner with the Health Council governance committees, as discussed above, to review screening options, articulate the goals of the process, and adopt standards for community practice grounded in evidence and expected benefit. We also plan to deploy a variety of technical assistance strategies. We expect to use resources such as those available through our participation in the Accountable Health Communities project and local experience such as that of FQHCs and other providers in piloting the PRAPARE tool developed by the Oregon Primary Care Association. PSCS will also deploy our employed quality improvement staff to meet with practice leadership individually and in groups. These interactions will assist clinics in developing workflows, adopting screening and referral tools, and addressing barriers to implementation.

When it comes to changing health care practices, we know the power of data and performance reporting. Once providers have adopted screening and referral standards, we will use claims data, EHR data, and HIE referral tracking to monitor processes, identify outliers, and respond if processes appear to be lagging. As an element of implementation, we have added this requirement for screening to our provider contracts. While this is not our lead strategy, it allows us to articulate that the service is a required element to participate in the network.

Attachment 11, Section E.2.g: Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.

PSCS will address the needs of this population through our internal integrated care management program, which brings together physical and BH clinicians. This program serves members who need ongoing case management intervention and planning over time. Members may have multiple chronic conditions, need for assistance with BH conditions, or need additional support due to worsening of their conditions or rising risk.

We also serve this population through provision of high quality, evidence-based interventions by our contracted network of providers and their care coordinators, THWs, and BH consultants. We support their work with analytics that help identify members who need specialized support. We also deploy regionally oriented internal CM Teams that coordinate closely with local providers and Member Support Specialists who understand each community’s medical and social service resources and how to access them. A PSCS director also participates on the Early Childhood Regional CHP workgroup and on the board of the Early Learning Hub. In addition, PSCS staff have contributed to the statewide process to use multiple data sources to identify children with medical, social, and health complexity and then transfer this information to CCOs for use in supporting those children and their families.
Attachment 11, Section E.2.h: How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?

PSCS will continue to work to establish services at this level in our service area where the population of our rural and frontier communities can support them. For members placed outside of the area, we will take all reasonable measures, such as accessing Flexible Services to support family travel expenses, to support the continuation of dyadic treatment. When children are placed outside the area, we will attempt to access Dyadic Treatment for the child and parent in the region of placement when possible and clinically appropriate. We will also utilize local BH programs to continue to provide services to parents locally, in order to improve chances of success when children return home.

Attachment 11, Section E.2.i: Describe Applicant’s annual training plan for Applicant’s staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.

PSCS has a long history of supporting community-based efforts to advance trauma informed practices. PSCS has contributed funding and personnel resources to advance region-wide efforts to build a community culture grounded in the principles of trauma informed care in each of our CCO service areas. PSCS has intentionally hired staff with extensive experience and knowledge of trauma informed and trauma responsive approaches and will capitalize on those resources to develop a robust annual training plan that will encompass the needs of internal staff, providers and community partners. We regularly deliver ACEs training to our staff. One training for staff and provider is scheduled for June 2019.

The annual training plan will include:

- Regularly scheduled trainings for internal member-facing and administrative teams at least quarterly with more frequent learning collaborative group meetings;
- Regularly scheduled regional trainings targeting provider partners and community members at least quarterly; and
- Webinars and/or online learning series targeting provider partners.

The trainings will build upon one another and be designed in such a way that they can also stand alone as an individual training. Trainings will cover the Near Sciences (Neuroscience, Epigenetics, ACEs, and Resilience), trauma-responsive approaches to care, effective screening tools for trauma history, and the SAMHSA six key principles of a Trauma Informed Approach. PSCS will be prepared to provide detailed information about staff and provider training activities, including reporting on training subjects, content outlines, target audiences, delivery systems, training hours, training attendance logs, and trainer qualifications. Training goals and objectives will be measurable and enable measurement of progress towards increasing knowledge, skills, and attitude to provide care and services that promote healing from trauma and support of resiliency for members and their families.
Attachment 11, Section E.3.a: Describe Applicant’s screening and stratification processes for Care Coordination, specifically:

Our care coordination strategy is a comprehensive and integrated approach that addresses the member needs across the continuum of care for high-quality, cost-effective health care delivery. The graphic below outlines the process, including stratifying members into subsets based on needs, screening members, and aligning members to appropriate care coordination programs.

Attachment 11, Section E.3.a(1): How will Applicant determine which enrollees receive Care Coordination services?

PSCS uses population health data, direct referrals, ICC and special needs categorizations, and screening to identify and stratify members who may benefit from care coordination services. Based on these results, we identify which members will be best served by an array of care coordination programs.

Population Health Data
PSCS uses an integrated relational data warehouse for population health data. We currently integrate information in the following areas to identify eligible members to determine and support care needs and stratify them using risk scores for appropriate referrals to care coordination programs:

- Medical/BH and pharmacy claims/encounters
- Laboratory data
- Co-morbid diagnosis data (medical and BH conditions)
- Demographic characteristics from OHA files
- SDOH data
- Barriers to access to care
- Cost and utilization trends (e.g. high dollar members, high emergency department utilization, and no PCP visit)
- Members with SPMI
- Children with serious emotional disorders (SED)
- Individuals in MAT for SUD

Direct Referrals
We support and promote direct referrals into PSCS care coordination to optimize our “human intelligence” and ensure streamlined access to care coordination. Any of the following programs or individuals may initiate or identify a direct referral to PSCS:

- Clinical providers, including physicians, dentists, BH providers, and clinical staff
Agency case workers and community partners
Members or member representatives
Internal PSCS referrals through UM or customer service
Tobacco cessation program assessments
HIE reports and notification
Long-term care or Long-Term Service and Supports case managers
DHS Aging and People with Disabilities
Office of Developmental Services
Health Risk Screenings delivered by PSCS

ICC and Special Needs Categorization
ICC services are a specialized CM service available to members who are aged, blind, or disabled, and/or who have complex medical needs, multiple chronic conditions, and severe and persistent BH issues, as well and those receiving Medicaid-funded long-term care or long-term services and supports. We provide children and youth with ICC services or other care management services according to their presenting needs. We flag members in Dynamo who are eligible for ICC services, to ensure appropriate services and supports are offered.

PSCS also utilizes an integrated team approach to managing dually eligible members. Clinical and ancillary support staff, trained in both Medicaid and Medicare, act as a single point of contact to manage all care coordination needs. PSCS has developed enhanced partnerships with APD to address the unique needs of this population. Our approach is guided by a memorandum of understanding that is developed in collaboration with APD and outlines our shared intention to hold regularly scheduled meetings designed specifically to address the needs of dually eligible members and create a strong community approach to comprehensively manage the care of this population.

Screening
Our CM Team is comprised of integrated physical and BH care manager clinicians (e.g. RNs, LCSWs, LPCs, and LMFs) and non-clinician member support specialists who provide ancillary support. The CM Team receives referrals as described above.

Once a member is identified as eligible for care coordination, the CM Team reaches out to the member via telephone to develop a relationship and assess the member’s needs, using our custom screening tool embedded in Dynamo. The screening includes clinical/functional status, social supports, need for additional community-based resources, and assessment of SDOH. The screening tool is supported in Dynamo with evidence-based pathways and branching logic to aid in the development of an individual plan of care. The CM Team collaborates with the member to establish a comprehensive plan of care that includes details of the supports, desired outcomes, activities, and resources required to address interrelated medical, social, cultural, developmental, behavioral, educational, spiritual and financial needs in order to achieve optimal outcomes.

Care Coordination Programs
The screening and plan of care processes allow us to align our members with the most appropriate care coordination program to support their needs and improve outcomes. The programs include:
Attachment 11, Section E.3.a(2): How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

As discussed above, we use a combination of methods to identify members who need care coordination and target members accordingly. Once identified, we contact members telephonically and screen them for appropriate intervention by the clinical care team. Member Support Specialists (MSSs) and clinicians on staff will support members using integrated care frameworks to provide a comprehensive, holistic approach to total member care.

We contact members telephonically at different times of day, on varying days of the week, at least twice, and follow up with information by letter with detailed information on how to access the care team if our outreach is unsuccessful. In some cases, we will also meet with members in person as part of interdisciplinary care team meetings. We also contact the primary care provider and any community agencies that support the member, to best coordinate care and connect the member with necessary services. PSCS also provides customized monthly member reports to our provider partners to help proactively identify members with gaps in care, new diagnoses, and other clinical indicators for needed care. We reinforce these reports in regular care management work stream meetings between PSCS and our provider partners to ensure we maximize care efforts, avoid duplication, and share best practice strategies for member outreach and engagement, track trends, and measure outcomes for ongoing process improvement. Using these strategies, we ensure members who need care coordination are able to access these services.

Attachment 11, Section E.3.a(3): How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees?

Our MSS staff identify members for coordination and case management services through a variety of methods, including claims data and reports. As discussed above, we may identify a member through a variety of means or process referrals for care coordination. We focus on early engagement with PSCS to support members in achieving optimal health outcomes by effectively utilizing their benefits. In addition to conducting welcome calls to every new member (with warm hand offs to the CM Team, as appropriate), our staff complete comprehensive screenings, as discussed above. In the event that early engagement does not promote utilization, we use a variety of strategies to contact and assess members. We distribute monthly lists of members with
identified gaps in care to our provider partners to help address underutilization. We also use our medical management platform, Dynamo, to identify members for outreach at a prescribed point in time, such as those with no claims history within three months of initial enrollment. We plan to implement an enhanced strategy to specifically identify members without claims history as well as those with identified gaps in care for targeted outreach by three months of initial enrollment. Our plan includes educating members about their benefits and the importance of preventive care, as well as how to access our staff for support. We will conduct outbound outreach, send letters, and coordinate with community providers to maximize our outreach.

Attachment 11, Section E.3.b: How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).

PSCS has already operationalized these requirements and timelines. We use the following strategies to complete initial screenings and assessment of ICC within the designated timeline:

- **Member Identification.** We use the processes discussed above to identify members eligible for ICC services. These processes are key because they trigger follow up by PSCS. For example, we send all new members a health risk screening upon enrollment and we analyze a variety of data feeds and rate group information to flag members for ICC services, including information that suggests members may have special health care needs. We act on these results and make assignments to care managers within three business days. We generate a letter and conduct outreach to detail the benefits of care coordination and explain how to access services. We send this letter to members within five business days. We stratify ICC members using analytics to identify members with particularly high complexity.

- **Tracking Timelines.** We use the Dynamo system to generate reporting that reflects ICC services eligibility. Next, our staff distributes reporting to primary care providers, specialists, dental providers, and BH providers. PSCS also delivers reporting to provider partners to monitor the health of ICCS members. We schedule monthly coordination meetings with the member’s care team and schedule focused meetings to address care coordination needs and updates to a member’s care plan. We develop care plans within ten days of enrollment and update them for prioritized populations at least every 90 days or more frequently if needs change.

Attachment 11, Section E.3.c: Please describe Applicant’s proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans. PSCS utilizes Dynamo to deploy care coordination programs across lines of business. Our systematic approach enables us to proactively identify or “flag” ICC members to trigger outreach by the CM Team within three business days. Once flagged, we track members for timely outreach. As discussed above, the CM Team completes timely screenings and uses Dynamo to timely develop care coordination plans. We include direct input from the member and/or the member’s family or representative whenever possible. Our automated logic functionality suggests care plan elements that we prioritize and customize based on the member’s personal goals and input in order to achieve optimal health and wellness outcomes. The result is an individualized, member-centric plan of care designed to address the member’s specific health needs and engagement level. We share the plan of care and coordinate its execution with
providers and specialists to incorporate unique needs, including cultural and linguistic factors as appropriate and in compliance with applicable privacy requirements.

PSCS monitors care plans and adjusts them to reflect the ongoing needs of the member as well as to inform the need for case closure or transition to outside community or provider-based care. Such monitoring and adjustment occurs at least monthly or more frequently based on the needs of the member. We also monitor overall outcomes and effectiveness by tracking key process measures. Such measures include: timeliness of initial outreach, assessment and plans of care; clinical outcomes such as readmission rates; closing gaps in care; and tracking preventive screenings. Our monitoring results inform our ongoing process improvements, as well as targeted areas of focus with our providers and community partners.

**Attachment 11, Section E.3.d: How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?**

PSCS applies a three-tiered approach to provide cost-effective integrated Care Coordination. We have incorporated the use of MSSs in our CM Team to work in collaboration with clinicians to optimize staffing resources. MSSs are non-clinical support staff whose primary function is to address members’ SDOH and access needs by working directly with members and contributing to the plans of care in partnership with clinicians. All of our CM programs include comprehensive assessments of health and social support systems in order to effectively address member needs, coordinate care with providers and community resources, and ensure care is provided to achieve the Triple Aim. Our structured care coordination work stream meetings with provider partners help avoid duplication of costly services and increase efficiencies by proactively identifying targeted members for outreach by each team and monitoring clinical, process, and member experience outcomes. Lastly, our community-based work involves the use of community huddles. Huddles serve as a core cost-effective strategy to educate multiple community partners at once, coordinate resources, and collaborate to meet member needs in partnership with a variety of community health and social support stakeholders.

**Attachment 11, Section E.3.e: What is Applicant’s policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?**

PSCS has policies, procedures and practices in place to ensure that members receive coordinated care that is person and family centered, delivered in a culturally and linguistically appropriate manner, and is guided by the principles of trauma informed care. In a simple organizational assessment utilizing the Trauma Informed Oregon Standards of Practice for Trauma Informed Care, PSCS recognized that PSCS has a strong foundation of practices that are grounded in a trauma informed approach to care.

Examples of practices that are supported by policies and are currently meeting standards:

- Health Council Board and/or organizational leadership have received information/training on trauma and trauma informed care (TIC);
- Trauma informed principles and culturally responsive values are incorporated into the mission, values and strategic plan at both the Health Council and Health Plan;
- OHP members with lived experience hold decision-making roles;
- At the Health Plan level workforce wellness is systematically addressed;
• Our CCO demonstrates a commitment to diversity and equity within the organization and with the members we serve;
• Grievance and Appeals policies allow employees and OHP members to raise safety concerns and have them addressed;
• Our member on-boarding practices are designed to be welcoming and engaging;
• Our care plans are developed utilizing a careful screening practice that addresses an individuals’ trauma history, culture, and personal health goals;
• Our organization has taken steps to ensure that member facing materials are provided using plain language guidelines, are easy to read and outline core services, key rules and policies and a clear process for grievances and appeals;
• Our organization has adopted the Culturally and Linguistically Appropriate Standards (CLAS); and
• The importance of relationship is recognized and supported through policy and practice.

While PSCS and our Health Council partners have made strong progress in adopting policies, procedures and practices that ensure care is person centered, culturally responsive, and guided by the principles of trauma informed care, we will continue to improve in this area. Specifically, we will adopt a more strategic approach to the development and implementation of training plans both internally at the Health Plan level and externally with provider partners.

PSCS has already hired a Health Equity and Diversity Strategist and employs staff who specialize in promising practices for trauma informed care. PSCS will draw on these resources to develop a comprehensive plan to offer an annual series of trainings, designed to ensure that CCO staff and provider partners develop the knowledge, skills and attitudes to deliver services that are person centered, culturally responsive and trauma informed. The comprehensive training plan will be informed by the Cultural Competence Continuing Education (CCCE) Committee and the SAMHSA Concept of Trauma and Guidance for a Trauma Informed Approach. PSCS will be prepared to provide detailed information of staff and provider training activities, including reporting on training subjects, content outlines, objectives, target audience, delivery system, evaluations, training hours, training attendance logs, and trainer qualifications. Through the comprehensive planning process, PSCS will set cultural responsiveness, implicit bias, and trauma informed training goals and objectives that are measureable, to allow for monitoring of progress.

Attachment 11, Section E.3.f: Does Applicant plan to delegate Care Coordination outside of Applicant’s organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?
No, PSCS does not delegate or plan to delegate care coordination services to outside entities. We will continue to provide comprehensive care coordination services to our members across the scope of the CCO benefit package and the OHA requirements.

Attachment 11, Section E.3.g: For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.
PSCS uses a fully integrated CM Team structure. We leverage the combined clinical and educational experience of our staff to encourage whole-person care with all members, including dual eligible members. As discussed in Attachment 6, PSHP, an affiliate of PSCS, operates
several MA plans. We are also exploring additional affiliation and MA plan opportunities across the state, also described in Attachment 6. We use this alignment to enhance access to care for dually eligible members through care coordination. For example, in 2018, we implemented Medicare reimbursement for counseling services delivered by Licensed Marriage and Family Therapy (LMFT) and Licensed Professional Counselor (LPC) providers for members enrolled in our affiliated Medicare Advantage plans. In addition, auto-enrollment of CCO members in affiliated MA plans has expanded our ability to engage with this population, improving coordination of care and access to resources for our members.

We serve dual eligible members with highly trained nurse and BH care managers and MSSs who are experts in Medicare and Medicaid. They receive annual training on both lines of business, and we validate their competencies in both areas using staff who monitor documentation and adherence to government standards for care coordination services. A single point of contact for care coordination allows us to seamlessly coordinate services internally and externally.

Our dually trained CM Team has the expertise to quickly assess the member’s MA plan, whether managed by PSCS or other carriers, and determine the benefits available for the member. For example, MA does not cover peer support or ACT for members with BH needs. Our team recognizes this gap and ensures that members are connected with CMHPs to access peer support and ACT services. In addition to monitoring benefits, we are proactive in setting up member-focused meetings to enhance care coordination. These meetings are designed to involve as many providers, caregivers, and community partners as possible with the intent to positively impact the member’s care and promote effective care coordination.

We also partner with other agencies and community-based organizations to provide exceptional service for dual-eligible members. We have established interdisciplinary care teams, which include PSCS, primary care providers, specialists, Long Term Support Services (LTSS), and state agency representatives, as well as other agencies and providers working with members. This interdisciplinary care team coordinates care and develops individualized care plans for dual-eligible high-needs members. PSCS care coordination leadership and APD managers meet quarterly to assess whether the Memorandum of Understanding (MOU) agreements have been executed, identify strengths of the partnership, identify any challenges or barriers to meeting care management of dual eligible member needs, and review unexpected opportunities.

Attachment 11, Section E.3.h: What is Applicant’s strategy for engaging specialized and ICC populations? What is Applicant’s plan for addressing engagement barriers with ICC populations?

PSCS uses a stratified approach to engage with specialized and ICC populations to address barriers to engagement, by deploying targeted strategies at the member level, provider level, and community level. A core part of our strategy is our comprehensive motivational interviewing training for all care coordination staff in clinical and non-clinical roles, enterprise-wide. This comprehensive curriculum serves as the basis for all of our care coordination outreach strategies and guides our interactions with members. We have supported provider partners in completing this training, as well, and will expand this offering in the future. We also provide culturally responsive and trauma informed care trainings to help our staff utilize evidence-based approaches (including tools such as ACE screenings and appropriate ways to partner in
delivering interpreter services) to quickly and effectively build rapport and respectful, trusting relationships with members.

Once we establish a connection with a member, we contact the member’s care team to coordinate care and work collaboratively to best address member needs while avoiding duplication. On a broader scale, we have established care coordination work streams with provider partners to identify the most appropriate, effective, and efficient ways to coordinate services and member needs via our different programs. Dynamo enables us to share customizable reports to enable timely access to this information.

On a broader community level, MSSs actively participate in the Central Oregon community. For example, we support the Community Huddle and email chain in Central Oregon, which represent real-time access points for community partners seeking assistance in locating resources for members. Our goal is to enhance the overall availability and knowledge of community services and expand engagement with specialized populations. One specific strategy we have used is via the MOMS program, which was co-developed by St. Charles Center for Women’s Health and BestCare Treatment Services. MOMS attempts to engage pregnant women suffering from IV drug addiction with treatment and prenatal care. MOMS utilizes the Intentional Peer Services (IPS) model to reach out and engage pregnant women. These peer support mentors are moms in recovery themselves, who have a history of using IV drugs, experienced shared fears of losing their child, and also subsequently often avoided pre-natal care. This program continues to grow and develop, but early outcome data is promising, with an engagement rate of approximately 60% by mothers who otherwise may not have sought prenatal care.

Attachment 11, Section E.3.i: Please describe Applicant’s process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.

When care coordination services conclude and members are discharged from care coordination and ICC services, all members receive a letter from their care manager and MSS. The letter explains the termination of care coordination services with PSCS and provides instructions and contact information for future assistance, should members identify a need or have questions for follow-up services. By phone and in writing, we alert members that discharge for completion of care coordination services does not in any way impact or terminate their benefit coverage, care, or the availability of services provided by PSCS. We follow this process for all members being discharged from care coordination or ICCs.

PSCS recognizes that engagement with members is our highest priority in improving health outcomes and coordinating care for our members. In order to achieve high engagement rates with our members, PSCS focuses efforts on telephonic outreach, letters, and email engagement, as discussed above. If a member is being discharged due to lack of engagement, the care manager first connects with the member’s primary care provider and other members of the care team to facilitate coordinated contact with the member. If the care manager is unsuccessful in engaging the member, PSCS sends the member a letter describing how to access services should the member decide at a later time to request assistance or engage in care coordination.
Attachment 11, Section E.3.j: Describe Applicant’s plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant’s Service Area. How will Applicant coordinate with Providers across levels of care?

PSCS has developed both internal and external care coordination strategies to ensure continuity of care for members experiencing care transitions, including those involving out-of-area transitions. We use Dynamo, which alerts the CM Team about high-risk members admitted to an acute care facility. This process allows us to start discharge planning at the time of admission in collaboration with our UM Team and facility-based discharge planning staff. PSCS staff meet in daily huddles to solve challenging care situations and to ensure members are discharged to an appropriate level of care at the right time with all of the necessary resources in place. Both the UM and CM Teams meet bi-weekly in our census meeting under the direction of our medical directors to ensure member care is coordinated, timely, and complete.

One key element of our strategy to coordinate care across levels of care is to build a strong relationship with the member’s primary care provider as part of our initial assessment and care planning process. On a broader scale, we meet with provider partners to establish work streams to ensure continuity of care and maximize resources to best address member needs in different regions. We share customizable reports with providers to measure the effectiveness of our shared work in order to support ongoing process improvement efforts, such as reducing readmission rates, responding to identified trends, and changing approaches as needed. PSCS also has a Transition of Care policy, which addresses the specific needs of members transferring between one CCO and another or from OHP fee-for-service enrollment to enrollment in PSCS, as discussed in Attachment 16. We follow this policy to ensure continuity of care.

As an existing CCO with medical directors employed in-house, we have extensive experience coordinating care to ensure continuity of care for members outside our service area and outside the state. We have expertise in coordinating care for members who require specialized behavioral and physical health needs, which requires us to work with internal and external state and hospital agencies to coordinate transitional care. We manage out-of-state referrals that require specialized air transportation, hospital stabilization, facility onboarding, DME alignment, pharmacy follow up, and coordination with providers throughout each transition. While members are out of state receiving care, PSCS coordinates weekly team calls with inpatient and outpatient providers to maintain continuity of care and work with various state agencies to develop plans to support effective transitions back to Oregon or elsewhere.

Attachment 11, Section E.3.k: How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?

PSCS manages discharge planning proactively. We immediately assess, review, and plan for post-discharge needs once we receive an alert that a member has been admitted to a facility or hospital-based services. In collaboration with our UM team, our CM Team meets weekly to review all acute care admissions (including BH and SUD), referred to as census review, to coordinate care for members who are admitted to an acute care facility. Our medical directors lead this process to ensure members are enrolled with a care manager and that we follow up on members who need discharge planning assistance. We reinforce this practice in daily work flows in between meetings by delivering real-time care coordination assistance using Dynamo. Care
managers coordinate with our UM Team to work proactively with discharge planning staff to coordinate transitional care planning.

Through our team-based approach, we are able to effectively and efficiently manage care transitions with our providers and community agency partners. PSCS staff actively participate in the discharge planning process for members admitted to inpatient BH facilities. Our clinicians identify providers most appropriate to meet the member’s needs, facilitate relationships between community mental health program providers and acute care facilities, provide history of barriers to access in care, and review housing options, while providing statewide referrals for placement. Finally, our inpatient BH Care Manager coordinates discharge planning with all out-of-area members who have been admitted to BH acute care facilities. We also coordinate with local providers when our members are admitted to acute care facilities.

Attachment 11, Section E.3.l: What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

PSCS manages and supports members in transitions of care from all settings, including, but not limited to, hospitals, skilled nursing facilities, subacute, and OSH placements. Our CM Team identifies members in other systems through Dynamo, UM processes, and weekly census meetings, which include a detailed review of all acute inpatient admissions across all lines of business. Through this identification strategy, we actively place all ICC members in transition of care support while monitoring their status, discharge needs, DME requirements, outpatient follow up, lay caregiver coordination, community resource management, transportation, medication management, and coordination of benefits. Our CM Team participates in the discharge planning process to ensure members receive a follow-up visit with a BH provider within seven days of their discharge, or three days if a member is eligible for ICCS.

PSCS supports members with SPMI by coordinating the care of those members transitioning through acute stabilization environments to step down facilities. One way we complete this work is through Choice Model Services contract arrangements. By actively engaging in care coordination planning with CMHP staff, we are able to effectively transition members with SPMI requiring facility-based support to the most independent environment by limiting long-term institutional care and reducing recidivism rates. Outside of the Choice Model, our team has worked with multiple service providers within and outside our service area to locate supportive housing.

Attachment 11, Section E.3.m: Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

As discussed above, once we identify members for ICC, we focus on member engagement to complete initial assessments and care plans. Our CM clinicians work in partnership with MSSs to best address SDOH needs as well as clinical needs. We use this partnership strategy to work with members in a comprehensive, cost-effective way. We also work in collaboration with providers to coordinate care and avoid duplication of services. We track ICC members, document and track our outreach attempts, and monitor our caseloads via Dynamo, which provide us with the tools to ensure we are able to adhere to the 15:1 required staffing ratio. As part of our ongoing process improvement efforts, we will continue to evaluate and assess staffing
needs to be able to meet the needs of our ICC members. In addition, we will conduct quarterly reviews of caseload requirements to track compliance.

Attachment 11, Section E.3.n: Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination? Our Care Coordination strategy is designed to support members across the continuum of care, and we utilize tools and metrics to measure the effectiveness of our care coordination programs. We evaluate performance effectiveness in two core areas: process and clinical quality outcomes.

With respect to process, we use Dynamo to monitor performance and measure effectiveness. We track timeliness and completion of the screening process (including member outreach and initial assessments), care plan completion, and whether member goals were met. Dynamo also tracks barriers to care.

With respect to clinical quality outcomes, we designed the care coordination programs discussed above (transition care coordination, community care coordination, and intensive care coordination) using a variety of evidence-based tools and national and state quality metrics to monitor and measure effectiveness. The evidence-based tools we employ are national tools and models such as the Coleman Model for transition care coordination, Milliman Care Guidelines, LACE index for readmissions, and PHQ-2/PHQ-9 depression screening. In addition, we use national (Healthcare Effectiveness Data and Information - HEDIS) and state (Quality Incentive Measures) clinical quality metrics to monitor outcomes such as readmissions and prevention screenings. Each care coordination program has specific goals and outcomes that we monitor to track effectiveness and support continuous improvement. We strive to continuously update our approach using best practice tools to improve the quality of care and assess our performance against industry standards.

Attachment 11, Section E.3.o: How will Applicant ensure that Member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the Member is receiving needed services and Care Coordination?
PSCS uses several strategies to share qualitative and quantitative information with an array of providers, care managers, and other appropriate parties. We use a suite of reports, integrated care meetings, and HIE methods. We discuss each in turn, below.

- **Gaps in Care Data.** We deliver member-level reports on gaps in care to providers on a monthly basis.
- **Member Insight Reports.** We deliver comprehensive member-level risk stratification reporting to providers on a monthly basis. We work in partnership with providers and others to ensure that they have support to act on this rich information source.
- **Claims, Encounters, and Eligibility Data.** We deliver this data to providers in a format that allows them to conduct their own analytics to support risk stratification and understand member needs. Our IT and analytics teams support this work.

We work in partnership with primary care providers, specialists, BH providers, care managers, and other appropriate parties to conduct integrated care meetings and member-focused meetings. These meetings are designed to ensure timely and accurate information sharing to enhance care
coordination and communication between all parties. PSCS also uses HIE strategies to share member information and detailed clinical records for viewing and use by providers, as appropriate per HIPAA. We rely on regional governance for HIE, Reliance eHealth Collaborative, and PreManage, among other HIE tools. We are committed to advancing the use and effectiveness of HIE to improve clinical quality outcomes, control costs and enhance member and provider experiences.

Attachment 11, Section E.4.a: How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

PSCS works closely with, and will continue to work closely with, the OHA as well as other agencies and entities to identify areas where treatment and services for adult members with SPMI can be improved. We will continue to partner in learning collaboratives and dedicate our staff expertise, partner with housing agencies, and work collaboratively with other agencies.

PSCS was an active participant in the OHA-sponsored BH Collaborative, which refined OHA policy priorities and strategies. We are active participants in the monthly CCO BH Directors meeting. We supported the OHA’s recommendation for this meeting as part of the structured engagement between the OHA and CCOs. This has been a useful forum for rich discussion between OHA BH leaders and staff and CCO BH representatives on a wide range of important topics of public policy and strategic planning. Moreover, our BH Medical Director and Medicaid Medical Director are active members of both the CCO Medical Directors meeting and the Quality and Health Outcomes Committee where they engage in opportunities to address and improve the quality of care for members with SPMI.

As a Choice Model Services contractor, we also participate in monthly Long Term Care Coordination meetings at the OSH, focused on strategies at the regional and local level that CCOs and CMHPs can employ to help the OHA meet the goals and benchmarks in the Oregon Performance Plan (OPP). We also participate in the Executive Level Choice Model meetings. These are valuable collaborative opportunities to adapt our strategies to ensure people with SPMI are able to live and work in the most independent settings possible, with necessary community supports to help them be productive and successful in the communities of their choice.

We have also worked closely with Housing Agencies in carrying out CHA and CHP activities. This is an important collaboration, given the well-documented health care costs related to homelessness and the documents provided by the OHA that summarize the state of the literature in Supportive Housing.

Lastly, PSCS maintains Memorandums of Understanding with the Oregon Department of Human Services, Aging and People with Disabilities regional and local offices. While SPMI conditions do not result in determination of APD service eligibility, there are APD service eligible individuals who also have SPMI conditions. PSCS is committed to coordination of policy, administration, and service delivery to serve as a platform for improving care and health outcomes in this vulnerable population.
Attachment 11, Section E.4.b: How will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

PSCS provides oversight, care coordination, and transition management through a policy partnership with the OHA. Particularly, in this context related to the OPP, through CM when our members are receiving services outside of one of our service areas, and through oversight of the contracted CMHPs that perform care coordination and provide other critical community based services specifically designed for members with SPMI, such as ACT, Supported Employment, and Supported Housing. We discuss each in turn below.

Policy Partnership. Our BH leadership and staff that are integrated into UM and CM Teams, are well informed when it comes to the Olmstead decision that confirmed people with intellectual and psychiatric disabilities have the same rights to public accommodation as individuals with other disabling conditions. Our team collaborated with officials from the OHA through the voluntary agreement with the USDOJ and now we collaborate through the policy goals and performance targets in the OPP. We utilize this information to ensure our staff are well informed and to inform our oversight of contracted CMHPs that provide many community-based services and supports for members with SPMI.

Care Management. PSCS has integrated staff, who are licensed BH Clinicians with significant experience with the covered populations, into our UM and CM Teams. While we have strategically separated the UM and CM functions, we hold regular clinical consultation sessions so staff can consult with our BH Medical Director. PSCS has a licensed BH clinician on the integrated CM Team that has a specific focus to ensure members with SPMI receive coordinated services specific to their needs.

We meet regularly with CMHP staff to discuss challenging cases, patterns, and trends as well as share success stories in an effort to promote learning across the state. When members require facility based services in Acute Psychiatric Inpatient Hospital settings, OSH, or adult mental health residential settings outside of our service area, our CM Team opens a case and actively ensures discharge planning and transition to the home community are occurring, keeping the CMHP team as actively involved as possible. For members temporarily outside our service area, providing transition of care-type CM services using our own staff gives us the flexibility to take steps to authorize primary care, specialty medical, dental, or additional BH services as needed. We have received positive feedback from out-of-area residential providers for our approach.

Oversight. Due to our role as a Choice Model Services contractor, we collect data on all of our members and Choice clients who are not our members who receive services in OSH, adult mental health residential settings, or community supports financed by Choice Model funds, and submit that data to OHA quarterly. Referrals from Acute Inpatient Psychiatric Hospitals to OSH require approval by PSCS, which gives us an opportunity to re-evaluate how member needs can be addressed and divert members from institutional settings when possible.
Our role in implementing Choice Model functions, services, and supports has prepared us to serve as a CCO partner in regions where we collaborate with other entities the OHA has selected to administer the Choice Model Services contract. As the OHA takes steps to integrate responsibilities for individuals admitted to OSH, we will work closely with the OHA, OSH, providers of residential adult MH facilities, CMHPs, and other specialty providers to ensure the individual’s needs are met in the most independent setting possible and contribute to meeting the goals in the OPP.

Attachment 11, Section E.4.c: How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member’s housing needs?

Housing is one of the most important community supports and, in most communities, the most challenging support to obtain. We work with CMHP staff, who facilitate access to supported housing programs, and we also use Choice Model Services funds for transitional living environments, while longer term housing arrangements are solidified. We also support transitional housing needs consistent with the OHA’s FAQ on Health-Related Services.

PSCS has work flows in place to assure new members who meet the OHA definition of a member with SPMI receive ICC. We also transmit information to PCPCH and CMHP provider partners because we support the close connection of service provision and care coordination. We have revised Dynamo to document our CM work to assure complete assessments and plans are completed. The new assessment format includes a section on SDOH, including Housing.

All members who are admitted to Psychiatric Inpatient Hospital settings are evaluated for transitions of care case management by the PSCS Care Manager assigned to members with SPMI. All members temporarily in out-of-area adult mental health residential settings or OSH receive ICC from a PSCS Care Manager who specializes in members with SPMI. This is one of the most challenging and most important components of CM. As part of this work, we ensure members receive ICC support in finding appropriate housing and coordinated support in addressing their housing needs.

Our members with SPMI also receive care coordination from CMHP providers and other community providers to address their housing needs. We also host monthly Choice Model meetings, which bring together CMHP staff from multiple regions and provide us with an opportunity to review specific members. We have developed relationships using this model and CMHP representatives often contact our CM Team to seek consultation on client-specific situations. Our integrated CM Team also holds regular meetings with primary care clinics to clarify respective roles of care managers in clinics and at PSCS, review metrics, and consult on particular members. We consult with CM staff on clinical and SDOH matters, including housing, employment, and food insecurity. THWs work directly with members to assist them in finding appropriate housing.
Attachment 11, Section E.4.d: How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice? 

Informed consent, individualized treatment goals, and social supports are long standing operating principles in working with individuals with SPMI. PSCS works closely with LMHA and CMHP staff, along with our own teams, to help members with SPMI obtain housing. Please see our response to Section E.4.c for more information about funding streams. PSCS coordinates with CMHPs and PCPCHs to assure members with Special Health Care Needs (including SPMI) receive ICC services individualized to their needs. We work with community partners to assure our respective ICC functions are complimentary and not duplicative. We have shared interest in helping address SDOH needs. Each of the communities we serve has some capacity to provide supported housing and transitional living for members with SPMI. On a case-by-case basis, we collaborate on the member’s treatment goals, clinical needs and individualized needs and choices. The OHA Choice Model Services contract provides resources for temporary transitional living, which is often needed while we explore more permanent supported housing or independent living options.

Attachment 11, Section E.4.e: How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255? 

ACT is an important evidence-based practice with well documented outcomes of reducing the use of Acute Inpatient Psychiatric Hospital Services. Increasing the availability and participation in ACT is also one of the objectives in the OPP. PSCS is committed to ensuring ACT services are available for members who meet the criteria and choose to participate. PSCS plans to work with the Oregon Center of Excellence for Assertive Community Treatment (OCEACT), CHMP providers, and ACT providers to conduct past fidelity reviews and assure each provider has a plan in place for expansion if referrals exceed current capacity. We will also review and revise CMHP oversight strategies to include assessment of compliance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255.

All members transitioning out of OSH are offered ACT services, and our staff are directly involved in screening and referral. We are also committed to a planning process that will enable us to identify additional reporting requirements that may provide us greater visibility to occasions when members may be screened and denied a specialized BH service designed to serve members with SPMI, such as, but not limited to, ACT. To date we have not experienced problems with denials of ACT services as reported by other regions of the state. PSCS is fortunate to partner with high-quality ACT programs. While we have not experienced problems, we will nonetheless expand our provider training and will comply with all new ACT reporting requirements.

Attachment 11, Section E.4.f: How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member? 

PSCS works closely with the contracted providers of ACT and other specialized services for members with SPMI. It is important to note that ACT should not be the only access point to a
member receiving care coordination. We have also worked with our contracted provider network to ensure the individuals conducting screenings are skilled at motivational interviewing and motivated to develop individualized approaches necessary to meeting each members specialized needs. We are also actively working with providers of ACT to assure they will be able to expand or develop additional teams should the demand for these services increase.

PSCS has already launched an updated training initiative for CMHP staff in order to ensure notices of adverse benefit decisions (NOABDs) are issued as required. We review all NOABDs for appropriateness using staff who have extensive knowledge of government BH programs and we report all NOABDs to the OHA. We review NOABDs for ACT with provider staff to ensure we appropriately apply eligibility criteria and improve the reporting of client notices and documentation of reasons for denials.

Attachment 11, Section E.4.g: How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member’s participation as required by the Contract?

As discussed above, we believe it is essential that ACT not be the only option for comprehensive services that include care coordination, and we work with contracted providers across the service array to ensure we meet members’ needs. We believe that providers should use motivational interviewing and deploy experienced THWs to find the right balance between an intensive package of services and member consent. We often pull together providers across the service array to engage members who are eligible but decline to participate in ACT, by working together as a coordinated team. Going forward, we will expand our documentation of shared coordination plans to engage all eligible members who decline to participate in ACT.

Attachment 11, Section E.4.h: How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care Coordination?

PSCS will work with CMHP staff to scrutinize members declining to participate in ACT by performing root cause analysis. We will also deploy other options like Early Assessment and Support Alliance for younger adults, Supported Employment, and Supported Housing, as appropriate. We will screen those members for ICC services, but members also must consent to CM as well. In our experience, some members that are reluctant to engage initially are very willing to talk with our CM staff about physical health or SDOH, and those topics often open doors to discuss their engagement in comprehensive BH services such as ACT.

Fortunately, we have invested considerable energy in establishing PCPCHs with integrated BH clinicians and CCHBCs, and we plan to expand on this strategy going forward. Some integrated PCPCHs are able to provide a full range of medical, BH, pharmacy, and care coordination. This option requires specific case consultation, warm hand off, and member consent, but it is an option that we use for some members as a means of providing comprehensive and integrated care to members with SPMI, who often have multiple chronic medical conditions. We will also expand the motivational interviewing training we make available to providers during 2019.
Attachment 11, Section E.4.i: How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed Member with SPMI, who no longer needs placement in an SRTF, to a placement in the most integrated Community setting appropriate for that person?

Our staff that implement the Choice Model Services contract also provide CM for members who are receiving treatment in an SRTF or other licensed residential settings, so our work flows already exist. By virtue of this work, we have already operationalized the 2020 CCO requirement. Our staff have developed relationships with SRTFs and Commitment Investigators that must approve changes in living arrangements for civilly committed persons. In our experience, the best transition planning occurs when there is a documented plan that reflects both clinical need and member choice. We strive to have a consistent team made up of both community and PSCS staff to provide transition management and endeavor to maintain contact with the facility or member on a regular basis, in order to keep current on their progress and assure both member and provider that we are ready to assist them with the discharge transition as soon as the member is ready. Of course, the goal is to get the member to the most independent living environment with appropriate supports as quickly as possible. We take pride in helping our members return home.

Attachment 11, Section E.4.j: How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?

PSCS will conduct an assessment of supported housing, less formal housing supports, and linkages between BH providers and housing authorities to identify opportunities for short-term gains in this important area. We have experience working with housing organizations and Oregon Housing and Community Services through CHA/CHP processes since 2012. Our ongoing work across the state demonstrates our commitment to addressing housing needs as a key SDOH.

We will work in partnership with the Health Council to improve connections between health care and housing professionals. Through these forums, we will solicit information as to strategies our partners believe would be most effective to increase the availability of housing settings that can be paired with specialized and appropriate treatment resources for supported housing. We will emphasize criteria within the OPP and the desire to ensure that individuals with SPMI are integrated into the communities in which they live, not socially segregated by the use of congregate housing. The additional reporting required in Exhibit M, Section 3 of the 2020 CCO Contract will provide some of the information we need to quantify the goal of expanding access to supported housing. We will also consider if additional data points could be useful.

Attachment 11, Section E.4.k: Provide details on how Applicant will ensure appropriate coverage of and service delivery for Members with SPMI in acute psychiatric care, an emergency department, and peer-directed services, in alignment with requirements in the Contract.

PSCS is committed to supporting members who require acute psychiatric inpatient care and/or utilize emergency departments. We welcome the opportunity to develop a management plan, policies, and procedures targeting decreased use of the emergency department, by members with SPMI, and decreased psychiatric hospital readmissions. In 2018, as part of our Transformation
and Quality Strategy (TQS) work, we took steps to expand the use of PreManage. In 2019, we are working to develop work flows in partnership with CMHP staff to identify and provide individualized outreach to members who have repeat emergency department visits or psychiatric admissions. We expect that the 2020 management plan will give us broader context to sustain this work over time.

While we cover and deliver these services for members in alignment with the requirements of the 2020 CCO Contract, we are also committed to carefully considering the needs of our members and our provider network, along with any new partners. We propose to conduct a careful community-based needs assessment on the following timeline:

- May-June 2019: Develop details of planning process, including topics, sub-topics, key participants, and an initial gap analysis.
- July-September 2019: Develop approaches, policies, and procedures. Finalize the plan.
- September-December 2019: Work with community partners and internal departments to ensure we are prepared to implement the plan or revise as needed to achieve compliance with applicable requirements.

Attachment 11, Section E.5.a: How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an Emergency Department in a six-month period? The management plan must show how the Contractor plans to reduce admissions to Emergency Departments, reduce readmissions to Emergency Departments, reduce the length of time Members spend in Emergency Departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit within three days.

In 2018, we designed and implemented a TQS project that established goals for connecting CMHP and PCPCHs to PreManage so they had the capacity to receive notifications when their patients used the emergency department. For those that used the PreManage system, we provided them information about established SPMI cohorts. This initiative was so successful that we exceeded our Year 2 goals in Year 1. As a result, we have made significant changes to this TQS project, and in 2019, we will identify select clinics to build specific workflows to support interventions for SPMI members with multiple emergency department visits. We plan to learn from these efforts and inform our policies and procedures accordingly.

Before January 2020, we will convene stakeholders to develop specific strategies and workflows that will inform our policies related to members who are frequent users of the emergency department. We will develop policies and procedures that specify the target population, interventions, and methods of measuring results. The policy will include strategies to reduce admissions and readmissions to emergency departments, reduce the length of time Members spend in emergency departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an emergency department, including a follow-up visit within three days.

Work has already begun on this plan, and we have convened discussions with community partners to review data and evaluate trends. In order to gain additional insight into emergency department visits in this population, local hospital systems have undertaken chart reviews,
looking for trends, rationale, and opportunities for improvement. Building on this work, as well as evaluating other ongoing initiatives that are in place to address this inappropriate utilization, we will develop a plan to offer services to all members with SPMI who access an emergency department in a six-month period of time.

The emergency department utilization rate in the Bend area is below the statewide average, but the utilization rates at emergency departments in Madras and Prineville are among the highest in the state. The two counties with the highest emergency department utilization rate among members with SPMI are in Central Oregon. We are actively seeking and deploying strategies to address this issue. For example, the Health Council approved a pilot project to utilize paraprofessionals with training in mental health and SUD to do targeted outreach to members in this cohort during or after their emergency department visit in three rural hospitals within the region. The timeframe for this project was 2018, and evaluation of its impact is pending (anticipate June 2019). Another strategy that is currently funded to address this population’s use of the ED is the placement of certified addiction counselors and peer professionals with the smaller EDs, to provide outreach and warm handoffs for those members with both SPMI and SUD. That trial is ongoing.

Attachment 11, Section E.6.a: How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

PSCS plans to use our experience as a Choice Model Services contractor to inform our partnerships across the state and collaborate with the OHA assigned Choice Model contractors for those regions. As an OHA Choice Model Services contractor in Central Oregon and the Columbia Gorge, PSCS is responsible for approving referrals to OSH for any member in Acute Psychiatric Inpatient Hospital settings. We take this responsibility seriously and because the OHA provides the Long Term Care criteria, we are very selective about approving OSH referrals. We assess every member in Acute Psychiatric Inpatient Hospital settings for CM needs and offer CM to members that lack an existing community-based team or other necessary supports. We offer CM to all members referred to OSH, even if they have an existing community team.

When we approve an OSH referral, we have already coordinated with the CMHP or BH provider and Acute Care Hospital, and often the OSH referral coordinator. A preliminary discharge plan is in place and the community team identifies key clinical indicators of the member’s readiness to transition out of OSH. We emphasize the importance of CMHP staff involvement in Individualized Discharge planning Teams (IDT) when the member is at OSH.

Our CM Team participates in IDTs and is accountable for ensuring all of the transition-related tasks are completed. Coordination with OSH social workers is routine. When the recommendation is to refer a member to a licensed residential facility, we coordinate with KEPRO, and our staff then follow established work flows. The CM Team stays closely involved until the member is living in a non-licensed independent setting in the community of their choice and has needed supports in place.
Attachment 11, Section E.6.b: How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant’s Service Area when the Member has been deemed ready to transition?

As described above, we are a Choice Model Services contractor for Central Oregon and the Columbia Gorge. We have experienced staff on our integrated CM Team that work directly with members in Acute Inpatient Psychiatric Hospitals. When absolutely necessary and a diversion plan does not seem medically appropriate, our staff approve referrals to OSH.

We work closely with the team of community providers serving the member, and if a team, doesn’t exist, we work quickly to establish one to ensure a community-based, individualized plan for post OSH services and supports is in place prior to discharge. Our staff participates in OSH IDT meetings to track the member’s progress in treatment. We encourage the community provider to participate in these meetings and to visit the member while they are at OSH in order to reinforce that they have a community-based team and plan. We always take the members’ preferences into consideration when developing the community-based plan. If a member requires further stabilization in a licensed mental health facility before living independently, our team continues to play the primary role coordinating the member’s transitions. Our preference is to utilize the community team as the primary point of contact with the member, but these decisions are made on an individualized basis, and there are instances when our staff assume the primary point of contact for the member.

Our staff stay engaged in the member’s care and communicate with the member and providers on a regular basis. One of the benefits of the integrated CM approach is that we deploy our ability to arrange for primary care, dental care, and other covered services our member may require while a resident of a licensed mental health facility outside our service area. When members are transitioned to a non-licensed living situation, with appropriate community supports, we transition the primary CM responsibility to the community-based team. The CM Team continues to be available for consultation and meets monthly with CMHP staff.

Attachment 11, Section E.7.a: How will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295?

Supported Employment is a well-researched, evidence-based practice proven to decrease psychiatric hospital utilization in people with SPMI. Oregon has a long history of promoting Supported Employment and it is a covered service under the Rehabilitative Services option in the State Plan.

We are fortunate to work with high-quality Supported Employment programs. While we currently provide access to these services, we are aware of some limitations in service delivery. Therefore, we plan to implement three changes in order to assure access to Supported Employment and that the services are delivered in accordance with applicable Oregon Administrative Rules:

- Work with the Oregon Supported Employment Center of Excellence to review past fidelity reviews and strategies for improving quality and expanding capacity;
- Work with CMHP staff to ensure they have policies and protocols in place to expand Supported Employment capacity as needed; and
- Review and revise CMHP oversight strategies to include assessment of compliance with OAR 309-019-0275 through -0295.

Attachment 11, Section E.8.a: What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?

PSCS will collaborate with multiple community partners to fully implement a System of Care (SOC) governance structure that functions as described in the SOC Wraparound Initiative Guidance Document. The SOC governance structure and Fidelity Wraparound Services ensure that care is individualized to the needs and preferences of each youth and family, culturally responsive, and, to the maximal extent possible, community based.

PSCS supports the SOC governance model as an optimal structure to meet the needs of multi-system-involved youth and children and their families and to create collaborative funding models to improve service quality and availability. Prior to the start date of the 2020 contract, PSCS will engage in dialogue with community partners to determine the most appropriate process to designate a single organization to serve as the convener of the SOC governance structure including, if necessary, issuing a formal request for proposals. The convener, which may be PSCS or another organization, must be willing and able to complete the work, have the right balance of local relationships and political neutrality, and adhere to a scope of work with explicit responsibilities. We will detail these responsibilities in written agreements, which will include recruiting for the governance council and committees, providing administrative support for meetings, tracking and following up on assignments to participating organizations, and staying in close contact with the OHA, DHS, and other stakeholder organizations.

PSCS commits to retain ultimate accountability for Fidelity implementation of SOC governance and Wraparound Services and will fulfill this responsibility directly or through careful contracting and monitoring of work completed by other organizations, and by identifying a single point of contact related to the Wraparound Initiative.

PSCS recognizes that success depends on the engagement and collaboration of youth and family representatives, including Family Support Specialists (Family Partners) and Youth Support Specialists (Youth Partners), as well as participants from a broad range of organizations with expertise and decision-making authority. For this reason, SOC governance will include at least 51% participation by individuals representing youth and family voice, who are adequately prepared for participation, prioritizing local individuals and augmenting this participation with youth and family representatives accessed through Oregon Family Support Network and Youth ERA, if needed. Core SOC participants will include representatives of DHS Child Welfare, IDD programs, K-12 education, special education, juvenile justice, Oregon Youth Authority, and health care, including mental health, SUD treatment and primary care. These community partners bring multiple resources to the work, including their existing organizational and client relationships, their ability to access diverse funding streams, their varied legal and regulatory scopes of work, and a range of expertise. In addition, individual care coordinators providing Wraparound Services will use SOC governance, starting with the Practice Level Workgroup, to access an unlimited range of community resources outside the core organizations listed above. The scope of these services cannot be defined in advance because they will be determined by
unique individual client or family needs, but examples include resources to address social and educational needs and facilitate the availability of natural supports.

To augment SOC effectiveness, we expect PSCS and local providers will work collaboratively with Portland State University, Oregon Family Support Network, Youth ERA, and system partners in workforce development. PSCS will encourage the SOC convener and participating organizations to develop a diverse workforce through hiring or contracting with Family Partners, Youth Partners, and staff who are reflective of the diversity of the community and members served.

Attachment 11, Section E.8.b: Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

Working through the designated convener, PSCS will operate the SOC governance structure consistent with the SOC Wraparound Initiative Guidance Document produced by the OHA, and other relevant resources, such as those from Portland State University and the University of Washington.

A full SOC governance structure, encompassing the four levels of responsibility, will be operational at the beginning of calendar year 2020. Each of the councils, work groups, or committees will develop charters for their work and orientation materials for new council or committee members, which will be completed by the end of 2020. In addition, the convener and PSCS will ensure quarterly reports are created to track resolved and unresolved barriers to implementing the SOC, as well as an annual SOC Brief, which will summarize local issues addressed through the SOC governance structure and data-informed priorities for the coming year. In rural and frontier communities, in order to avoid the work of these committees becoming duplicative or imposing an undue burden on participating organizations, up to two committees may be combined to meet as one group that addresses the duties of both levels of governance. As a result, the four levels of governance will function through two to four committees, fully addressing the required functions.

Our experience is that Executive Council and Advisory Committees function most effectively when they cover an entire region, encompassing multiple counties or jurisdictions. This allows for high level system change to have widespread effect and avoids the need for senior leaders in an organization to participate in multiple groups, each covering a different county or community. Conversely, we have experienced that Practice Level Workgroup and Wraparound Review Committees function best when they operate as close as possible to the individuals and community being served. For this reason, these two lower levels of governance may operate at the county or community level, depending on what the SOC convener and participants determine will function best. In our current service areas, we have experience working with a range of region-wide and county-specific governance structures. In collaboration with the identified convener of the SOC governance structure and participants, PSCS will review and facilitate mergers of county-specific structures where a regional approach will better achieve SOC principles. The following narrative describes PSCS’s preferred model:

The SOC Practice Level Workgroups will include at least 51% youth and family representatives, plus supervisory-level individuals. It will consist of CCO representatives, providers, child-
serving agencies, and other agencies, including young adults and peer support, families and family partners, and advocacy organizations reflective of local culture. Practice Level functions will include reviewing Wraparound practice barriers, removing barriers when possible, and submitting barriers that remain unresolved to the SOC Advisory Committee and/or Executive Council for resolution or advancement to the Statewide System of Care Steering Committee as needed.

The Wraparound Review Committee may also function as part of the Practice Level Workgroup where the two are combined. It will receive referral information from PSCS on clients and reviews and select clients for enrollment in Wraparound according to locally established criteria and the process detailed in the OHA guidance documents. The Review Committee assists in managing enrollment to the targeted number of referrals, oversees transitions out of Wraparound to create opportunity for incoming referrals, and examines the demographics of referred clients to identify and address disparities or concerning patterns in the attributes of clients being referred to Wraparound.

SOC Advisory Committee may serve the full region or there may be multiple Advisory Committees within the service area. The Committee includes mid-level organizational managers and advises on policy development, financing, implementation, Fidelity, outcomes, and provides oversight using a shared decision-making model. The Committee responds to the barriers that the Practice Level Workgroup cannot resolve, making recommendations to the Executive Council as needed. The SOC Advisory Committee consists of 51% youth and family advocates as well as representatives of PSCS, DHS, juvenile justice, Oregon Youth Authority, developmental disabilities agencies, health care providers, advocacy organizations, and individuals reflective of local culture. The SOC governance convener will track relevant cultural and linguistic representation in the Advisory Committee and undertake targeted recruiting and training to improve the degree to which the Committee reflects the population that it serves.

The SOC Executive Council develops and approves policy, engages in shared decision-making regarding funding and resource development, reviews project outcomes, and identifies unmet needs in the community in order to support expansion of the service array. The group will use the Statewide SOC Committee for assistance in removing identified system or funding barriers to ensure optimal service delivery and will work with the OHA on matters related to funding, Fidelity, and the interface between the available service array and the CCO benefit package. The Executive Council consists of leaders with decision-making and financial authority within their organizations, including the CCO, juvenile justice, service providers, child serving state agencies and other organizations along with young adults, Youth Partners, family representatives and Family Partners, advocacy organizations, and individuals reflective of local culture.

Attachment 11, Section E.8.c: How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?

The convener will be responsible for providing staff and creating operational processes to ensure that barriers submitted to the SOC governance groups are tracked as to status: submitted, resolved, and unresolved. PSCS will require that the convener of the SOC use minutes and agendas to share the status of identified barriers with governance councils and committees and to document steps taken to address identified barriers.
The process for addressing barriers will start with submission of barriers to the Practice Level Workgroup and filter up to the Advisory Committee and Executive Council if they cannot be resolved at the lower levels. If high-level policy or funding barriers remain unresolved, the group will outreach to the Statewide System of Care Committee, and the convener will monitor the outcome.

**Attachment 11, Section E.8.d:** What strategies will Applicant employ to ensure that the above governance groups are comprised of youth, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent?

PSCS will ensure that the convener of SOC governance implements the requirement of 51% participation of youth and family voice representatives through contracts and/or policies. PSCS will use periodic audits and routine reporting to monitor whether the requirement is being met and facilitate improvement if it is not.

PSCS will use the following strategies to support youth and family participation, including holding meetings at times that facilitate attendance, providing a stipend for participation, reimbursing expenses, removing physical, language, and other accessibility barriers, providing transportation and childcare, and ensuring that SOC governance functions effectively. Community participants in our work during CCO 1.0 have reported that one of the strongest motivators for them to stay engaged is a clear sense that their work is valued and contributes to the wellbeing of their community. In addition, PSCS and the SOC convener will work with Oregon Family Support Network to access participants and obtain support for local youth and family participation.

PSCS is committed to ensuring an effective SOC, including how its meetings are facilitated, how follow-up actions are completed, and how participants are supported to engage in the meetings. We believe that making the process matter is key to maintaining engagement of youth and family representatives, including Youth and Family Partners, as well as all of the other participants who contribute to successful SOC governance.

**Attachment 11, Section E.9.a:** Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

PSCS will contract with an adequate and diverse range of providers to deliver Wraparound services to eligible CCO members and their families. The contracted duties of these Wraparound agencies will include use of the Wraparound Fidelity Assessment System and other OHA-identified tools to assess program Fidelity, including administration of the WFI-EZ tool and data entry in WrapTrack. As part of pre-contract review process, PSCS will validate that each organization’s staff training is adequate to administer the process correctly. If interview formats are chosen, rather than written responses, PSCS will require that interviewers be trained in proper administration of the tool.

Wraparound agencies will offer the WFI-EZ tool to parents/caregivers and youth after six months of participation, using a process that clearly informs respondents that their services and their relationship with their Child and Family Team will not be affected by their responses. PSCS will use its BH quality improvement staff and structured clinical oversight processes to monitor
WrapTrack reporting for use of the WFI-EZ, as well as examining results for positive and negative feedback on the Wraparound Services provided by each agency using Report 8 from WrapTrack, among other resources. If we identify issues, we will use strategies ranging from technical assistance, to corrective action, to re-contracting for services, as needed, to work in partnership with a provider network that provides high quality Wraparound services and collects reliable assessment data that provides transparency into the experience of youth and families who receive services.

Attachment 11, Section E.9.b: How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?
PSCS will share results with the SOC Advisory Council at least four times per year. Such data shall include WFI-EZ, the Team Observation Measure, quarterly enrollment in Wraparound services, other utilization data, and other measures of system. We will share more frequent reporting if we identify concerns or upon request.

Attachment 11, Section E.9.c: How does Applicant plan to receive a minimum of 35 percent response rate from youth?
PSCS understands the importance of achieving statistical significance in using evaluation tools and will require that the operator of each Wraparound agency receive a WFI-EZ response rate of at least 35% and provide mitigation plans if responses fall below that level. Any Wraparound agency with a response rate below 35% will be placed on corrective action, with the expectation that we will conduct a root cause analysis to evaluate the cause of low response rates. If administrative issues are identified as a source of deficient response rates, PSCS and the Wraparound agency will work together to resume proper functioning of the administration process. If the process is functioning as designed but not receiving adequate responses, possible improvement strategies include administering the WFI-EZ when the respondent is in a facility, administering electronically, shifting administration to a more neutral setting than the Wraparound agency, taking steps to increase anonymity, such as returning numbered surveys by mail, providing financial or other incentives for response, and providing multiple opportunities for response when one has not been provided. PSCS and Wraparound agencies will work with the Portland State University System of Care Institute to obtain technical assistance if initial steps to increase response rates above 35% are not successful.

Attachment 11, Section E.9.d(1): How Wraparound services are implemented and monitored by Providers?
Our Wraparound policy will ensure that providers of Wraparound services understand Wraparound principles, including intensive services such as Day Treatment and residential programs, that they understand the Wraparound process, and that they understand how to coordinate services for enrolled patients. The PSCS Wraparound Policy will ensure that services are consistent and applied throughout the region, including that contracted Providers (Wraparound agencies) implement the Wraparound service planning process in accordance with identified best practices, and monitor their processes for adherence to these standards in the conduct of the following:

- Maintaining a ratio of Care Coordinators, Family Partners, and Youth Partners to clients that is no more than 1:15
• Tracking progress through the Wraparound phases of engagement, initial plan development, plan implementation, and transition
• Convening and facilitating Child and Family Team Meetings using the Team Facilitation process and Family Search and Engagement, among other strategies
• Creation of Child and Family Team Meeting Summaries, Strengths & Needs Assessments, Crisis & Safety Plans, and a Wraparound Plan of Care
• Documentation of progress notes
• Administration of the Child and Adolescent Needs and Strengths (CANS Oregon) screening by a staff credentialed by the Praed Foundation within 30 days and every 90 days thereafter
• Assessing members upon discharge from Wraparound for enrollment in Intensive Care Coordination

In addition, our Wraparound Policy will clearly identify the services and supports that a Child and Family Team can select, and which options need prior approval of PSCS or the service provider, as well as the process to receive approval. The PSCS Wraparound Policy will also require that no eligible youth be placed on a waitlist and that mechanisms are in place to adjust capacity as needed to serve additional clients. We will revise the Wraparound Policy in collaboration with Wraparound agencies, clients of Wraparound, other participants in the process, and SOC governance groups. PSCS will submit its Wraparound Policy to the OHA annually and upon request.

PSCS will monitor Wraparound agencies through remote and on-site processes to ensure that services meet the following criteria:
• Strengths based;
• Family and youth driven;
• Community based;
• Comprehensive;
• Coordinated across the continuum of care;
• Culturally and linguistically appropriate; and
• Supportive of youth beyond existing established structures.

The Child and Family Team will be at the core of the Wraparound process and its work will lead to a written plan, which will become the guide for implementation and monitoring of services and supports. In addition to internal and ad hoc structures, we will use all state-specified information technology platforms to aggregate data, monitor outcomes, and evaluate effectiveness of Wraparound agencies and their plans of care.

PSCS will assess services provided by Wraparound agencies through enrollment tracking, which will be reported quarterly to the OHA, and also including review of evaluation results from sources like the WFI-EZ and the Team Observation measure tool (TOM) 2.0. A trained rater will administer the TOM with Wraparound Care Coordinators a minimum of six times a year during their first year and a minimum of twice a year thereafter. We will submit outcomes of the tool to the OHA twice a year, aligning with the reporting dates for CANS administration.
Child and Family Teams will identify multiple options for services and supports for youth and families, including natural supports whenever possible. In addition, PSCS will make Flexible Services available to meet identified needs that are not traditionally funded through the services available to the youth and family. In its monthly meetings, the Child and Family Team will assess past services and their completion, review upcoming services, and become the focal point for assessment of the quality and delivery of services. The Child and Family Team will identify problems or barriers and when this is not successful, the Child and Family Team will access the Practice Level Workgroup and subsequent levels of the governance structure up to and including the Statewide System of Care Steering Committee.

Attachment 11, Section E.9.d(2): How Applicant will ensure Wraparound services are provided to Members in need, through Applicant’s Providers?
PSCS will contract with an adequate and diverse range of Providers to deliver Wraparound services to eligible CCO members and their families. The duties of these Wraparound agencies will include using their own staff and resources to convene each Child and Family Team, document each youth’s plan of care, and monitor effectiveness and adequacy of the plan over time. These Wraparound agencies will support each enrolled youth and their family, to create their Child and Family Team from people with whom they are connected, to implement the clients’ vision, and respond to needs by creating a flexible, customized array of services and supports.

Each Child and Family Team will integrate information gained from the youth and family, including results from the Child and Adolescent Needs and Strengths Assessment (CANS). The Team will have authority to create a plan of care from across the array of services provided by participants in SOC governance, as well as other community organizations, providers, and non-medical resources to address unmet social, economic, and other needs.

PSCS will be an integral participant in SOC governance structures and will conduct auditing and routine oversight of Wraparound agencies. Through routine oversight, we will ensure that Wraparound agencies maintain adequate resources for supervision and coaching of Care Coordinators and Family and Youth Partners and that participants in Child and Family Teams receive adequate initial and ongoing training. In addition, we will monitor data from evaluation tools such as CANS, WFI-EZ, and TOM. Through this engagement, we will identify any quality or capacity issues in our network of Wraparound agencies and will address problems through a range of strategies, including technical assistance, corrective action, and addition or removal of contracted Wraparound providers.

Attachment 11, Section E.9.e: Describe Applicant’s plan for serving all eligible youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant’s strategy to ensure there is no waitlist for youth who meet criteria.
PSCS has not placed youth on a waitlist when they are eligible for Wraparound services and will continue to facilitate services whenever there is need. When enrollment has risen to the 1:15 limit, PSCS has provided additional funds to account for the costs of adding care coordinators on a full-time or part-time basis. We are committed to continuing a contracting model that provides financial support to meet the 1:15 ratio and expands capacity when more youth need to be enrolled in the system. PSCS is also willing to work with Wraparound agencies to support a
temporary or part time workforce that can be activated to meet the need in a time of high enrollment. PSCS will monitor SOC Wraparound Review and Wraparound agency data regarding referrals, results of review, enrollment, and the reasons any youth who are offered Wraparound services do not enroll, to ensure that capacity is not impacting these decisions. In addition, we are committed to meeting the needs of youth and families who decline Wraparound services or who have high levels of need but do not qualify for the Wraparound model of care. For these members, we will make Intensive Treatment Services, Intensive Care Coordination, and other types of BH services and case management available to meet the youth and family’s goals of care and preferred mode of service delivery.

Attachment 11, Section E.9.f: Describe Applicant’s strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professionals as indicated (for example: Wraparound coaches and Wraparound supervisors are filled by two different individuals).

PSCS will only contract with providers of Wraparound services that pass an initial review for capacity and ability to provide services consistent with fidelity standards. PSCS will work with organizations that seek to provide the Wraparound services to ensure that their structure includes all necessary roles for fidelity services. This includes verifying that the Wraparound services planning process will include qualified Wraparound Care Coordinators, Family Partners, Youth Partners, Wraparound coaches, and Wraparound supervisors as detailed in the Wraparound Best Practice Guide published by Portland State University and the OHA System of Care Wraparound Initiative Guidance Document, and other relevant resources.

Family and Youth Partners and Wraparound Care Coordinators will receive both agency-based supervision from their employers and role-specific coaching, also known as peer supervision. Agency-based supervision will be provided within each organization, using a supervisor who fully understands their agency’s policies, processes, expectations, and overall mission, vision, and strategic goals. Wraparound agencies will ensure these supervisors are familiar with the model, including through participation in Wraparound trainings. In addition to agency-based supervision, each Wraparound agency will be required to employ or contract individuals who can provide role-specific coaching for the Family and Youth Partners and Wraparound Care Coordinators that the agency employs. Peer coaches with expertise in Wraparound help Wraparound Care Coordinators develop skills and shape their understanding about how skilled practice is connected to positive change for youth and families. Similarly, coaches with Family or Youth Partner expertise support their clients to develop their skills and their understanding of how skilled practice supports youth and family to gain autonomy and agency in their lives. While it is our goal that all of these roles be available in each community we serve, that may not be possible in rural areas where the population supports only a few Family and Youth Partners or Wraparound Care Coordinators. In those situations, PSCS will assist Wraparound agencies in accessing the resources of regional or statewide organizations to ensure that peer supervision resources are available for their Wraparound staff.
Attachment 12 - Cost and Financial Questionnaire

Attachment 12, Section A.1: Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.

PSCS has a variety of measures of clinical value and efficiency. We devote significant resources to measuring value and efficiency to inform delivery of services to members and will continue to do so. We are developing additional measures in 2019, for use beyond this year as well. These measures are part of a strategy to increase the delivery of high-value services and ensure more efficient use of medical services through internal monitoring, as well as external transparency with information sharing to our provider partners and the Health Council. Through the information sharing process, PSCS identifies specific areas to collaborate, troubleshoot, mitigate, or resolve.

By way of example and not by way of limitation, PSCS uses the following internal measures of clinical value and efficiency:

- **Hospital:** measures include all-cause inpatient readmission rates, behavioral health readmissions, inpatient length of stay and risk-adjusted length of stay, hypoglycemia in inpatients receiving insulin, potentially avoidable emergency department visit rates, and emergency department visit rates, including specific emergency department visit rates for members with Severe and Persistent Mental Illness (SPMI). In prior years, PSCS also monitored, reviewed, and used the Hospital Transformation Performance Program (HTPP) measure set for DRG hospitals as indicators of clinical value and quality. These measures included health care-associated infections (central line-associated bloodstream infections and catheter-associated urinary tract infections), adverse drug events due to opioids, excessive anticoagulation with warfarin, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures (staff always explained medicines and staff gave patient discharge information), and reducing visits for frequent emergency department users.
- **Behavioral Health:** measures include behavioral health readmissions, specific emergency department visit rates for members with SPMI, follow-up after hospitalization for psychiatric inpatient stays, engagement of behavioral health services for members with SPMI, and engagement of behavioral health services after assessment.
- **Oral Health:** measures include utilization of dental visits, preventive dental visits, dental visits for diabetics, dental visits during pregnancy, and dental sealants rates.
- **Other:** other health measures for clinical value and efficiency include utilization of preventive screenings such as immunizations, colorectal cancer screening, breast cancer screening, chlamydia screening, and others, as well as adherence to evidence-based care such as comprehensive diabetes care measures, potentially avoidable emergency department utilization, potentially avoidable inpatient admissions, prenatal and postpartum care, CAHPS access to care and satisfaction with care measures, and utilization measures such as primary care and primary care group visits and behavioral health visits.

PSCS has built a roadmap for additional measure sets. By way of example and not by way of limitation, PSCS plans to expand the use of measures including the relative value units for services provided per provider per month, the number of patient visits per provider per month,
and the cost per episode of care, including complication rates where applicable. PSCS has also committed to developing provider-specific efficiency scores based on each provider’s relative cost, obtained by calculating the ratio of actual (observed) cost of care, to the average (expected) cost for similar types of care provided by peer groups, based on episodes of care using the Optum Episode Treatment and Procedure Episode Groupers.

Attachment 12, Section A.2: What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs? PSCS uses a variety of tools to identify areas of opportunity to eliminate waste and inefficiency, improve quality and outcomes, and lower costs. We are committed to using these tools internally and sharing results externally with provider partners and the community, to identify areas where PSCS and provider partners can collaborate to maximize these opportunities. Below, we set forth our existing tools that we plan to continue to deploy and new tools we plan to develop and deploy.

PSCS has begun implementing the Milliman MedInsight Waste Calculator (the “Waste Calculator”) measures and will complete onboarding of this tool in early 2019. The Waste Calculator is a stand-alone software tool designed to help health care organizations leverage value-based principles by identifying wasteful services, as defined by national initiatives, such as Choosing Wisely and the U.S. Preventive Services Task Force. This tool can add significant value to existing cost and quality reporting capabilities, specifically those efforts designed for efficiency and effectiveness measurement. Measure categories range from diagnostic testing, screening tests to preoperative evaluation, and routine follow up and monitoring. The Waste Calculator measure roadmap includes both primary care and specialist measures directed at a variety of specialties. Here are a few examples:

- Screening for 25-OH-Vitamin D deficiency: do not perform population based screening for 25-OH-vitamin D deficiency.
- Opioids for acute back pain: do not prescribe opiates in acute disabling low back pain before evaluation and a trial of other alternatives is considered.
- Concurrent use of two or more antipsychotic medications: do not routinely prescribe two or more antipsychotic medications concurrently.
- Coronary angiography: do not perform coronary angiography in patients without cardiac symptoms unless high risk markers are present.

As mentioned in our response to Attachment 9 (the HIT Roadmap), PSCS plans to develop reporting on Waste Calculator measures to share with provider partners, as part of the strategy to provide partner-specific feedback around areas that can be impacted, to improve efficiency and outcomes as well as reduce cost and waste in the healthcare system. PSCS has used episode treatment group software for several years. As mentioned in the HIT Roadmap, in 2019, PSCS will phase out the existing Truven Medical Episode Grouper with Optum’s Symmetry Episode Treatment Groups. These groupers are designed to do the following:

- Measure and compare the utilization and financial performance of health care providers;
- Provide a basis for evaluating whether physicians are adhering to treatment guidelines and protocols;
- Enable member tracking throughout the course of an illness; and
- Support clinical benchmarking.
The tool groups medical, behavioral, and pharmacy claims, eligibility, and provider data together in acute and chronic episodes of care. The grouping method recognizes comorbidities, complications, and treatments that influence a member’s clinical profile, enabling accurate case-mix adjustment. The tool also measures and compares preventive services. PSCS will integrate the output of this tool into the Member Insight and Provider Insight platform to allow for visual analytics to help inform internal stakeholders as well external stakeholders, such as our provider partners, regarding opportunities to improve efficiency, cost and outcomes.

In addition to the Episode Treatment Grouper, PSCS previously implemented a procedure episode grouper. As mentioned in the HIT Roadmap, in 2019, PSCS will phase out the existing Truven Outpatient Procedure Episode Grouper (distinct from the Medical Episode Grouper discussed above) with Optum’s Symmetry Procedure Episode Groups. PSCS is currently using the Procedure Episode Groups to analyze the cost and quality of surgical providers, procedures, and related services. The base unit of analysis for measuring surgical care is the surgical procedure. Each procedure episode includes the work up and conservative care that occurred before the procedure, the procedure itself and the follow-up care after the procedure, including repeated procedures.

PSCS will also deploy a variety of other reports and visualizations to share with our provider partners as part of our strategy to reduce and eliminate waste and inefficiency by identifying specific areas to impact. In 2019 and 2020, we will develop reports that will show a provider’s experience in specific waste calculations, while also providing member-level detail so the provider can research specific drivers of the experience. In conjunction with the Episode Groupers and Procedure Episode Groupers, this will help providers understand how their use of services compares with others to help pinpoint what types of changes they need to make to reduce waste and inefficiency.

PSCS also analyzes reporting from the Truven/Watson Health Payment Integrity Program to detect instances of fraud, waste, and abuse. This program uses algorithms and predictive modeling, tailored to our plan characteristics, to review claims payments in order to identify changes in patterns for providers submitting claims, procedures billed, and inappropriate claims payment. See Section J.2 below for details and examples of reports utilized.

Lastly, as part of the HIT Roadmap discussed in our response to Attachment 9, PSCS is evaluating the use of Altarum’s PROMETHEUS Value product as a possible enhancement to our existing toolbox and Roadmap, specifically to help identify key drivers of low-value care.

Attachment 12, Section A.3: Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.
Yes, PSCS has a strategy to use Health-Related Services (HRS) to reduce avoidable health care services utilization and cost. Our strategy for using HRS to reduce utilization and cost is founded in the evidence basis that supports housing, physical activity, and education investments as integral to each aspect of the Triple Aim. Because the evidence supporting health-related interventions varies substantially in its rigor, our strategy has been to focus on housing, physical activity, and education, for which there is the strongest evidence of both decreasing cost and unnecessary utilization.
PSCS has a multi-disciplinary committee that sets the strategic plan for use of these funds, reviews overall goals of the program on an annual basis, and allocates funding for certain high-cost flexible services requests. The committee works in compliance with the Oregon Health Authority (OHA)-approved PSCS Health-Related Services Policy. This committee includes representatives from both clinical staff and Medicaid administration, including those individuals who serve as liaisons to each Health Council. The mission statement of this group is “Through evidence based practices, health related services will be a catalyst for change in our communities, with a focus on housing, physical activity, and education.”

PSCS receives members-specific HRS requests from contracted providers and manages requests in two different software platforms. PSCS Member Support Specialists conduct outreach to providers to encourage requests that are non-trivial, in order to increase efficiency of the system. All requests are reviewed and approved (or rejected) by the medical director. While we will consider any request in compliance with OAR 410-141-3150, we encourage requests that focus on physical activity, housing, and educational interventions. Providers and members are notified of funding decisions, by letter, for ad hoc requests. Other programs rely on invoicing (e.g. current funding arrangements with SDOH-HE partners like Bend Parks and Recreation and the Bethlehem Inn). In addition, our arrangement with Bethlehem Inn, a local homeless shelter, includes a tiered reimbursement, based on member outcomes at the time of exit from the facility (maximum 30 days), which evaluates such assets as employment, income, and health coverage.

Decisions about funding community-based HRS are made in partnership with the Health Council, as such initiatives may impact the community more broadly. Using the community-based governance model, we are able to better understand and target the specific community’s need and create more efficient use of funds, by tailoring to each community’s highest priorities. This approach promotes alignment between HRS strategy and the Community Health Improvement Plan (CHP). Decisions are always based on the potential for the intervention to improve health and/or reduce cost, and alignment with the CHP. Going forward, we plan to focus our investments to incorporate the input of the Community Advisory Council (CAC) on the most pressing needs of the community. This could include an additional focus on housing, education, or other SDOH-HE needs. Please see additional detail in our response to Attachment 10.

Attachment 12, Section A.4: What is the Applicant’s strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

PSCS realizes the importance of HRS investments that improves health care quality, however we also feel that the development of health information technology is an equally important component to the overall strategy to create efficiencies and improve the quality of service delivery. While our HRS investments often include activities that improve health care quality, including expenditures related to health information technology, PSCS has elected, thus far, not to devote our HRS funds solely or primarily to these types of interventions—primarily because we have already invested significant community shared savings to stand up regional Health Information Exchange (HIE) infrastructure, support providers in adopting certified EHRs, and invest in community-based prevention. In total, we have returned over $30 million in community shared savings in Central Oregon and the Columbia Gorge. However, consistent with our strategy set forth above regarding housing, physical activity, and education, we have deployed funding for HRS to support the ECHO project, a program run out of OHSU, that provides
training for local providers to deliver specialty services that members would otherwise need to
travel long distances for, or have to wait for specialty referral to receive. An example is treatment
of hepatitis C. This increases the efficiency of the system, lowers cost, and improves the member
experience by expanding the skill and scope of the primary care medical home.

We also plan to consider additional investments in 2020, exploring such activities as medication
reconciliation, wellness assessment, lifestyle coaching programs designed to achieve specific and
measurable improvements, and providing electronic health records, patient portals, and tools to
facilitate patient self-management. These decisions will be considered by the internal HRS
committee and the Health Council committees, including the Community Advisory Council.

Attachment 12, Section A.5: What process and analysis will the Applicant use to evaluate
investments in Health-Related Services and initiatives to address the Social Determinants of
Health & Health Equity (SDOH-HE) in order to improve the health of members?

PSCS undertakes significant effort to evaluate investments in HRS and initiatives to address the
SDOH-HE in order to improve the health of members and is committed to doing so going
forward. We continue to refine our processes and analyses. PSCS conducts evaluations at two
key points: in determining whether to fund an investment and in assessing the impact of an
investment. We address each in turn below.

Funding
PSCS initially evaluates each HRS and SDOH-HE funding opportunity to determine whether the
opportunity meets criteria mandated by the OHA. PSCS considers if it is designed to improve
health quality; increases likelihood of desired outcomes in a way that can be measured; can be
targeted to either individuals or segments of enrollee population; and if it has an evidence-base,
guideline, best practice, or criteria issued by a recognized or accredited body, such as a
government agency, professional association, or a health care quality organization. In
determining if an opportunity has an evidence-base behind it, PSCS will utilize one of the many
resources for published studies or evidence provided by OHA, including Social Interventions
Research and Evaluation Network, Centers for Disease Control, University of California, San
Francisco Social Interventions Research & Evaluation Network, and others. Lastly, a potential
investment must meet at least one of these criteria, as outlined in the “Health-Related Services
FAQ” produced by the OHA:

- Improves health compared to a baseline and reduces health disparities
- Prevents avoidable hospital readmissions
- Improves patient safety, reduces medical errors, and lowers infection and mortality rates
- Implements, promotes, and increases wellness and health activities
- Supports expenditures related to health information technology and meaningful use
  requirements

Impact
PSCS currently conducts investment-specific evaluations, such as that described above, related
to the investment in, and partnership with, the Bethlehem Inn. Going forward, PSCS intends to
standardize the process to evaluate investments in HRS and SDOH-HE. PSCS still intends to
develop and deploy specific analytical tools for each investment that considers specific project
goals. This helps ensure that analyses and evaluations are appropriate for the investments themselves and not measured against unrelated or meaningless measures.

We intend to deploy the following stepwise process to evaluate investments:

- Review investments and clearly identify the goals for the investments
- Review existing analytical tools, measures, and opportunities for measurement that are applicable to the specific investments; determine if any are viable options for use
- Incorporate evaluation in early stages of investment planning to identify potential areas for a targeted evaluation and corresponding analysis, to ensure the necessary mechanisms are in place for us to track and measure relevant data points
- If any measurement opportunities are viable, reliable, and implementable, create an evaluation plan to outline method for measurement and analysis
- Develop evaluation activities that are practical and affordable
- Publish the outcome of each evaluation through the community governance process

Given the nature of SDOH-HE work, we recognize that some investments intervene farther “upstream” than conventional health care services. We will tailor our analytical and evaluation activities and ensure our processes are calibrated accordingly. We recognize that outcomes from some investments may not be actualized for several years; therefore, evaluation activities will prioritize identifying and measuring early signs of success, such as successful implementation of project funding. Where appropriate, evaluation activities may include stakeholder feedback and review of secondary data sources. Depending on the investment and appropriateness, some activities may include use of process measures, rapid-cycle feedback systems, and Plan-Do-Study-Act (PDSA) cycles.

We are sensitive to the cost of evaluation and want to avoid dissuading small organizations from partnering with us for HRS and SDOH-HE activities. As a result, we will work to leverage existing evaluation plans, published studies, and other sources of evidence. The process of analyzing and evaluating investments will include working with evaluation experts to determine measurement appropriateness, when and how to measure it, and if the process itself is practical and affordable. We observe that the community governance model and Health Council committees create unique opportunities to spread best practices and investment outcomes to improve the health of members.

Attachment 12, Section B.1: Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.

Yes, PSCS currently measures, tracks, and evaluates the quality and value of hospital services. We use a combination of reporting, contract metrics, internal reviews, and other methods to accomplish this work. We evaluate the quality or value of hospital services through external and internal reporting. For example, we use publicly available hospital quality reporting from a variety of sources, including CMS and the OHA (such as past years’ OHA’s Hospital Transformation Performance Program data). We also monitor admissions, readmissions, length of stays, hospital days, and admission types. We further analyze this data by populations of interest and associated levels of acuity.
PSCS also has experience building value-based payments tied to quality metrics. In order to be successful in value-based payment strategies, we measure, track, and evaluate the value of hospital services in many communities. In the past, we have monitored and tracked ten quality metrics tied to hospital financial incentives. These measures include emergency department visit rates, readmissions, and iatrogenic hypoglycemia, as well as more innovative measures, such as assuring PCP follow up after discharge and measuring the outcomes of a psychologist embedded in the hospital. In 2019, we expanded our value-based payment strategies to build a metric that links hospitals and behavioral health providers in shared financial incentives. We also build measures linked to member satisfaction with care received. Consistent with the OHA’s vision for health system transformation, we already take steps to align our quality measures and value strategies with the OHA’s quality goals and documented community needs.

Attachment 12, Section C.1: Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non-clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered.
Attachment 12, Section C.2: How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers.
Attachment 12, Section C.3: How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?

Attachment 12, Section C.4: How will the Applicant decide and govern its spending of the Quality Pool earnings?

Attachment 12, Section C.5: When will Applicant invest its Quality Pool earnings, compared with when these earnings are received?

Attachment 12, Section C.6: Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?

Attachment 12, Section D.1: Please describe the PBM arrangements Applicant will use for its CCO Members.
Attachment 12, Section D.2: Does the Applicant currently have a “no-spread” arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible).

Attachment 12, Section D.3: Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive?

Attachment 12, Section D.4: Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?
Attachment 12, Section E.1: Does Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA. Yes, PSCS currently publishes its PDL on its publicly accessible website and will continue to do so.

Attachment 12, Section E.2: Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner. Yes, PSCS currently publishes its pharmacy coverage and Prior Authorization criteria on our publicly accessible website in advance of changes made and will continue to do so.

Attachment 12, Section E.3: To what extent is Applicant’s PDL aligned with OHA’s fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant’s PDL as compared to the fee-for-service PDL.

Attachment 12, Section E.4: Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe expectations. Yes, PSCS will align drug-classes in its PDL with the fee-for-service PDL as required.

Attachment 12, Section F.1: Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant. Yes, two affiliates of PSCS report on NAIC health insurance forms. One affiliate, PacificSource Community Health Plans (PCHP), is the parent of the Applicant and offers Medicare Advantage plans. The other affiliate is PacificSource Health Plans, the parent of PCHP, which offers commercial health insurance plans.

Attachment 12, Section F.2: Does the Applicant currently participate and file financial statements with the NAIC? No, but DFR-regulated PacificSource entities do.

Attachment 12, Section F.3: Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit. Yes, PSCS has prepared a financial statement with a RBC calculation. Please see the Attachment 12 UCAA Supplemental Financial Analysis workbook, which includes an RBC calculation for the years 2020-2022.
Attachment 12, Section F.4: Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?
Yes, PSCS has experience reporting in SAP through affiliates. The last financial exam on the affiliates by the Oregon Division of Financial Regulation resulted in no changes to the financials and no recommendations.

Attachment 12, Section F.5: Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant’s plan to be ready to use SAP in 2021.
No, PSCS does not seek an exemption from SAP and NAIC reporting for 2020.

Attachment 12, Section F.6: Please submit pro forma financial statements of Applicant’s financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant’s Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant’s pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit. Please see attached templates and other required documentation.

Attachment 12, Section G.1: What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?
Attachment 12, Section G.2: How will the CCO allocate and monitor expenditures across all categories of services?

Attachment 12, Section G.3: What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?
Attachment 12, Section G.4: What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

Attachment 12, Section G.5: Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

Yes, PSCS has achieved the per-member expenditure growth target of 3.4% in the past. In Central Oregon, we achieved a rate of -1.3% in CY17 over CY16 and in the Columbia Gorge, we achieved a rate of -5.5% in CY16 over CY15. We also note that in evaluating a 3-year annualized trend, Central Oregon achieved a 3.6% growth rate, which is very close to the target and the third lowest 3-year annualized trend in the state. The Columbia Gorge, even considering
the high cost A/B hospitals with reimbursement established by the OHA, still had a lower 3-year annualized trend than the statewide average.

Attachment 12, Section H.1: What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)

PSCS currently holds an excess loss reinsurance policy for 2019 and intends to renew a similar policy for 2020 in the absence of a statewide Medicaid reinsurance program. Our current policy has an attachment point of $500,000, coinsurance of 90% (with 10% retained by PSCS) up to $5 million, and 100% coinsurance beyond $5 million. This reinsurance policy covers all eligible OHP medical and pharmacy expenses for our CCO and Cover All Kids members.

Attachment 12, Section H.2: What is the Applicant’s reasoning for selecting the reinsurance policy described above?

The excess loss reinsurance policy is intended to protect against an unexpected increase in the frequency and/or severity of large claims. The selection of the attachment point of $500,000 is the result of careful analysis and consideration of the cost of reinsurance, historical large claims experience, current and projected membership, and the financial stability and capital position of the organization.

Attachment 12, Section H.3: What aspects of its reinsurance policy are the most important to the Applicant?

It is important to us that all eligible claims expenses be covered by the reinsurance policy and that the reinsurance company have adequate financial strength to pay claims. It is also important to us to have a clearly defined claims reporting and submission process. Finally, it is important to us that we have the ability to select reinsurance policy terms (deductible, coinsurance, and annual limit) that best fit our specific membership, historical and projected experience, and financial position.

Attachment 12, Section H.4: Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?

Attachment 12, Section H.5: Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?
Attachment 12, Section I.1: Please describe Applicant’s past sources of capital. PSCS’s past sources of capital have come from initial infusions from its parent company, PCHP, at the time of its inception in 2003, and from operations and investment earnings on reserved capital since that time.

Attachment 12, Section I.2: Please describe Applicant’s possible future sources of capital. PSCS’s future sources of capital will also come from operating results, investment earnings, and contributions from its parent company, PCHP, or an Affiliate, as needed.

Attachment 12, Section I.3: What strategies will the Applicant use to ensure solvency thresholds are maintained?
Attachment 12, Section I.4: Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe.

Yes, PSCS has a parent company, PCHP, and other Affiliated entities. Those companies have the financial capability to contribute additional funds. The consolidated holding system is structured such that cash can be transferred up or down the organization as needed without adverse tax consequences. We have provided consolidated audited financials showing no long-term debt and strong capital.

Attachment 12, Section J.1: Please describe Applicant’s capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data. PSCS has a dedicated Encounter Team (ET), which consists of three team members and the Manager of Government Operations. The members of this team have coding experience (or are coding certified) as well as backgrounds in monitoring and researching encounter data, including the raw 837, 835, and 999 data sets. The ET actively researches encounter issues, monitors pended encounters, and participates in the All Plan System Technical meetings with the OHA. PSCS uses Encounter Management (EM) designed by Edifecs. This system allows PSCS to import encounters from its claims processing system, Facets, and have full visibility to our data throughout the full encounter cycle.

The ET uses a combination of reports from the OHA and through the EM product to verify and reconcile encounter data. Through EM, PSCS has visibility into claims that fail at every transmission point (Facets > EM > OHA > EM). The ET is able to verify and correct any claim that rejects at the OHA level or internally—Facets or EM. This also allows the ET to consistently provide root cause analysis work to correct issues and prevent them from continuing to occur.

The OHA provides a series of reports that the ET uses to verify data against PSCS’s own data and reporting. The OHA reports contain info on the number of claims received from the CCO, claims paid for deceased members or members not enrolled with the CCO on the date of service, and encounters that have fallen into a Denied Must Correct (DMC) status within the OHA’s system.

Our internal Analytics Department compiles dashboards to monitor claim volumes and identify any anomalies. We review dashboards no less than weekly to ensure providers are submitting at expected volumes and times. There are specific reports that focus on subcontractors and delegated entities to monitor submission timeliness and claim volume. PSCS has also developed a number of reports to ensure that encounter data is accurate and meets the timelines established by the OHA. We monitor these reports weekly, investigate any issues, and take corrective action.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Category</th>
<th>Measure Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clean claims submitted</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of pended encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of pended encounters corrected within 63 days</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>Measure Name</td>
<td>Measure Category</td>
<td>Measure Frequency</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>% of pended encounters corrected within 30 days</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of encounters submitted within 45 days of adjudication</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>avg. number of days to correct pended encounters (turnaround time)</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of rejected encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of rejected encounters related to code logic</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of provider pends per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of claims based pends per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>number of encounters submitted (breakout: INPT, OUTPT, LTC, PROF)</td>
<td>Volume</td>
<td>Weekly</td>
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<tr>
<td><strong>Dental Health</strong></td>
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<td></td>
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<tr>
<td>% of clean claims submitted</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of pended encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of pended encounters corrected within 62 days</td>
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<td>Weekly</td>
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<tr>
<td>% of pended encounters corrected within 30 days</td>
<td>Timeliness</td>
<td>Weekly</td>
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<tr>
<td>% of encounters submitted within 45 days of adjudication</td>
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<td>Weekly</td>
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<tr>
<td>% of rejected encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>number of encounters submitted</td>
<td>Volume</td>
<td>Weekly</td>
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<tr>
<td><strong>Pharmacy</strong></td>
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<td>% of clean claims per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
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<td>% of rejected encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
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<tr>
<td>% of rejected claims corrected within 30 days</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of rejected claims corrected within 62 days</td>
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<td>Weekly</td>
</tr>
<tr>
<td>number of encounters submitted</td>
<td>Volume</td>
<td>Weekly</td>
</tr>
<tr>
<td><strong>Provider Enrollment</strong></td>
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<td>avg. number of days to process 3108 (received from provider to state submission)</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>avg. number of days for OHA processing</td>
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<td>Weekly</td>
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<tr>
<td>% of rejected 3108 submissions</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>avg. number of days for corrected 3108 submissions (turnaround time)</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>number of 3108’s received</td>
<td>Volume</td>
<td>Weekly</td>
</tr>
</tbody>
</table>

Attachment 12, Section J.2: Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities.

Yes, PSCS currently performs a variety of activities to validate claims data at the chart level. PSCS is committed to continuing to perform these activities and to enhance them going forward.
PSCS analyzes reporting from the Truven/Watson Health Payment Integrity Program. This program uses algorithms and predictive modeling, tailored to our plan characteristics, to review claims payments to identify changes in patterns for providers submitting claims and procedures billed, as well as inappropriate claims payment. The program generates reports, which are reviewed quarterly for member exposure and escalation to the Compliance Department or our internal Special Functions Team for investigation. By way of example and not by way of limitation, we utilize this set of reports to take follow-up action with chart reviews:

- **E&M Upcoding.** Identifies providers who are billing evaluation and management (E&M) codes more frequently than their peers
- **Physician MUE.** Identifies claims paid with medically unlikely edits (MUEs) units over the allowed amount in the OHA’s CCI MUE file
- **Bilateral Procedures.** Identifies claims paid with bilateral modifiers when the code description states bilateral
- **Repeat Procedures.** Identifies a procedure repeated within 3 days of initial procedure
- **Inpatient-Only Procedures.** Identifies outpatient claims paid when the procedure code is on the industry standard list of procedures that should only be performed in an inpatient setting
- **Physician Unbundling.** Identifies claims where the procedure is a component of another procedure or one of a pair of mutually exclusive procedures per the NCCI tables
- **Outpatient Facility Unbundling.** Identifies claims where the procedure is a component of another procedure or one of a pair of mutually exclusive procedures per the NCCI tables
- **Multiple Procedure Physician.** Identifies procedure codes on a professional claim requiring reduced payment when billed by the same provider on the same date of service for the same patient
- **New Patient Exam.** Identifies providers who were paid for a new patient office visit when the provider or a different provider with the same specialty and group has an established relationship
- **Overuse of Modifier 25.** Identifies claims with Modifier 25 for providers who overuse Modifier 25
- **Overuse of Modifier 59.** Identifies claims with Modifier 59 for providers who overuse Modifier 59
- **Modifier Inappropriate.** Identifies two paid professional claims with matching provider, patient, date of service, and procedure code where modifier 59 is also billed on the claim

The Special Functions Team is comprised of registered nurses who play an integral role in the identification and prevention of fraud, waste, and abuse across all lines of business. The Special Functions Team follows up on reports from the ET and also conducts a series of chart audits. Audits conducted by the Special Functions Team include, but are not limited to, pre/post payment line item billing auditing, clinical review of identified quality/never events, clinical review of appeals, and ad hoc clinical review of items of concern.

PSCS also conducts a random sampling of 2% of the adjudicated claims monthly, using the following process:

- The ET pulls chart notes for the identified claims sample using Truven/Watson Health Payment Reporting.
- The Special Functions Team reviews the charts for the level of care received to ensure
accuracy.
- The Special Functions Team sends letters to providers of any claims where the level of care is not met. Additional escalation steps may be taken.
- The Special Functions Team will request reprocessing for recoupment of any claims that do not meet the level of care.

If we determine a provider is billing incorrectly and education is warranted instead of further escalation, we send this information to our Provider Service Representatives. The Provider Service Representatives add guidance to our provider-facing web page and education topics to their provider workshops, send provider education emails, and discuss issues with providers individually as needed. Any ongoing issues with noncompliance with approved billing practices are managed through the Quality Department and the Compliance Department.

PSCS also conducts annual audits of subcontractors and delegated entities, including DCOs and NEMT brokerages. During these audits, the team reviews random samples to ensure billing accuracy. PSCS uses education and corrective action to resolve identified issues.

In addition to the processes set forth above, PSCS sends Verification of Services letters to members using a randomly selected claims sample. These letters ask the member to verify that the listed services have been received and that they did not have any cost share. Our internal teams follow up on any identified issues.
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Jeffrey  Middle: Bruce  Last: Barber

2. a. Are you a citizen of the United States?
   
   Yes [x]  No

   b. Are you a citizen of any other country?

   Yes  No [x]

   If yes, what country?

3. Affiant’s occupation or profession: Self Employed

4. Affiant’s business address: 

   Business telephone:  

   Business Email:

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<td>College/University</td>
<td>City/State</td>
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<tr>
<td>Other Training: Name</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
<td>Degree/Certification Obtained</td>
</tr>
</tbody>
</table>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit  Page 1 of 182
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officeships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Beginning/Ending Dates (MM/YY):** 09/16 - Present

**Employer's Name:** PacificSource

**Address:** 110 International Way  
City: Springfield  
State/Province: OR

**Country:** USA  
Postal Code: 97477  
Phone: 541.686.1242

**Type of Business:** Health Insurance  
Supervisor/Contact: NA

**Beginning/Ending Dates (MM/YY):**

**Beginning/Ending Dates (MM/YY):**

**Beginning/Ending Dates (MM/YY):**

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FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit  
Page 2 of 182
9. a. Have you ever been in a position which required a fidelity bond?
   
   Yes [ ] No [X] 
   
   If any claims were made on the bond, give details: ____________________ 
   
   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   
   Yes [ ] No [X] 
   
   If yes, give details: ____________________ 

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NA

Non-Insurance Regulatory Phone Number (if known): ______________________ 

Organization/Issuer of License: ____________________________ Address: ____________________________ 

City: ____________________________ State/Province: ____________________________ Country: ____________________________ Postal Code: ____________________________ 

License Type: ____________________________ License #: ____________________________ Date Issued (MM/YY): ____________________________ 

Date Expired (MM/YY): ____________________________ Reason for Termination: ____________________________ 

Non-Insurance Regulatory Phone Number (if known): ______________________ 

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever: 
   
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   
   Yes [ ] No [X] 
   
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Attachment 12-Form 11 NAIC Biographical Affidavit
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes  No  [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes  No  [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes  No  [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes  No  [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes  No  [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes  No  [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes  No  [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes  No  [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]  
If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]  
If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental/licensing agency?

Yes [ ] No [x]  

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]  

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [x] No [ ]
Applicant Company Name: PacificSource Community Solutions
NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19 day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Jeffrey Barben.

and:

☐ who is personally known to me, or

☐ who produced the following identification: ____________________________

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Kristin E. Kernutt
Printed Notary Name
517 1222
My Commission Expires
<p>**BIOGRAPHICAL AFFIDAVIT**</p>

**Supplemental Personal Information**

*Print or Type*

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names):

**PacificSource Community Solutions**

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

1. **Affiant’s Full Name (Initials Not Acceptable):** First: Jeffrey Middle: Bruce Last: Barber
   
   If answer is “NONE,” so state.

2. **Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?**
   
   Yes [ ] No [x]
   
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. **Affiant’s Social Security Number:** [Redacted]

4. **Government Identification Number if not a U.S. Citizen:**

5. **Foreign Student ID# (if applicable):**

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Revised 03/26/18

FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

6. Date of Birth: (MM/DD/YY): [Redacted] Place of Birth, City: [Redacted] Country: USA

7. Name of Affiant's Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this [Redacted] day of [Redacted], 20[Redacted] at [Redacted]. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

[Signature of Affiant]

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this [Redacted] day of [Redacted], 20[Redacted] by [Redacted]

[Redacted] [Redacted] [Redacted] [Redacted] [Redacted]

[SEAL] KRISTIN E. KERNUTT NOTARY PUBLIC-OREGON COMMISSION NO. 974438 MY COMMISSION EXPIRES MAY 07, 2022

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAFIAl AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Robert Middle: Wells Last: Bentley

2. a. Are you a citizen of the United States?
   - Yes [x] No [ ]
   b. Are you a citizen of any other country?
   - Yes [ ] No [x]
   If yes, what country?

3. Affiant’s occupation or profession: Physician

4. Affiant’s business address: 
   Business telephone: 
   Business Email: 

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<th>Graduate Studies</th>
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<th>Dates Attended (MM/YY)</th>
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<thead>
<tr>
<th>Other Training: Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit
6. List of memberships in professional societies and associations:

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<th>Name of Society/Association</th>
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</table>

7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Beginning/Ending Dates (MM/YY):**

**Employer’s Name:**

**Address:**

**City:**

**State/Province:**

**Country:**

**Postal Code:**

**Phone:**

**Offices/Positions Held:**

**Type of Business:**

**Supervisor/Contact:**

**Beginning/Ending Dates (MM/YY):**

**Employer’s Name:**

**Address:**

**City:**

**State/Province:**

**Country:**

**Postal Code:**

**Phone:**

**Offices/Positions Held:**

**Type of Business:**

**Supervisor/Contact:**

**Beginning/Ending Dates (MM/YY):**

**Employer’s Name:**

**Address:**

**City:**

**State/Province:**

**Country:**

**Postal Code:**

**Phone:**

**Offices/Positions Held:**

**Type of Business:**

**Supervisor/Contact:**

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
9. a. Have you ever been in a position which required a fidelity bond?

   Yes [ ]  No [X]

   If any claims were made on the bond, give details:

   __________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

   Yes [ ]  No [X]

   If yes, give details:

   __________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NA

   Non-Insurance Regulatory Phone Number (if known):

   Organization/Issuer of License: ___________________ Address: ___________________

   City: ___________________ State/Province: ___________________ Country: ___________________ Postal Code: ___________________

   License Type: ___________________ License #: ___________________ Date Issued (MM/YY): ___________________

   Date Expired (MM/YY): ___________________ Reason for Termination: ___________________

   Non-Insurance Regulatory Phone Number (if known):

   ___________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

   Yes [ ]  No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

   ___________________
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

   a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

      Yes [ ] No [x]

   b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

      Yes [ ] No [x]

   c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

      Yes [x] No [ ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19 day of March 2019 at Portland, Oregon. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019, by

Robert Bentley

and:

☐ who is personally known to me, or

☐ who produced the following identification: ________________________________

[SEAL]

KIRSTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public

Kristin E. Kernutt
Printed Notary Name

My Commission Expires
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Robert Middle: Wells Last: Bentley
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X ]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
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<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specified: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the biographical affidavit personal supplemental information.

3. Affiant’s Social Security Number: [-----]-----

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY): [Redacted]  Place of Birth, City: [Redacted]  Country: USA

7. Name of Affiant's Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/DD/YY)</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of MARCH, 2019 at PORTLAND, OREGON, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  County of: Multnomah

The foregoing instrument was acknowledged before me this 9th day of MARCH, 2019 by Robert Beverly

Who is personally known to me, or

Who produced the following identification:

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

My Commission Expires

Notary Public
Kristin E. Kernutt
Printed Notary Name
5/1/2023

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Attachment 12-Form 11 NAIC Biographical Affidavit
Page 16 of 182
BIographiesal AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: George  Middle: Joseph  Last: Brown

2. a. Are you a citizen of the United States?
   Yes [x]  No [ ]

   b. Are you a citizen of any other country?
   Yes [ ]  No [x]

   If yes, what country?

3. Affiant's occupation or profession: Retired

4. Affiant's business address:

   Business telephone:

   Business Email:

5. Education and training:

   College/University  City/State  Dates Attended (MM/YY)  Degree Obtained

   Graduate Studies  College/University  City/State  Dates Attended (MM/YY)  Degree Obtained

   Other Training: Name  City/State  Dates Attended (MM/YY)  Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 09/16 - Present

Employer's Name: PacificSource

Address: 110 International Way
City: Springfield
Postal Code: 97477
State/Province: OR
Country: USA
Phone: 541.686.1242
Offices/Positions Held: Board Member

Type of Business: Health Insurance
Supervisor/Contact: Jeffrey Barber, Board Chair

Beginning/Ending

Beginning/Ending

Beginning/Ending

See Additional Employment Information attached

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Revised 03/26/18

Attachment 12-Form 11 NAIC Biographical Affidavit Page 18 of 182
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [x] 
   If any claims were made on the bond, give details:

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [x] 
   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NA

Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [x] 
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Revised 03/26/18
FORM 11
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [ ]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [ ]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [ ]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [ ]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [ ]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [ ]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [ ]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [ ]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details: __________________________

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 9th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 9th day of March, 2019 by

[Signature]

and:

☐ who is personally known to me, or

☐ who produced the following identification: ________________________________

[SEAL]

KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

My Commission Expires

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Revised 03/26/18
FORM 11
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: George  Middle: Joseph  Last: Brown
   If ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ]  No [x]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY) __________ Place of Birth, City: __________ Country: USA

7. Name of Affiant's Spouse (if applicable): __________

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
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Dated and signed this 19th day of March, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

Signature of Affiant

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by George Brown

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]
Kirstin E. Kernutt
Notary Public
Printed Notary Name
517 602-22
My Commission Expires May 07, 2022

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Revised 03/26/18
FORM 11
Attachment 12-Form 11 NAIC Biographical Affidavit Page 24 of 182
List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
</tr>
</thead>
</table>

Additional Licenses:
Additional Employment:

Beginning/Ending

Beginning/Ending

Beginning/Ending
**BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” so state.

1. Affiant’s Full Name (Initials Not Acceptable): First: Kathryn Middle: Golden Last: Correia

2. a. Are you a citizen of the United States?  
   Yes [x] No [ ]
   b. Are you a citizen of any other country?  
   Yes [ ] No [x]
   If yes, what country?

3. Affiant’s occupation or profession: President and Chief Executive Officer

4. Affiant’s business address:

   Business telephone: [ ]

Business Email: [ ]

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [x]

If any claims were made on the bond, give details:

________________________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [x]

If yes, give details:

________________________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

NA

Organization/Issuer of License: __________________________ Address: __________________________

City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________

License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________

Date Expired (MM/YY): __________________________ Reason for Termination: __________________________

Non-Insurance Regulatory Phone Number (if known): __________________________

Organization/Issuer of License: __________________________ Address: __________________________

City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________

License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________

Date Expired (MM/YY): __________________________ Reason for Termination: __________________________

Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [ ]

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Revised 03/26/18

FORM 11
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Plead guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

   a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?
      Yes [ ] No [X]

   b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?
      Yes [ ] No [X]

   c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?
      Yes [X] No [ ]
Applicant Company Name: PacificSource Community Solutions

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Kathryn Carson

and:

☐ who is personally known to me, or

☐ who produced the following identification: ________________________________

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public
Printed Notary Name
My Commission Expires

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Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Kathryn Middle: Golden Last: Correia

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes [x] No [ ]

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Beginning/Ending</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
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</thead>
<tbody>
<tr>
<td>Date(s) Used (MM/YY)</td>
<td>Specify: First, Middle or Last Name</td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [ ]

4. Government Identification Number if not a U.S. Citizen: [ ]

5. Foreign Student ID# (if applicable): [ ]
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY) [redacted] Place of Birth, City: [redacted] Country: USA

7. Name of Affiant’s Spouse (if applicable): Stephen Correia

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Kathryn Correia and:

☐ who is personally known to me, or

☐ who produced the following identification: __________________________

[SEAL]

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

©2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Edwin Middle: Eric Last: Dahlberg

2. a. Are you a citizen of the United States?
   Yes [ ] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [x]

   If yes, what country?

3. Affiant’s occupation or profession: Retired

4. Affiant’s business address:
   Business telephone: __________  Business Email: ______

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<tbody>
<tr>
<td>Graduate Studies</td>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
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<tr>
<td>Other Training: Name</td>
<td>City/State</td>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
Applicant Company Name: __________________________ NAIC No.: __________________________

6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Beginning/Ending Dates (MM/YY):**

**Employer’s Name:**

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**Employer’s Name:**

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Revived 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [X]

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [X]

If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

NA

Organization/Issuer of License: __________________________ Address: __________________________

City: ______________ State/Province: ______________ Country: ______________ Postal Code: ______________

License Type: ______________ License #: ______________ Date Issued (MM/YY): ______________

Date Expired (MM/YY): ______________ Reason for Termination: __________________________

Non-Insurance Regulatory Phone Number (if known): __________________________

Organization/Issuer of License: __________________________ Address: __________________________

City: ______________ State/Province: ______________ Country: ______________ Postal Code: ______________

License Type: ______________ License #: ______________ Date Issued (MM/YY): ______________

Date Expired (MM/YY): ______________ Reason for Termination: __________________________

Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [X]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18

FORM 11
Applicant Company Name: PacificSource Community Solutions

office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☒ No ☐
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon
County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by

[SEAL]

KRYSTIN E. KERNUTT
NOTARY PUBLIC
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

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Attachment 12-Form 11 NAIC Biographical Affidavit
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Edwin Middle: Eric Last: Dahlberg
   If answer is “NONE,” so state.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [x ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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</tbody>
</table>

   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

Date of Birth: (MM/DD/YY): [Redacted] Place of Birth, City: [Redacted] Country: USA

Name of Affiant’s Spouse (if applicable): [Redacted]

List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Edwin Dillberg and:

☐ who is personally known to me, or

☐ who produced the following identification: _____________

[SEAL]

Notary Public

Kristin E. Kernutt
Printed Notary Name

My Commission Expires

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Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Peter Middle: Fletcher Last: Davidson

2. a. Are you a citizen of the United States?

   Yes [X] No

   b. Are you a citizen of any other country?

      Yes [ ] No [X]

      If yes, what country?

3. Affiant’s occupation or profession: Chief Financial Officer

4. Affiant’s business address: 110 International Way; Springfield, OR 97477

   Business telephone: ____________________ Business Email: ____________________

5. Education and training:

   College/University     City/State     Dates Attended (MM/YY)     Degree Obtained
   ____________________   ____________________   ____________________   ____________________

   Graduate Studies     College/University     City/State     Dates Attended (MM/YY)     Degree Obtained
   ____________________   ____________________   ____________________   ____________________

   Other Training: Name     City/State     Dates Attended (MM/YY)     Degree/Certification Obtained
   ____________________   ____________________   ____________________   ____________________

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Revised 03/26/18
FORM 11
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-059510

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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</thead>
<tbody>
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</tbody>
</table>

7. Present or proposed position with the Applicant Company: EVP and Chief Financial Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 03/08 - Present
Employer’s Name: PacificSource (as successor to PacificSource Health Plans)
Address: 110 International Way City: Springfield State/Province: OR Country: USA Postal Code: 97477 Phone: 541.686.1242 Offices/Positions Held: EVP and CFO
Type of Business: Health Plan Supervisor/Contact: Ken Provencher, President&CEO

Beginning/Ending

Beginning/Ending

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 47 of 182
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [ X ]

If any claims were made on the bond, give details: ________________________________
b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [ X ]

If yes, give details:

--------------------

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

NA

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   Yes [ ] No X

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   Yes [ ] No X

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   Yes [ ] No X

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No X

e. Plead guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No X

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No X

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   Yes [ ] No X

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   Yes [ ] No X

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   Yes [ ] No X

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
   Yes [ ] No X

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.
12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation,
receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [x] No [ ]

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 1 day of April 2019 at 7:53 AM. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 1 day of April 2019 by Peter Davidson and: who is personally known to me, or who produced the following identification:

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022

Linda Anne Martin
Printed Notary Name

My Commission Expires

Revised 03/26/18
FORM 11

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BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Peter Middle: Fletcher Last: Davidson
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes No X

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending
   Date(s) Used (MM/YY)  Name(s) Specify: First, Middle or Last Name  Reason (If none, indicate such)

   ____________

3. Affiant’s Social Security Number:

4. Government Identification Number if not a U.S. Citizen: NA

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Revised 03/26/18
FORM 11
5. Foreign Student ID# (if applicable) : NA
6. Date of Birth: (MM/DD/YY) : [redacted] Place of Birth, City: [redacted] State/Province: [redacted] Country: USA
7. Name of Affiant's Spouse (if applicable) : [redacted]
8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
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</tbody>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 1st day of April, 2019 at 7:53 Am, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 1st day of April, 2019 by Peter Davidson and:

who is personally known to me, or

who produced the following identification:

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022

Linda Anne Martin
Printed Notary Name
June 14, 2022
My Commission Expires
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave, Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Erick Middle: Trask Last: Doolen

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]
   b. Are you a citizen of any other country?
   Yes [ ] No [X]
      If yes, what country?

3. Affiant’s occupation or profession: EVP and Chief Operating Officer

4. Affiant’s business address: 110 International Way, Springfield, OR 97477
   Business telephone: [Redacted]  Business Email: [Redacted]

5. Education and training:

<table>
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<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<td>Graduate Studies</td>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
</tr>
</tbody>
</table>

   Other Training: Name | City/State | Dates Attended (MM/YY) | Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit Page 55 of 182
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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</table>

7. Present or proposed position with the Applicant Company: Chief Operating Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY): 08/05 -</th>
<th>Employer’s Name: PacificSource (as successor of PacificSource Health Plans)</th>
</tr>
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<tbody>
<tr>
<td>Address: 110 International Way</td>
<td>City: Springfield</td>
</tr>
<tr>
<td>Country: USA</td>
<td>Postal Code: 97477</td>
</tr>
<tr>
<td>Phone: 541-684-5596</td>
<td>Offices/Positions Held: CIO/COO</td>
</tr>
</tbody>
</table>

| Type of Business: Health Insurance       | Supervisor/Contact: Ken Provencher/President and CEO                    |

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<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer’s Name:</th>
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<td>Address:</td>
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<td>Phone:</td>
<td>Offices/Positions Held:</td>
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</table>

| Type of Business:                       | Supervisor/Contact:                                                      |

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<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer’s Name:</th>
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<td>Phone:</td>
<td>Offices/Positions Held:</td>
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</tbody>
</table>

| Type of Business:                       | Supervisor/Contact:                                                      |
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details: ________________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details: ________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: ____________________________
   Address: ____________________________
   City: ____________________________
   State/Province: ____________________________
   Country: ____________________________
   Postal Code: ____________________________
   License Type: ____________________________
   License #: ____________________________
   Date Issued (MM/YY): ____________________________
   Date Expired (MM/YY): ____________________________
   Reason for Termination: ____________________________
   Non-Insurance Regulatory Phone Number (if known): ____________________________

   Organization/Issuer of License: ____________________________
   Address: ____________________________
   City: ____________________________
   State/Province: ____________________________
   Country: ____________________________
   Postal Code: ____________________________
   License Type: ____________________________
   License #: ____________________________
   Date Issued (MM/YY): ____________________________
   Date Expired (MM/YY): ____________________________
   Reason for Termination: ____________________________
   Non-Insurance Regulatory Phone Number (if known): ____________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]
b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-
management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details: ________________________________

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 1st day of April 2019 at 7:56 AM. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon    County of: Lane

The foregoing instrument was acknowledged before me this 1st day of April 2019 by Erick Doolen, and:

who is personally known to me, or

who produced the following identification:

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 975018
MY COMMISSION EXPIRES JUNE 14, 2022

Linda Anne Martin
Printed Notary Name
June 14, 2022
My Commission Expires

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Attachment 12-Form 11 NAIC Biographical Affidavit

Revised 03/26/18
FORM 11
Page 60 of 182
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Erick Middle: Trask Last: Doolen
IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

Yes ☐ No ☒

If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable) :
6. Date of Birth: (MM/DD/YY): [REDACTED]  
Place of Birth, City: [REDACTED]
State/Province: [REDACTED]  
Country: USA

7. Name of Affiant's Spouse (if applicable): [REDACTED]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
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</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15th day of April, 2019 at 7:30 AM, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  
County of: Lane

The foregoing instrument was acknowledged before me this 15th day of April, 2019 by Erick Doolen

[SEAL]

LINDA ANNE MARTIN  
NOTARY PUBLIC - OREGON  
COMMISSION NO. 876018

My Commission Expires June 14, 2022

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Revised 03/26/18

FORM 11
**BIOGRAPHICAL AFFIDAVIT**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions.

2965 NE Conners Ave., Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Anna Middle: Lynn Last: Loomis

2. a. Are you a citizen of the United States?
   
   Yes [X] No

   b. Are you a citizen of any other country?
   
   Yes [ ] No [X]

   If yes, what country?

3. Affiant's occupation or profession: Health System Executive

4. Affiant's business address: [Redacted]

   Business telephone: [Redacted] Business Email: [Redacted]

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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</thead>
<tbody>
<tr>
<td>Graduate Studies</td>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
</tr>
<tr>
<td>Other Training: Name</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
<td>Degree/Certification Obtained</td>
</tr>
</tbody>
</table>

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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<tbody>
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7. Present or proposed position with the Applicant Company:

Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Employer’s Name</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
<th>Phone</th>
<th>Offices/Positions Held</th>
<th>Supervisor/Contact</th>
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-2018 National Association of Insurance Commissioners 2

Revised 03/26/18

FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 64 of 182
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [x]
   If any claims were made on the bond, give details:
   ____________________________________________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [x]
   If yes, give details:
   ____________________________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

Certified Public Accountant

Organization/Issuer of License: ___________________________ Address: ___________________________

City: ___________________________ State/Province: ___________________________ Country: ___________________________ Postal Code: ___________________________

License Type: ___________________________ License #: ___________________________ Date Issued (MM/YY): ___________________________ Date Expired (MM/YY): ___________________________ Reason for Termination: ___________________________ Non-Insurance Regulatory Phone Number (if known): ___________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [x]
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
      Yes [ ] No [x]
Applicant Company Name: PacificSource Community Solutions
FEIN: 81-3059510

1. Applicant has been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   Yes [ ] No [x]

2. Applicant has been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No [x]

3. Applicant has pleaded guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No [x]

4. Applicant has had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   Yes [ ] No [x]

5. Applicant has been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking; or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   Yes [ ] No [x]

6. Applicant has been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   Yes [ ] No [x]

7. Applicant has had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   Yes [ ] No [x]

8. Applicant has had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
   Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

2018 National Association of Insurance Commissioners
Revised 03/26/18
FORM 11
Attachment 12-Form 11 NAIC Biographical Affidavit
Page 66 of 182
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

None

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details: __________

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
Applicant Company Name: PacificSource Community Solutions

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity for information.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March 2019 by Anne Loomis and:

Who is personally known to me, or

who produced the following identification:

[SEAL]

Notary Public

Kristin E. Kernutt

Printed Notary Name

My Commission Expires May 07, 2022
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions.

2965 NE Conners Ave, Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Anna  Middle: Lynn  Last: Loomis
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [X]  No [ ]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
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   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: ____________________________

4. Government Identification Number if not a U.S. Citizen: ____________________________

5. Foreign Student ID# (if applicable): ____________________________

Revised 03/26/18
Applicant Company Name: PacificSource Community Solutions

6. Date of Birth: (MM/DD/YY): __________ Place of Birth, City: __________
   State/Province: __________ Country: USA

7. Name of Affiant's Spouse (if applicable): __________

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this __________ day of March, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this __________ day of March, 2019 by Anne Loonis

and:

✓ who is personally known to me, or

who produced the following identification:

[SEAL]

Notary Public
Kristin E. Kernutt
Printed Notary Name
5/1/2022
My Commission Expires

2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable):
   First: John Middle: Edward Last: McEachern

2. a. Are you a citizen of the United States?
   Yes [ ] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [x] xx

   If yes, what country?

3. Affiant’s occupation or profession: Physician

4. Affiant’s business address: 110 International Way Springfield OR 97479

   Business telephone: [ ]
   Business Email: [ ]

5. Education and training:

   College/University City/State Dates Attended (MM/YY) Degree Obtained

   [ ]

   Graduate Studies
   College/University City/State Dates Attended (MM/YY) Degree Obtained

   [ ]
Other Training: Name | City/State | Dates Attended (MM/YY) | Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

6. List of memberships in professional societies and associations:

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<tr>
<th>Name of Society/Association</th>
<th>Address of Society/Association</th>
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7. Present or proposed position with the Applicant Company: Chief Medical Officer and EVP
8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending
Dates (MM/YY): 10/15 - current
Employer's Name: PacificSource Health Plans

Address: 110 International Way
City: Springfield
State/Province: OR
Country: USA
Postal Code: 97479
Phone: Offices/Positions Held: Medical Director, CMO

Type of Business: Health Plan / Insurer

Supervisor/Contact: Ken Provencher CEO 541-686-1242
9. a. Have you ever been in a position which required a fidelity bond?

Yes ☐  No ☒

If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes ☐  No ☒

If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.
In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   - Yes [ ] No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   - Yes [ ] No [x]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   - Yes [ ] No [x]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   - Yes [ ] No [x]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   - Yes [x] No [ ]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   - Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.
12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by,” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

None

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒
b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [XX]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [XX] No [ ]

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 4th day of April 2019 at Boise, Idaho. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

☑ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

The foregoing instrument was acknowledged before me this 4th day of April, 2019, by Edward McEachern

who is personally known to me, or

who produced the following identification:

[Notary Public Seal]

Catherine L. Gilchrist
Printed Notary Name

My Commission Expires Sept 28, 2022
RFA OHA-4690-19-PacificSource Community Solutions-Central Oregon
Applicant Company Name: PacificSource Community Solutions NAIC No. NA
FEIN: 81-059510

BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: John Middle: Edward Last: McEachern
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes ☐ No ☐
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen:

5. Foreign Student ID# (if applicable):

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FORM 11
Revised 03/26/18

Attachment 12-Form 11 NAIC Biographical Affidavit  Page 81 of 182
Applicant Company Name: PacificSource Community Solutions 
NAIC No.: NA 
FEIN: 81-059510 

6. Date of Birth: (MM/DD/YY): __________ Place of Birth, City: __________
State/Province: __________ Country: __________

7. Name of Affiant's Spouse (if applicable): __________

8. List your residences for the last ten (10) years starting with your current address, giving:

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<th>Beginning/Ending Dates (MM/YY)</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 4th day of April, 2019 at Boise, Idaho. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Idaho County of: Ada
The foregoing instrument was acknowledged before me this 4th day of April, 2019 by Edward M. Fadem

who is personally known to me, or

who produced the following identification:

[SEAL]

CATHERINE L. GILCHRIST
COMMISSION #66500
NOTARY PUBLIC
STATE OF IDAHO
MY COMM. EXPIRES SEP 28, 2022

©2019 National Association of Insurance Commissioners
Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Kenneth    Middle: Paul    Last: Provencher

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [X]

   If yes, what country?

3. Affiant’s occupation or profession: President and CEO

4. Affiant’s business address: 110 International Way; Springfield, OR 97477

   Business telephone: [Redacted]    Business Email: [Redacted]

5. Education and training:

   College/University    City/State    Dates Attended (MM/YY)    Degree Obtained

   Graduate Studies    College/University    City/State    Dates Attended (MM/YY)    Degree Obtained

   Other Training: Name    City/State    Dates Attended (MM/YY)    Degree/Certification Obtained
Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: President and CEO

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 01/95 - Present

Employer's Name: PacificSource (as successor to PacificSource Health Plans)

Address: 110 International Way City: Springfield State/Province: OR

Country: USA Postal Code: 97477 Phone: 541.684.5286 Offices/Positions Held: President/CEO; VP Ops; Provider Contracting Dir.

Type of Business: Health Plan Supervisor/Contact: Jeff Barber, Board Chair

Beginning/Ending Dates (MM/YY): - Employer’s Name:

Address: City: State/Province:

Country: Postal Code: Phone: Offices/Positions Held:

Type of Business: Supervisor/Contact:

Beginning/Ending Dates (MM/YY): - Employer’s Name:

Address: City: State/Province:

Country: Postal Code: Phone: Offices/Positions Held:

Type of Business: Supervisor/Contact:

Beginning/Ending Dates (MM/YY): - Employer’s Name:

Address: City: State/Province:

Country: Postal Code: Phone: Offices/Positions Held:

Type of Business: Supervisor/Contact:

Beginning/Ending

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Attachment 12-Form 11 NAIC Biographical Affidavit

Page 84 of 182
Applicant Company Name: PacificSource Community Solutions

Dates (MM/YY): __________

Employer's Name: __________________________

Address: __________________________

City: __________________________

State/Province: __________________________

Country: __________________________

Postal Code: __________________________

Phone: __________________________

Offices/Positions Held: __________________________

Type of Business: __________________________

Supervisor/Contact: __________________________

9. a. Have you ever been in a position which required a fidelity bond?

   Yes [X] No [ ]

   If any claims were made on the bond, give details: NA

   __________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

   Yes [ ] No [X]

   If yes, give details: __________________________

   __________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________

   Address: __________________________

   City: __________________________

   State/Province: __________________________

   Country: __________________________

   Postal Code: __________________________

   License Type: __________________________

   License #: __________________________

   Date Issued (MM/YY): __________________________

   Date Expired (MM/YY): __________________________

   Reason for Termination: __________________________

   Non-Insurance Regulatory Phone Number (if known): __________________________
11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   - Yes [ ] No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   - Yes [ ] No [x]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
   - Yes [ ] No [x]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
   - Yes [ ] No [x]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
   - Yes [ ] No [x]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
   - Yes [ ] No [x]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
   - Yes [ ] No [x]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
   - Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.
12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by," and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☑

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☑

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☑

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation,
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-059510

receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 1st day of April 2019 at 12:50 p.m. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 1st day of April 2019 by Kenneth Provencher

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022

Linda Anne Martin
Printed Notary Name
June 14, 2022

My Commission Expires

©2019 National Association of Insurance Commissioners
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conner Ave, Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Kenneth Middle: Paul Last: Provencher
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
6. Date of Birth: (MM/DD/YY) [mm/dd/yy] Place of Birth, City: [city] State/Province: [state] Country: USA

7. Name of Affiant’s Spouse (if applicable): [name]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 1\textsuperscript{st} day of April, 2019 at 12:50 p.m., I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(State of: Oregon County of: Lane)

The foregoing instrument was acknowledged before me this 1\textsuperscript{st} day of April, 2019 by Kenneth Povenden and:

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022

©2019 National Association of Insurance Commissioners
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names): ______________________________

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Roger Middle: Maxamillian Last: Saydack

2. a. Are you a citizen of the United States?  
   Yes [x] No

   b. Are you a citizen of any other country?  
   Yes [x] No

   If yes, what country?

3. Affiant’s occupation or profession: Retired

4. Affiant’s business address: ______________________________

   Business telephone: ______________________________
   Business Email: ______________________________

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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</thead>
<tbody>
<tr>
<td>Graduate Studies</td>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
</tr>
</tbody>
</table>

   Other Training: Name: ______________________________
   City/State: ______________________________
   Dates Attended (MM/YY): ______________________________
   Degree/Certification Obtained: ______________________________

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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6. List of memberships in professional societies and associations:

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<th>Name of Society/Association</th>
<th>Contact Name</th>
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</table>

7. Present or proposed position with the Applicant Company: **Board of Directors**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Beginning/Ending**

**Beginning/Ending**

**Beginning/Ending**

**Beginning/Ending**

**Beginning/Ending**

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<th>Offices/Positions Held:</th>
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<th>Type of Business:</th>
<th>Supervisor/Contact:</th>
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</table>
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [X]

If any claims were made on the bond, give details:
________________________________________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [X]

If yes, give details:
________________________________________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

Non-Insurance Regulatory Phone Number (if known):
________________________________________________________________________

Organization/Issuer of License: __________________________ Address: __________________________

City: _____________ State/Province: _____________ Country: _____________ Postal Code: _____________

License Type: _____________ License #: _____________ Date Issued (MM/YY): _____________

Date Expired (MM/YY): _____________ Reason for Termination: ____________________________________________________________________

Non-Insurance Regulatory Phone Number (if known):
________________________________________________________________________
Applicant Company Name: PacificSource Community Solutions  
NAIC No. NA  
FEIN: 81-3059510

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
Yes [ ] No [x]  
d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]  
e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]  
f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]  
g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
Yes [ ] No [x]  
h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
Yes [ ] No [x]  
i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
Yes [ ] No [x]  
j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
Yes [ ] No [x]  

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____________________________________

If any of the stock is pledged or hypothecated in any way, give details. _____________________________________

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]  

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities. _____________________________________

If any of the shares of stock are pledged or hypothecated in any way, give details. _____________________________________

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]  

If yes, provide details: _____________________________________

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]  

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]  

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 28 day of March 2019 at Springfield, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  County of: Lane

The foregoing instrument was acknowledged before me this 28 day of March, 2019 by

Roger Saydack

and:

✓ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

LINDA ANN MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 876018
MY COMMISSION EXPIRES JUNE 14, 2022

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Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant's Full Name (Initials Not Acceptable): First: Roger Middle: Maxamillian Last: Saydack
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending
   Date(s) Used (MM/YY)   Name(s)   Specify: First, Middle or Last Name   Reason (If none, indicate such)
   ______________________  ______________________  ______________________  ______________________
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   ______________________  ______________________  ______________________  ______________________

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA

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Revised 03/26/18
FORM 11
Applicant Company Name: PacificSource Community Solutions

<table>
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<tr>
<th>Date of Birth: (MM/DD/YY)</th>
<th>Place of Birth, City, Country</th>
</tr>
</thead>
</table>

| Name of Affiant’s Spouse (if applicable): |

| List your residences for the last ten (10) years starting with your current address, giving: |

<table>
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<tr>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 28 day of March, 2019 at Springfield, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Lane

[SEAL]

LINDA ANNE MARTIN
NOTARY PUBLIC - OREGON
COMMISSION NO. 976018
MY COMMISSION EXPIRES JUNE 14, 2022

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 98 of 182
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Patricia Middle: Jean Last: Schmitt

2. a. Are you a citizen of the United States? [ ] Yes [ ] No
   b. Are you a citizen of any other country? [ ] Yes [ ] No
      If yes, what country?

3. Affiant’s occupation or profession: Retired CPA

4. Affiant’s business address:
   Business telephone: ___________________ Business Email: ___________________

5. Education and training:

   College/University: ___________________ City/State: ___________________
   Dates Attended (MM/YY): ___________________ Degree Obtained: ___________________
   Graduate Studies: ___________________ College/University: ___________________
   City/State: ___________________ Dates Attended (MM/YY): ___________________ Degree Obtained: ___________________

   Other Training: Name: ___________________ City/State: ___________________
   Dates Attended (MM/YY): ___________________ Degree/Certification Obtained: ___________________

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Revised 03/26/18
FORM 11
6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: **Board of Directors**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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Beginning/Ending

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<th>Dates (MM/YY):</th>
<th>Employer’s Name:</th>
<th>Address:</th>
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<th>State/Province:</th>
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</tbody>
</table>

Type of Business: ________________
Supervisor/Contact: ________________
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Revised 03/26/18
Attachment 12-Form 11 NAIC Biographical Affidavit
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X] 
   If any claims were made on the bond, give details:

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   na

   Non-Insurance Regulatory Phone Number (if known):

   Organization/Issuer of License: ____________________________ Address: ____________________________

   City: ____________________________ State/Province: ____________________________ Country: ____________________________ Postal Code: ____________________________

   License Type: ____________________________ License #: ____________________________ Date Issued (MM/YY): ____________________________

   Date Expired (MM/YY): ____________________________ Reason for Termination: ____________________________

   Non-Insurance Regulatory Phone Number (if known):

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   Yes [ ] No [X]
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
Yes [ ] No [x]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [x]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
Yes [ ] No [x]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
Yes [ ] No [x]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
Yes [ ] No [x]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☒ No ☐
Applicant Company Name: PacificSource Community Solutions

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah
The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Patricia Schmitt

and:

☐ who is personally known to me, or

☐ who produced the following identification: 

Notary Public

Kristin E. Kernutt

Printed Notary Name

My Commission Expires May 07, 2022
**BIOGRAPHICAL AFFIDAVIT**  
**Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions  
2965 NE Conners Ave; Bend, OR 97701  
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: **Patricia**  
   Middle: **Jean**  
   Last: **Schmitt**  
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  
   Yes [x]  
   No [ ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Blacked out]

4. Government Identification Number if not a U.S. Citizen: **NA**

5. Foreign Student ID# (if applicable): **NA**
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY): [Blacked Out]
   Place of Birth, City: [Blacked Out]
   Country: USA

7. Name of Affiant’s Spouse (if applicable): [Blacked Out]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

[Signature of Affiant]

State of: Oregon County of: Multnomah
The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Patricia Schmitt

☑ who is personally known to me, or

☐ who produced the following identification: ____________________________

[SEAL]

Kristin E. Kernutt
Notary Public
Printed Notary Name
5/17/2022
My Commission Expires May 07, 2022
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Divya Middle: __________ Last: Sharma

2. a. Are you a citizen of the United States?  
   Yes [ ] No [ ]

   b. Are you a citizen of any other country?  
   Yes [ ] No [X]

   If yes, what country? ___________________________

3. Affiant's occupation or profession: Medical Doctor

4. Affiant's business address: _________________  
   Business telephone: ___________________________

5. Education and training:

<table>
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<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<th>City/State</th>
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<tr>
<th>Other Training: Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

©2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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</table>

7. Present or proposed position with the Applicant Company: **Board of Directors**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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©2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit   Page 108 of 182
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details:

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   na

Non-Insurance Regulatory Phone Number (if known):
See attached additional licenses

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
      Yes [ ] No [X]
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

---

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [x]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [x]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [x]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [x]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [x]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

---

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X ]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X ]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental licensing agency?

Yes [ ] No [X ]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X ]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X ] No [ ]
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at 12:08 p.m. Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019, by

Drew Sharma

and:

☑ who is personally known to me, or

☐ who produced the following identification: ____________

[SEAL]

OFFICIAL STAMP
KIRSTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public
Printed Notary Name
Kristin E. Kernutt
My Commission Expires 5/7/2022
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave, Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Divya Middle: Middle: Last: Sharma
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [x]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

   Beginning/Ending
   Date(s) Used (MM/YY) | Name(s) Specify: First, Middle or Last Name | Reason (If none, indicate such)

   ____________
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   ____________
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   ____________
   ____________

   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: ____________

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY):
   Place of Birth, City: 
   Country: 

7. Name of Affiant's Spouse (if applicable): 

8. List your residences for the last ten (10) years starting with your current address, giving:

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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at 12:09 p.m., Portland, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

____ (Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Divya Sharma and:

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

KRYSTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

©2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 114 of 182
BIographiesal Affidavit

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Claire Middle: Leona Last: Spain-Remy

2. a. Are you a citizen of the United States?
   Yes [X] No

   b. Are you a citizen of any other country?
   Yes No [X]

   If yes, what country?

3. Affiant’s occupation or profession: Retired, Part-time Healthcare Consultant

4. Affiant’s business address: [Redacted]
   Business telephone: [Redacted] Business Email: [Redacted]

5. Education and training:

   College/University City/State Dates Attended (MM/YY) Degree Obtained

   [Redacted]

   Graduate Studies College/University City/State Dates Attended (MM/YY) Degree Obtained

   [Redacted]

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained

   [Redacted]

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
Applicant Company Name: PacificSource Community Solutions

6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details: __________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details: __________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NA

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   Yes [ ] No [X]
Applicant Company Name: PacificSource Community Solutions

NAIC No. N/A
FEIN: 81-3059510

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 119 of 182
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [x] No [ ]
Applicant Company Name: PacificSource Community Solutions NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March 2019 by

Claire Spahn-Denny

and:

☐ who is personally known to me, or

☐ who produced the following identification: ____________________________

[SEAL]

KARASTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

©2018 National Association of Insurance Commissioners

Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541-706-5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Claire Middle: Leona Last: Spain-Remy
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [x] No [_] 
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]
4. Government Identification Number if not a U.S. Citizen: NA
5. Foreign Student ID# (if applicable): NA
6. Date of Birth: (MM/DD/YY): [Redacted] Place of Birth, City: [Redacted] Country: USA

7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 15th day of March, 2019 at Portland, OR, I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019, by Claire Spanbauer

☐ who is personally known to me, or

☐ who produced the following identification: ______________

[SEAL]

KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public

Kristin E. Kernutt
Printed Notary Name

512 | 2022

My Commission Expires
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave, Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Dan Middle: Andrew Last: Stevens

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]

   b. Are you a citizen of any other country?
   Yes [ ] No [X]

   If yes, what country?

3. Affiant’s occupation or profession: EVP and Oregon Regional Director

4. Affiant’s business address: 2965 NE Conners Avenue, Bend, OR 97701

   Business telephone: [ ] Business Email: [ ]

5. Education and training:

<table>
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<th>College/University</th>
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<th>Dates Attended (MM/YY)</th>
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<th>Degree Obtained</th>
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<th>Other Training: Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
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6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: EVP and Oregon Regional Director

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officeships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

**Beginning/Ending Dates (MM/YY):** 09/10 - Present

**Employer's Name:** PacificSource (successor to PacificSource Health Plans)

**Address:** 2965 NE Conners Ave
**City:** Bend
**State/Province:** OR
**Country:** USA
**Postal Code:** 97701
**Phone:** 541-385-5315
**Offices/Positions Held:** SVP/EVP

**Supervisor/Contact:** Ken Provencher/President and CEO
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details: ___________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details: ______________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   NA

   Organization/Issuer of License: ____________________________
   Address: ___________________________
   City: __________________ State/Province: __________ Country: __________________ Postal Code: __________
   License Type: __________________ License#: __________________ Date Issued (MM/YY): __________
   Date Expired (MM/YY): __________ Reason for Termination: __________________

   Non-Insurance Regulatory Phone Number (if known): ________________
   Organization/Issuer of License: ____________________________
   Address: ___________________________
   City: __________________ State/Province: __________ Country: __________________ Postal Code: __________
   License Type: __________________ License#: __________________ Date Issued (MM/YY): __________
   Date Expired (MM/YY): __________ Reason for Termination: __________________

   Non-Insurance Regulatory Phone Number (if known): ________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

   [ ] Yes [ ] No
b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.
12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. 

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]
c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [ ]

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 3rd day of April 2019 at 3:25 p.m. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[Signature of Affiant]

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Deschutes

The foregoing instrument was acknowledged before me this 3 day of April 2019 by Don Stevens

[SEAL]

Layne K. Milowe
Notary Public
Printed Notary Name
4/24/2020

My Commission Expires April 24, 2020
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conneres Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: Dan Middle: Andrew Last: Stevens
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes  No X

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: ________________________

4. Government Identification Number if not a U.S. Citizen: ________________________

5. Foreign Student ID# (if applicable): ________________________

©2019 National Association of Insurance Commissioners  Form 11
6. Date of Birth: (MM/DD/YY) [Redacted] Place of Birth, City: [Redacted]  
State/Province: [Redacted] Country: USA  
7. Name of Affiant’s Spouse (if applicable): [Redacted]  
8. List your residences for the last ten (10) years starting with your current address, giving:  

<table>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
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</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 3rd day of April 2019 at 3:25 p.m., I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

X I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Deschutes  
The foregoing instrument was acknowledged before me this 3rd day of April, 2019 by Dan Stevens and:  
\checkmark who is personally known to me, or  
\checkmark who produced the following identification: ODL 4081352  

[SEAL]  

OFFICIAL STAMP  
LAYNE K MIL owe  
NOTARY PUBLIC-OREGON  
COMMISSION NO. 848923  
MY COMMISSION EXPIRES APRIL 24, 2020  

©2019 National Association of Insurance Commissioners
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Sharon ___ Middle: Louise ______ Last: Thomson ___

2. a. Are you a citizen of the United States?

   Yes [X]  No [ ]

   b. Are you a citizen of any other country?

   Yes [ ]  No [X]

   If yes, what country?

3. Affiant’s occupation or profession: EVP Community Strategy and Marketing

4. Affiant’s business address: 1500 SW 1st Ave, Suite 100A, Portland, OR 97201

   Business telephone: [Blank]

   Business Email: [Blank]

5. Education and training:

   College/University City/State Dates Attended (MM/YY) Degree Obtained

   Graduate Studies College/University City/State Dates Attended (MM/YY) Degree Obtained

   Other Training: Name City/State Dates Attended (MM/YY) Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: Executive Vice President

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending Dates (MM/YY): 09/15 - Present

Employer's Name: PacificSource (successor to PacificSource Health Plans)

Address: 1500 SW 1st Ave Ste 100A
City: Portland
State/Province: OR

Country: USA
Postal Code: 97201
Phone: 503-802-5958

Offices/Positions Held: EVP Community Strategy and Marketing
Supervisor/Contact: Ken Provencher/President and CEO

Type of Business: Health Plan

Beginning/Ending
9. a. Have you ever been in a position which required a fidelity bond?
   Yes ☐  No ☒
   If any claims were made on the bond, give details: __________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes ☐  No ☒
   If yes, give details: __________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: __________________________ Address: __________________________
   City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________
   License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________
   Date Expired (MM/YY): __________________________ Reason for Termination: __________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________ Address: __________________________
   City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________
   License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________
   Date Expired (MM/YY): __________________________ Reason for Termination: __________________________
   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes ☐  No ☒
b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-

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FORM 11
Attachment 12-Form 11 NAIC Biographical Affidavit
management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 8th day of April 2019 at Pacific Source. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 8th day of April 2019 by Sharon Thomson, and:

who is personally known to me, or

who produced the following identification: __________________________

[SEAL]

Notary Public

Alison Amber Gillmouth
Printed Notary Name
11.30.2019
My Commission Expires November 30, 2019
**BIOGRAPHICAL AFFIDAVIT**  
**Supplemental Personal Information**  

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions  
2965 NE Conners Ave; Bend, OR 97701

541.706.5066

1. **Affiant’s Full Name (Initials Not Acceptable): First: Sharon Middle: Louise Last: Thomson**  
   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?  
   Yes [X] No [ ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Reason (if none, indicate such)</th>
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<td>Date(s) Used (MM/YY)</td>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. **Affiant’s Social Security Number:**

4. **Government Identification Number if not a U.S. Citizen:** NA

5. **Foreign Student ID# (if applicable):** NA
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-059510

6. Date of Birth: (MM/DD/YY): [Redacted] Place of Birth, City: [Redacted]
State/Province: [Redacted] Country: USA

7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

| Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another. |

Dated and signed this 8th day of April 2019 at PacificSource Community. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

[Signature of Affiant]

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 8th day of April 2019 by Sharon Thompson and:

[Seal] Notary Public
Alison Amber Gillmouth
Printed Notary Name
11-30-2019

My Commission Expires November 30, 2019

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Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Please print or type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: David Middle: Andre Last: Vinson

2. a. Are you a citizen of the United States?
   Yes [X] No [ ]
   b. Are you a citizen of any other country?
   Yes [ ] No [X]
   If yes, what country?

3. Affiant’s occupation or profession: Health Information Technology & Digital Health Professional

4. Affiant’s business address:

   Business telephone: [Redacted]
   Business Email: [Redacted]

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<tr>
<td>Graduate Studies</td>
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<tr>
<td>NA</td>
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</tbody>
</table>

Other Training: Name: [Redacted]

City/State: [Redacted]

Dates Attended (MM/YY): [Redacted]

Degree/Certification Obtained: [Redacted]

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

<table>
<thead>
<tr>
<th>Name of Society/Association</th>
<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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<tbody>
<tr>
<td>NA</td>
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</table>

7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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</table>
9. a. Have you ever been in a position which required a fidelity bond?

   Yes [ ] No [X]

   If any claims were made on the bond, give details:

   

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

   Yes [ ] No [X]

   If yes, give details:

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body that has jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: __________________________ Address: __________________________

   City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________

   License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________

   Date Expired (MM/YY): ______________ Reason for Termination: __________________________

   Non-Insurance Regulatory Phone Number (if known): __________________________

   Organization/Issuer of License: __________________________ Address: __________________________

   City: __________________________ State/Province: __________________________ Country: __________________________ Postal Code: __________________________

   License Type: __________________________ License #: __________________________ Date Issued (MM/YY): __________________________

   Date Expired (MM/YY): ______________ Reason for Termination: __________________________

   Non-Insurance Regulatory Phone Number (if known): __________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

   Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

   Yes [ ] No [X]
Applicant Company Name: PacificSource Community Solutions

NAIC No. N/A
FEIN: 81-3059510

Yes ☐ No ☑

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐ No ☑

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐ No ☑

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐ No ☑

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐ No ☑

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐ No ☑

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐ No ☑

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

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Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X] No [ ]
If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

☐ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by

David Vinson.

and:

☐ who is personally known to me, or

☐ who produced the following identification: ____________________________ .

[SEAL]}

KIRSTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022
**BIOGRAPHICAL AFFIDAVIT**

**Supplemental Personal Information**

**(Print or Type)**

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

1. Affiant's Full Name (Initials Not Acceptable): First: David Middle: Andre Last: Vinson

   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

   Yes [ ] No [X]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510


7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 1st day of March, 2019, at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 1st day of March, 2019, by David Vinson and:

☑ who is personally known to me, or

☐ who produced the following identification: __________________________

[SEAL]

Kristin E. Kernutt
Notary Public

My Commission Expires May 07, 2022

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Attachment 12-Form 11 NAIC Biographical Affidavit

Page 147 of 182
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Mark Middle: Joseph Last: Werner

2. a. Are you a citizen of the United States?

Yes [x] No

b. Are you a citizen of any other country?

Yes [ ] No [x]

If yes, what country?

3. Affiant's occupation or profession: Physician, Healthcare Consultant

4. Affiant's business address: [Redacted]

Business telephone: [Redacted] Business Email: [Redacted]

5. Education and training:

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<th>Other Training: Name</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree/Certification Obtained</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.
6. List of memberships in professional societies and associations:

<table>
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<th>Name of Society/Association</th>
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7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Beginning/Ending

Beginning/Ending

Beginning/Ending

See attached for additional work experience
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X] 
   If any claims were made on the bond, give details:
   ________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X] 
   If yes, give details:
   ________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Non-Insurance Regulatory Phone Number (if known):
   ________________________________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
   Yes [ ] No [X] 
   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?
   ________________________________
Applicant Company Name: PacificSource Community Solutions

NAIC No.: N/A
FEIN: 81-3059510

Yes ☐  No ☑

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐  No ☑

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☑

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☑

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☑

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by," and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.
Applicant Company Name: PacificSource Community Solutions

office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☒ No ☐
Applicant Company Name: PacificSource Community Solutions  
NAIC No: NA  
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19 day of March 2019 at PacificSource, Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon  
County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019, by

Mark K. Werner

and:

who is personally known to me, or

who produced the following identification: ____________________________

[SEAL]

OFFICIAL STAMP  
KRISTIN E. KERNUTT  
NOTARY PUBLIC-OREGON  
COMMISSION NO. 974438  
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public

Kristin E. Kernutt

Printed Notary Name

5/17/2018

My Commission Expires
BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable); First: Mark Middle: Joseph Last: Werner

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [ ] No [X]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
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   Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant’s Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

6. Date of Birth: (MM/DD/YY): [Redacted] Place of Birth, City: [Redacted] Country: USA

7. Name of Affiant's Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at PacificSource, Portland. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Mark Werner

☐ who is personally known to me, or

☐ who produced the following identification: __________________________

[SEAL]

Notary Public
Kristin E. Kernutt
Printed Notary Name
5/17/2022
My Commission Expires May 07, 2022

©2019 National Association of Insurance Commissioners

Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
Additional Work Experience

Beginning/Ending
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NO” OR “NONE,” SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: John Middle: Wesley Last: Winter, Jr.
2. a. Are you a citizen of the United States?
   Yes [X] No
   b. Are you a citizen of any other country?
   Yes No [X]
   If yes, what country?

3. Affiant’s occupation or profession: Chief Financial Officer

4. Affiant’s business address: ______________________________________________________________________
   Business telephone: ___________________________ Business Email: ________________________________

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit
Page 157 of 182
Applicant Company Name: PacificSource Community Solutions

NAIC No. N/A
FEIN: 81-3059510

6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: Board Member

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

Beginning/Ending

Beginning/Ending

Beginning/Ending

See attached additional work experience
9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [x]

If any claims were made on the bond, give details: ___________________________________________

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [x]

If yes, give details: ________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

NA

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [x]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [x]
Applicant Company Name: PacificSource Community Solutions
NAIC No.: N/A
FEIN: 81-3059510

Yes  No  

1. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes  No  

2. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes  No  

3. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes  No  

4. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes  No  

5. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes  No  

6. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes  No  

7. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes  No  

8. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes  No  

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person:

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [ ] No [x]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [x]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [x]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [x]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [x] No [ ]
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

✓ I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March 2019 by

[SEAL]

Kristin E. Kernutt
Notary Public

Notary Public

[SEAL]

Kristin E. Kernutt
Notary Public

Printed Notary Name: Kristin E. Kernutt

My Commission Expires 05/07/2022

Revised 03/26/18
FORM 11

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Attachment 12-Form 11 NAIC Biographical Affidavit
### BIOGRAPHICAL AFFIDAVIT

**Supplemental Personal Information**

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

1. Affiant’s Full Name (Initials Not Acceptable): First: John  
   Middle: Wesley  
   Last: Winter, Jr.

   IF ANSWER IS “NONE,” SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

   Yes [X]  No [ ]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit personal supplemental information.

3. Affiant's Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA

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Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-3059510


7. Name of Affiant’s Spouse (if applicable): [Redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

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<th>Beginning/Ending Dates (MM/YY)</th>
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Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this 19th day of March, 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 5th day of March, 2019 by John Wintars.

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public
KRISTIN E. KERNUTT
Printed Notary Name
519-2022
My Commission Expires

©2019 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions

2965 NE Conners Ave; Bend, OR 97701

541.706.5066

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.


2. a. Are you a citizen of the United States?  
   Yes [X]  No [ ]
   
b. Are you a citizen of any other country?  
   Yes [ ]  No [X]
   If yes, what country?

3. Affiant's occupation or profession: Executive/Business Owner

4. Affiant's business address:  
   Business telephone:  
   Business Email:  

5. Education and training:

<table>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<th>Other Training: Name</th>
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Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit
6. List of memberships in professional societies and associations:

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7. Present or proposed position with the Applicant Company: **Board Member**

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years. Additional information may be required during the third-party verification process for international employers.

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<td>Supervisor/Contact:</td>
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</table>
Applicant Company Name: PacificSource Community Solutions
NAIC No.: N/A
FEIN: 81-3059510

9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details:
   ____________________________________________________________

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:
   ____________________________________________________________

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license(s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, “SSN”, “12-SSN-345” or “1234-SSN” (last 6 digits)). Attach additional pages if the space provided is insufficient.

   Organization/Issuer of License: ____________________________
   Address: _______________________________________
   City: __________ State/Province: __________ Country: __________ Postal Code: __________
   License Type: ________ License #: ________ Date Issued (MM/YY): ________
   Date Expired (MM/YY): ________ Reason for Termination: __________________
   Non-Insurance Regulatory Phone Number (if known): ______________

   Organization/Issuer of License (if known): ____________________________
   Address: _______________________________________
   City: __________ State/Province: __________ Country: __________ Postal Code: __________
   License Type: ________ License #: ________ Date Issued (MM/YY): ________
   Date Expired (MM/YY): ________ Reason for Termination: __________________
   Non-Insurance Regulatory Phone Number (if known): ______________

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:

   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Attachment 12-Form 11 NAIC Biographical Affidavit
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?
Yes [ ] No [X]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?
Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?
Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?
Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?
Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?
Yes [ ] No [X]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes  No [X]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes  No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes  No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes  No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [X]  No
Applicant Company Name: PacificSource Community Solutions
NAIC No. NA
FEIN: 81-3059510

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 19th day of March 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon
County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019, by

Richard Wight Jr.

and:

☐ who is personally known to me, or

☐ who produced the following identification: ____________________________

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public
Kristin E. Kernutt
Printed Notary Name
5/7/2022
My Commission Expires
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2965 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant's Full Name (Initials Not Acceptable): First: Richard Middle: Lee Last: Wright, Jr. IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases? Yes [ ] No [X] If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

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<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
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Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student identification number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [REDACTED]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions

6. Date of Birth: (MM/DD/YY) ___________, Place of Birth, City: ___________, Country: USA

7. Name of Affiant’s Spouse (if applicable): ___________

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
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Dated and signed this 19th day of March, 2019 at Portland, OR. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Richard Wright.

☐ who is personally known to me, or

☐ who produced the following identification: __________________________

[SEAL] KRISTIN E. KERNUTT NOTARY PUBLIC-OREGON COMMISSION NO. 974438 MY COMMISSION EXPIRES MAY 07, 2022

Notary Public

Kristin E. Kernutt
Printed Notary Name

Revised 03/26/18
FORM 11
BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

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In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant’s Full Name (Initials Not Acceptable): First: Charles Middle: Russell Last: Zachem, III

2. a. Are you a citizen of the United States? 
   Yes [X] No [ ] 
   b. Are you a citizen of any other country? 
   Yes [ ] No [X] 
   If yes, what country?

3. Affiant’s occupation or profession: Physician

4. Affiant’s business address: [Redacted]
   Business telephone: [Redacted] 
   Business Email: [Redacted]

5. Education and training:

<table>
<thead>
<tr>
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Other Training: Name [Redacted] City/State [Redacted] Dates Attended (MM/YY) [Redacted] Degree/Certification Obtained [Redacted]

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

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Attachment 12-Form 11 NAIC Biographical Affidavit

Form 11 Revised 03/26/18

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Revised 03/26/18
9. a. Have you ever been in a position which required a fidelity bond?
   Yes [ ] No [X]
   If any claims were made on the bond, give details:

   b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?
   Yes [ ] No [X]
   If yes, give details:

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   NA

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
   a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?
      Yes [ ] No [X]

   b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

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Revised 03/26/18
c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

Yes ☐  No ☒

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☒

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☒

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes ☐  No ☒

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes ☐  No ☒

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes ☐  No ☒

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes ☐  No ☒

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes ☐  No ☒

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate
office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.

NA

If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An “affiliate” of, or person “affiliated” with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes ☐ No ☒

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes ☐ No ☒

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes ☐ No ☒

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes ☐ No ☒

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes ☒ No ☐
Applicant Company Name: PacificSource Community Solutions

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity.

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this 7th day of April 2019 at 1:30. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 7th day of April 2019 by Charles Zachars and:

X who is personally known to me, or

X who produced the following identification: Oregon Drivers License

[SEAL]

OFFICIAL STAMP
KIM MARSHA KRAUSE
NOTARY PUBLIC-OREGON
COMMISSION NO. 901785
MY COMMISSION EXPIRES JUNE 29, 2020

Notary Public
Kim M. Krause
Printed Notary Name
June 29, 2020
My Commission Expires

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Attachment 12-Form 11 NAIC Biographical Affidavit
Page 180 of 182

Revised 03/26/18 FORM 11
To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority. The affiant may be required to provide additional information during the third-party verification process if they have attended a foreign school or lived and worked internationally.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

PacificSource Community Solutions
2985 NE Conners Ave; Bend, OR 97701
541.706.5066

1. Affiant's Full Name (Initials Not Acceptable): First: Charles Middle: Russell Last: Zachem, III
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?
   Yes [x] No [ ]
   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

<table>
<thead>
<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s) Specify: First, Middle or Last Name</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another. If applicable, provide the foreign student Identification Number and/or attach foreign diploma or certificate of attendance to the Biographical Affidavit Personal Supplemental Information.

3. Affiant's Social Security Number: [Redacted]

4. Government Identification Number if not a U.S. Citizen: NA

5. Foreign Student ID# (if applicable): NA
Applicant Company Name: PacificSource Community Solutions


7. Name of Affiant's Spouse (if applicable): [BLACKED OUT]

8. List your residences for the last ten (10) years starting with your current address, giving:

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this ___ day of April, 2019 at ___ . I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

(Signature of Affiant)

State of: OREGON County of: Lane

The foregoing instrument was acknowledged before me this 1st day of April, 2019 by [NAME]

and:

[ ] who is personally known to me, or

[ ] who produced the following identification: [IDENTIFICATION]

[SEAL]

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Attachment 12-Form 11 NAIC Biographical Affidavit
Independent Auditors' Report
Consolidated Financial Statements and
Supplemental Information
Years Ended December 31, 2015 and 2014
# PACIFICSOURCE AND SUBSIDIARIES

## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDEPENDENT AUDITORS' REPORT</strong></td>
<td>1-2</td>
</tr>
<tr>
<td><strong>FINANCIAL STATEMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated balance sheets</td>
<td>3</td>
</tr>
<tr>
<td>Consolidated statements of operations</td>
<td>4</td>
</tr>
<tr>
<td>Consolidated statements of comprehensive loss</td>
<td>5</td>
</tr>
<tr>
<td>Consolidated statements of fund balance</td>
<td>6</td>
</tr>
<tr>
<td>Consolidated statements of cash flows</td>
<td>7-8</td>
</tr>
<tr>
<td>Notes to consolidated financial statements</td>
<td>9-36</td>
</tr>
<tr>
<td><strong>SUPPLEMENTAL INFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated schedules of general and administrative expenses</td>
<td>37</td>
</tr>
<tr>
<td>Consolidating balance sheet</td>
<td>38</td>
</tr>
<tr>
<td>Consolidating statement of operations</td>
<td>39</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
PacificSource and Subsidiaries:

We have audited the accompanying consolidated financial statements of PacificSource and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive loss, fund balance, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of PacificSource and Subsidiaries as of December 31, 2015 and 2014, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated schedules of general and administrative expenses and the consolidating balance sheet and income statement are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and related directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Eugene, Oregon
May 27, 2016
## ASSETS

<table>
<thead>
<tr>
<th>Asset</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments</td>
<td>$120,105,945</td>
<td>$138,222,058</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>104,651,432</td>
<td>68,137,400</td>
</tr>
<tr>
<td>Trust funds</td>
<td>3,850,868</td>
<td>4,616,759</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>76,051,738</td>
<td>69,012,321</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>11,752,313</td>
<td>7,576,410</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>13,455,945</td>
<td>9,465,147</td>
</tr>
<tr>
<td>Property, net</td>
<td>29,555,635</td>
<td>32,129,037</td>
</tr>
<tr>
<td>Goodwill</td>
<td>12,611,772</td>
<td>12,611,772</td>
</tr>
<tr>
<td>Intangible assets, net</td>
<td>6,338,027</td>
<td>7,621,785</td>
</tr>
<tr>
<td>Deferred tax assets</td>
<td>-</td>
<td>2,079,700</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$378,373,675</td>
<td>$351,472,389</td>
</tr>
</tbody>
</table>

## LIABILITIES AND FUND BALANCE

**LIABILITIES:**

<table>
<thead>
<tr>
<th>Liability</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>$119,306,910</td>
<td>$96,185,220</td>
</tr>
<tr>
<td>Premium deficiency reserve</td>
<td>-</td>
<td>4,960,000</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>5,251,434</td>
<td>5,460,156</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>38,015,313</td>
<td>50,235,010</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>2,013,298</td>
<td>2,434,177</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>9,647,669</td>
<td>7,996,378</td>
</tr>
<tr>
<td>Accrued medical incentive pools and withholds payable</td>
<td>48,626,193</td>
<td>34,489,082</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>2,374,341</td>
<td>4,978,572</td>
</tr>
<tr>
<td>Collections for others</td>
<td>3,850,868</td>
<td>4,616,759</td>
</tr>
<tr>
<td>Notes payable</td>
<td>14,315,396</td>
<td>717,508</td>
</tr>
<tr>
<td>Deferred tax liabilities</td>
<td>650,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>244,051,422</td>
<td>212,072,862</td>
</tr>
</tbody>
</table>

**FUND BALANCE:**

| Fund balance, unrestricted                                     | 138,104,761   | 141,234,966   |
| Accumulated other comprehensive loss                          | (4,404,045)   | (2,405,907)   |
| Noncontrolling interests                                        | 621,537       | 570,468       |
| **Total**                                                       | 134,322,253   | 139,399,527   |

**Total**                                                        | $378,373,675  | $351,472,389  |

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Operations

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUMS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$564,891,771</td>
<td>$612,313,200</td>
</tr>
<tr>
<td>Medicare</td>
<td>301,577,532</td>
<td>328,645,614</td>
</tr>
<tr>
<td>Medicaid</td>
<td>340,997,255</td>
<td>274,106,015</td>
</tr>
<tr>
<td>Total</td>
<td>1,207,466,558</td>
<td>1,215,064,829</td>
</tr>
<tr>
<td>CLAIMS EXPENSE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>501,891,391</td>
<td>541,044,015</td>
</tr>
<tr>
<td>Medicare</td>
<td>288,280,340</td>
<td>305,936,452</td>
</tr>
<tr>
<td>Medicaid</td>
<td>295,113,012</td>
<td>236,524,570</td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>18,097,328</td>
<td>21,616,772</td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>(4,960,000)</td>
<td>(4,960,000)</td>
</tr>
<tr>
<td>Total</td>
<td>1,107,610,620</td>
<td>1,124,277,908</td>
</tr>
<tr>
<td>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</td>
<td>99,855,938</td>
<td>90,786,921</td>
</tr>
<tr>
<td>ADMINISTRATIVE REVENUES</td>
<td>15,524,667</td>
<td>13,229,330</td>
</tr>
<tr>
<td>GENERAL AND ADMINISTRATIVE EXPENSES</td>
<td>107,837,281</td>
<td>111,776,217</td>
</tr>
<tr>
<td>UNDERWRITING GAIN (LOSS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7,543,324</td>
<td>(7,759,966)</td>
</tr>
<tr>
<td>OTHER INCOME (EXPENSE):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment income</td>
<td>5,095,265</td>
<td>6,658,788</td>
</tr>
<tr>
<td>Interest expense</td>
<td>(306,921)</td>
<td>(570,119)</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(747,359)</td>
<td>(954,088)</td>
</tr>
<tr>
<td>Miscellaneous expense</td>
<td>(1,237,470)</td>
<td>(757,235)</td>
</tr>
<tr>
<td>Total</td>
<td>2,803,515</td>
<td>4,377,346</td>
</tr>
<tr>
<td>INCOME (LOSS) BEFORE INCOME TAXES</td>
<td>10,346,839</td>
<td>(3,382,620)</td>
</tr>
<tr>
<td>INCOME TAX EXPENSE</td>
<td>13,414,212</td>
<td>4,764,054</td>
</tr>
<tr>
<td>TOTAL LOSS</td>
<td>(3,067,373)</td>
<td>(8,146,674)</td>
</tr>
<tr>
<td>LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS</td>
<td>62,832</td>
<td>84,321</td>
</tr>
<tr>
<td>NET LOSS</td>
<td>$ (3,130,205)</td>
<td>$ (8,230,995)</td>
</tr>
</tbody>
</table>

See accompanying notes.
<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NET LOSS</strong></td>
<td>$ (3,130,205)</td>
<td>$ (8,230,995)</td>
</tr>
<tr>
<td><strong>OTHER COMPREHENSIVE LOSS, NET OF TAXES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation of investments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation arising during year (net of tax of $(866,000) in 2015 and $1,546,000 in 2014)</td>
<td>(1,443,812)</td>
<td>2,644,379</td>
</tr>
<tr>
<td>Reclassification adjustment for gains and losses realized in net loss (net of tax of $(486,000) in 2015 and $(374,000) in 2014), included in investment income</td>
<td>(810,628)</td>
<td>(639,468)</td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation of investments, net</td>
<td>(2,254,440)</td>
<td>2,004,911</td>
</tr>
<tr>
<td>Defined benefit pension plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss arising during year (net of tax of $(96,000) in 2015 and $2,690,000 in 2014), included in general and administrative expenses</td>
<td>(94,492)</td>
<td>(4,043,075)</td>
</tr>
<tr>
<td>Amortization of net loss (net of tax of $356,000 in 2015 and $280,000 in 2014), included in general and administrative expenses</td>
<td>350,794</td>
<td>420,659</td>
</tr>
<tr>
<td>Defined benefit pension plan, net</td>
<td>256,302</td>
<td>(3,622,416)</td>
</tr>
<tr>
<td>Total other comprehensive loss</td>
<td>(1,998,138)</td>
<td>(1,617,505)</td>
</tr>
<tr>
<td><strong>COMPREHENSIVE LOSS</strong></td>
<td>$ (5,128,343)</td>
<td>$ (9,848,500)</td>
</tr>
</tbody>
</table>

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Fund Balance

<table>
<thead>
<tr>
<th></th>
<th>Fund Balance</th>
<th>Unrealized Appreciation on Investments</th>
<th>Defined Benefit Pension Plan</th>
<th>Noncontrolling Interests</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BALANCE, January 1, 2014</td>
<td>$ 149,465,961</td>
<td>$ 1,388,831</td>
<td>$ (2,177,233)</td>
<td>$ 489,615</td>
<td>$ 149,167,174</td>
</tr>
<tr>
<td>Net (loss) income</td>
<td>(8,230,995)</td>
<td>-</td>
<td>-</td>
<td>84,321</td>
<td>(8,146,674)</td>
</tr>
<tr>
<td>Other comprehensive income (loss)</td>
<td>-</td>
<td>2,004,911</td>
<td>(3,622,416)</td>
<td>-</td>
<td>(1,617,505)</td>
</tr>
<tr>
<td>Redemption of IPN common stock</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(3,468)</td>
<td>(3,468)</td>
</tr>
<tr>
<td>BALANCE, December 31, 2014</td>
<td>141,234,966</td>
<td>3,393,742</td>
<td>(5,799,649)</td>
<td>570,468</td>
<td>139,399,527</td>
</tr>
<tr>
<td>Net (loss) income</td>
<td>(3,130,205)</td>
<td>-</td>
<td>-</td>
<td>62,832</td>
<td>(3,067,373)</td>
</tr>
<tr>
<td>Other comprehensive (loss) income</td>
<td>-</td>
<td>(2,254,440)</td>
<td>256,302</td>
<td>-</td>
<td>(1,998,138)</td>
</tr>
<tr>
<td>Redemption of IPN common stock</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(11,763)</td>
<td>(11,763)</td>
</tr>
<tr>
<td>BALANCE, December 31, 2015</td>
<td>$ 138,104,761</td>
<td>$ 1,139,302</td>
<td>$ (5,543,347)</td>
<td>$ 621,537</td>
<td>$ 134,322,253</td>
</tr>
</tbody>
</table>

See accompanying notes.
<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH FLOWS FROM OPERATING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums collected</td>
<td>$1,202,078,432</td>
<td>$1,179,905,592</td>
</tr>
<tr>
<td>Claims paid</td>
<td>(1,077,916,050)</td>
<td>(1,091,567,831)</td>
</tr>
<tr>
<td>General and administrative expenses paid</td>
<td>(118,679,844)</td>
<td>(74,602,268)</td>
</tr>
<tr>
<td>Investment income received</td>
<td>4,101,499</td>
<td>4,985,424</td>
</tr>
<tr>
<td>Other revenue received</td>
<td>15,524,667</td>
<td>13,229,330</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(308,109)</td>
<td>(571,228)</td>
</tr>
<tr>
<td>Income taxes paid</td>
<td>(13,583,310)</td>
<td>(9,689,705)</td>
</tr>
<tr>
<td><strong>Net cash provided by operating activities</strong></td>
<td>11,217,285</td>
<td>21,689,314</td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM INVESTING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from sale of investments</td>
<td>89,600,671</td>
<td>130,785,088</td>
</tr>
<tr>
<td>Investments purchased</td>
<td>(74,097,232)</td>
<td>(121,663,435)</td>
</tr>
<tr>
<td>Property purchased</td>
<td>(3,792,817)</td>
<td>(2,190,928)</td>
</tr>
<tr>
<td><strong>Net cash provided by investing activities</strong></td>
<td>11,710,622</td>
<td>6,930,725</td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM FINANCING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from notes payable</td>
<td>13,801,592</td>
<td>-</td>
</tr>
<tr>
<td>Payments on notes payable</td>
<td>(203,704)</td>
<td>(36,189,971)</td>
</tr>
<tr>
<td>Redemption of common stock</td>
<td>(11,763)</td>
<td>(3,468)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) financing activities</strong></td>
<td>13,586,125</td>
<td>(36,193,439)</td>
</tr>
<tr>
<td><strong>CHANGE IN CASH AND CASH EQUIVALENTS</strong></td>
<td>36,514,032</td>
<td>(7,573,400)</td>
</tr>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS, beginning of year</strong></td>
<td>68,137,400</td>
<td>75,710,800</td>
</tr>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS, end of year</strong></td>
<td>$104,651,432</td>
<td>$68,137,400</td>
</tr>
</tbody>
</table>

(Continued)
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Cash Flows (Continued)

Reconciliation of Net Loss to Net Cash
Provided by Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET LOSS</td>
<td>$ (3,130,205)</td>
<td>$ (8,230,995)</td>
</tr>
</tbody>
</table>

ADJUSTMENTS TO RECONCILE NET LOSS TO
NET CASH PROVIDED BY OPERATING ACTIVITIES:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income attributable to noncontrolling interest</td>
<td>62,832</td>
<td>84,321</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>7,649,977</td>
<td>9,770,484</td>
</tr>
<tr>
<td>Deferred tax expense</td>
<td>3,821,700</td>
<td>985,300</td>
</tr>
<tr>
<td>Gain on sale of investments</td>
<td>(1,142,982)</td>
<td>(1,777,423)</td>
</tr>
<tr>
<td>Loss on disposal of property and intangible assets</td>
<td>-</td>
<td>383,083</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>(4,960,000)</td>
<td>4,960,000</td>
</tr>
<tr>
<td>Adjustments resulting from changes in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>(7,039,417)</td>
<td>(38,394,530)</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>149,216</td>
<td>104,059</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(4,175,903)</td>
<td>(440,287)</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>(3,990,798)</td>
<td>(5,910,951)</td>
</tr>
<tr>
<td>Prepaid pension costs</td>
<td>-</td>
<td>3,699,390</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>23,121,690</td>
<td>(6,305,630)</td>
</tr>
<tr>
<td>Book overdraft</td>
<td>-</td>
<td>(5,745,948)</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>(208,722)</td>
<td>(3,333,916)</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>95,423</td>
<td>(3,598,239)</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>1,651,291</td>
<td>3,235,293</td>
</tr>
<tr>
<td>Incentive compensation payable</td>
<td>14,177,111</td>
<td>32,969,395</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>(2,604,231)</td>
<td>1,086,312</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>(12,219,697)</td>
<td>38,149,596</td>
</tr>
</tbody>
</table>

NET CASH PROVIDED BY OPERATING ACTIVITIES $ 11,217,285 $ 21,689,314

Supplemental Schedule of Noncash Investing and Financing Activities

At December 31, 2015, there was a decrease from December 31, 2014 in unrealized appreciation of investments, net of reclassification adjustments, of $(3,606,440) with deferred taxes of $1,352,000. At December 31, 2014, there was an increase from December 31, 2013 in unrealized appreciation of investments, net of reclassification adjustments, of $3,176,911 with deferred taxes of $(1,172,000).

At December 31, 2015, there were defined benefit pension plan adjustments of $516,302 with deferred taxes of $(260,000). At December 31, 2014, there were defined benefit pension plan adjustments of $(6,032,416) with deferred taxes of $2,410,000.

See accompanying notes.
1. Organization and Summary of Significant Accounting Policies

PacificSource and its subsidiaries are organized as follows:

- **PacificSource**
  - PacificSource Health Plans (PSHP)
    - PacificSource Administrators, Inc. (PSA)
    - Primary Health, Inc. (PHI)
      - IPN, Inc. (60%) (IPN)
    - PacificSource Community Health Plans (PCHP)
      - PacificSource Community Solutions, Inc. (PCS)

PacificSource is an Oregon not-for-profit holding company. PSHP is an independent, not-for-profit community health plan offering commercial medical and dental plans in Oregon, Idaho, Montana, and Washington.

PSA is a third-party administrator specializing in administration of self-funded employee health benefit plans, flexible spending accounts, health reimbursement arrangements, and COBRA administration based in Oregon.

PHI is a shell corporation which owns 60% of the outstanding shares of IPN, an Idaho based for-profit non-insurance entity. IPN is a physician contracting network.

PCHP is a health insurance company licensed in the states of Oregon and Idaho. They offer Medicare Advantage and, through their subsidiary PCS, Medicaid plans.

On December 31, 2014, PacificSource Community Health Plans, Inc. merged into a newly formed not-for-profit health care contractor company, PacificSource Community Health Plans.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The relative proportion of gross revenue attributable to each entity for the years ended December 31 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource</td>
<td>$449,002</td>
<td>$425,888</td>
</tr>
<tr>
<td>PSHP</td>
<td>573,339,466</td>
<td>617,712,845</td>
</tr>
<tr>
<td>PCHP and subsidiary</td>
<td>642,577,383</td>
<td>602,740,588</td>
</tr>
<tr>
<td>PSA</td>
<td>4,161,700</td>
<td>4,172,523</td>
</tr>
<tr>
<td>PHI and subsidiary</td>
<td>2,463,674</td>
<td>3,242,315</td>
</tr>
<tr>
<td>Gross revenue</td>
<td>$1,222,991,225</td>
<td>$1,228,294,159</td>
</tr>
</tbody>
</table>

**Principles of Consolidation.** The accompanying consolidated financial statements of PacificSource are consolidated with PSHP and its subsidiaries (collectively the Company). All significant intercompany balances and transactions have been eliminated in the consolidation.

**Basis of Presentation.** The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) that differ from statutory accounting principles used by regulatory authorities.

**Investments.** Investments in debt securities, equity securities, and mutual funds are classified as available-for-sale and are reported at fair value. Realized gains and losses on investments are recognized on the specific identification basis and recorded using the original cost of the security. Changes in fair value of investments are recorded as unrealized depreciation or appreciation directly in the fund balance as other comprehensive income or loss and have no effect on net income or loss. Certificates of deposit that had a maturity of more than three months at the time of acquisition are carried at cost.

Investments in other invested assets are accounted for using the equity method. Other invested assets consist of investments in partnerships. The equity method of accounting for investments requires the Company to recognize its pro rata share of the income or loss and distributions of the investments and to increase or decrease the carrying value of the investment accordingly.

**Restricted Deposits.** PSHP, PCHP, and PCS maintain deposits as required by regulatory authorities. At December 31, 2015 and 2014, the Company had total restricted deposits that were included at fair value in investments on the consolidated balance sheets of $3,871,738 and $2,611,738, respectively. At December 31, 2015 and 2014, the Company had total restricted deposits included in cash and cash equivalents on the consolidated balance sheets of $7,205,524 and $7,907,091, respectively.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Cash Equivalents. For purposes of the consolidated statements of cash flows, the Company considers all highly liquid debt instruments purchased with maturities of three months or less at the time of acquisition to be cash equivalents. Substantially all of the cash and cash equivalents are maintained at various banks whose deposits exceed federally insured limits. The Company has not experienced any losses on such accounts.

Trust Funds. Under the terms of administrative agreements for self-insurance and third-party administrator services, the Company is required to maintain separate cash trust accounts for benefit administration services received for various employers.

Accounts Receivable. Accounts receivable consist primarily of uncollected premiums from policyholders, amounts due from groups under administrative service contracts for uninsured health plans, pharmacy rebates, claims refunds collectible from providers, insureds and third parties, amounts due under the Patient Protection and Affordable Care Act (ACA) reinsurance, risk corridor and risk adjustment programs, and amounts due for contractual adjustments from the Centers for Medicare and Medicaid Services (CMS).

Management determines and evaluates past due balances on an account-by-account basis, and if amounts become uncollectible, they will be charged to operations when that determination is made. As of December 31, 2015 and 2014, management considered receivables to be fully collectible; accordingly, no allowance for doubtful accounts was considered necessary.

Health Care Reform. The ACA enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual premium-based health insurance provider fee and the establishment of federally-facilitated or state-based exchanges. The U.S. Department of Health and Human Services (HHS) pays a portion of the premium and a portion of the claim costs for low-income individual public exchange members. In addition, HHS administers three premium stabilization programs, as described more fully below.

ACA Reinsurance. The ACA established a temporary three-year reinsurance program, under which all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by HHS. Funds collected will be utilized to reimburse issuer's high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in claims expense - premium taxes and assessments, for all of the Company's insurance products with the exception of products associated with qualified individual members. At December 31, 2015 and 2014, the Company recorded an accrued expense for funding contribution fees under the program. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company recorded a receivable and offset claims expense to reflect its estimate of these recoveries.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Premiums ceded under the terms of the ACA reinsurance program were $7,908,627 and $12,754,985 in 2015 and 2014, respectively. Reinsurance recoveries were $19,282,251 and $19,207,012 in 2015 and 2014, respectively. The ACA reinsurance program does not relieve the Company from its primary obligation to policyholders.

Risk Adjustment. The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable and reflects the impact as an adjustment to premium revenue.

Risk Corridor. The ACA established a temporary three-year risk sharing program for qualified individual and small group insurance plans. Under this program the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs. The Company records a risk corridor receivable or payable as an adjustment to premium revenue on a pro-rata year-to-date basis based on its estimate of the ultimate risk sharing amount. The Company believes it is due a receivable of $7.2 million for the program year ended December 31, 2014; however the Company did not record the full receivable because the collectability of those payments from HHS are deemed uncertain. At December 31, 2015, the Company recorded a receivable of $2.0 million related to the 2014 program year, which is expected to be paid by HHS from future collections under the remaining life of the risk corridor program. During 2015, the Company collected approximately $778,000 under the 2014 program. The Company also believes it is due a receivable of $25 million for the program year ended December 31, 2015; however it did not record a risk corridor receivable for the 2015 program year because the collectability of those payments from HHS are deemed uncertain.

The Company will perform a final reconciliation and settlement with HHS of claims expense, ACA reinsurance, risk adjustment, and risk corridor during the subsequent year.

Medicare Part D. The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from an annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premium revenue for providing insurance coverage ratably over the term of its annual contract. CMS payments are subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, the Company is not at risk for amounts due for reinsurance, low-income cost subsidies, and certain discounts on brand name prescription drugs in the coverage gap. The Company expenses the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset claims expense when incurred.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require refunds to CMS for a portion of the premiums received. The Company records a receivable or payable at the contract level as an adjustment to premium revenue based on the timing of expected settlement. The Company performs a reconciliation of the final risk-sharing, low-income subsidy, and catastrophic amounts after the end of each contract year.

*Medicare Risk-Score Adjustment.* CMS utilizes a risk-score adjustment model which apportions premiums paid to Medicare plans according to health severity. The risk-score adjustment model pays more for enrollees with predictably higher costs, allowing health plans to be paid appropriately based upon members' overall health. Under the risk-score adjustment methodology, new members are assigned a risk score upon enrollment based upon a variety of factors, including demographics and health history. The risk score is then used in an actuarial model to calculate the rates paid to a health plan. The Company estimates risk-score adjustment revenues based on retrospective chart reviews of its members performed by a third party.

*Property.* Property is stated at cost. Depreciation is computed on the straight-line method based on the estimated useful lives of the assets. Property additions and improvements are capitalized, while repairs and maintenance are charged to expense as incurred.

*Goodwill.* The Company assesses goodwill for impairment annually and whenever events or changes in circumstances indicate it may be impaired. When an impairment is indicated, any excess of carrying value over fair value of goodwill is recorded as an operating loss. The Company completed annual tests for impairment at December 31, 2015 and 2014, and determined that the fair value of goodwill exceeded the carrying value, thus goodwill was not considered impaired.

*Intangible Assets.* Intangible assets with finite lives are amortized on a straight-line basis over their estimated useful lives. Customer relationships and contract arrangements are amortized over ten to twenty years. Estimated useful lives of intangible assets are periodically reviewed by management to determine if events or circumstances warrant a change in the remaining useful life of the asset.

The Company assesses the recoverability of intangibles whenever events or changes in circumstances indicate they may be impaired. When an impairment is indicated, any excess of carrying value over fair value of intangibles is recorded as an operating loss. The Company completed tests for impairment at December 31, 2015 and 2014 and determined that the fair value of intangibles exceeded the carrying value, thus intangibles were not considered impaired.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Liability for Unpaid Claims and Claims Adjustment Expenses. The Company establishes a liability, based on actuarial models, for unpaid claims and related administrative costs. The Company does not discount its liability for unpaid claims. The liability is an estimate, and while the Company believes that the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The estimate is continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in the period in which the revisions are determined. Actual payments will differ from the original estimates and may result in material adjustments to claims expense recorded in future periods.

Premium Deficiency Reserve. The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or actuarial forecasts indicate probable future losses. The Company establishes a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceed related future premiums under contracts without consideration of investment income. For purposes of premium deficiency losses, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts and represents the Company's best estimate in a range of potential outcomes. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. The Company recognized a premium deficiency liability of $4,960,000 and corresponding loss as of and for the year ended December 31, 2014. At December 31, 2015, the Company determined that a premium deficiency no longer existed.

Coordinated Care Organization Risk Sharing. The Company was awarded the Coordinated Care Organization (CCO) contracts with the State of Oregon which cover the Central Oregon and Gorge regions. Under the terms of the CCO contracts, the Company is subject to various risk sharing targets. Based on an annual review of performance and utilization, the Company may remit amounts to contract participants following the end of the Company's fiscal year. Amounts due under these contract provisions are recorded as accrued expenses on the accompanying consolidated balance sheets.

Provider Incentive Compensation and Withholds Payable. The Company contracts with certain medical provider groups to provide healthcare services to plan members that involve risk sharing arrangements. Contracts are renegotiated annually and based on revised contract terms, the recorded balance may fluctuate. Under the terms of the contracts with participating providers, a percentage of their fees are retained by the Company in an incentive pool reserve. Based on an annual review of performance and utilization, pool surpluses are generally paid to providers and pool deficits are generally retained by the Company.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

**Income Taxes.** PacificSource is a taxable Oregon nonprofit public benefit corporation. Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred taxes. Deferred income taxes arise principally from temporary differences relating to the deferred compensation plan, defined benefit pension plan, unrealized appreciation and depreciation of investments, depreciation and amortization, certain accrued and prepaid expenses, group life insurance and annuity contracts, premium deficiency reserve, discounting of the claims provision, partnership differences, goodwill, bad debts, alternative minimum tax credit carryforwards, charitable contribution carryforwards, and federal and state net operating loss carryforwards. PacificSource files consolidated federal income tax returns with its subsidiaries in accordance with applicable tax law.

**Revenue Recognition.** Premiums are recognized on a monthly basis over the policy term. Administrative revenues are recognized over the period the service is provided and include the operations of the non-insurance subsidiaries and administrative service contract fees which are received in exchange for performing certain claims processing and member services.

**Reinsurance.** The Company seeks to limit its loss on any single insured risk and to recover a portion of benefits paid by ceding reinsurance to its reinsurer under excess coverage agreements. Reinsurance agreements do not relieve the Company from its primary obligation to the policyholders, but provide the Company with insurance for large claims. Reinsurance premiums and reinsurance recoveries are offset against claims incurred. Amounts recoverable under reinsurance agreements include such amounts due from the reinsurer for the reimbursement of amounts paid on claims in excess of the insurance risk transferred to the reinsurer.

**Assessments.** Assessments are accrued at the time the events occur on which assessments are expected to be based.

**Advertising.** Costs for advertising are expensed as incurred. Advertising expense was $2,489,286 and $3,633,219 for 2015 and 2014, respectively.

**Fair Value Measurements.** Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value framework requires the categorization of assets and liabilities into three levels based upon the ability to observe the assumptions (inputs) used to value the assets and liabilities. Level One provides the most reliable and observable measure of fair value, whereas Level Three generally requires significant judgment. When valuing assets or liabilities, GAAP requires the most observable inputs to be used.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The fair value hierarchy is categorized into three levels based on the inputs as follows:

   Level One - Unadjusted, quoted prices in active markets for identical assets and liabilities.

   Level Two - Observable inputs, other than those included in Level One. For example, quoted prices for similar assets or liabilities in active markets or quoted prices for identical assets or liabilities in inactive markets.

   Level Three - Unobservable inputs reflecting assumptions about the inputs used in pricing the asset or liability.

The fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Recently Adopted Accounting Pronouncement. In January 2016, the Financial Accounting Standards Board issued Accounting Standards Update (ASU) 2016-01, Recognition and Measurement of Financial Assets and Financial Liabilities. This guidance eliminates certain disclosures previously required under GAAP. As part of the guidance, non-public business entities are no longer required to disclose the fair value of their financial instruments which are not recognized at fair value. Assets and liabilities that are measured at fair value on a recurring basis on the consolidated balance sheets are still subject to fair value disclosure requirements. The Company has chosen to early adopt this portion of the guidance in its 2015 consolidated financial statements and to retrospectively apply such guidance to its 2014 consolidated financial statements, presented herein for comparative purposes. Other portions of the ASU, which are not available for early adoption, have not been applied.

Estimates. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Concentrations of Credit Risk. The Company's financial instruments that are exposed to concentrations of credit risk consist primarily of debt securities, cash and cash equivalents, reinsurance receivables, and other accounts receivable. Credit risk related to investments varies depending on the nature of the investments. Management believes that its credit risk related to debt securities is limited due to the financial strength of the U.S. Government and supporting corporations securing such investments. Due to the Company's normal operating cash flow requirements, the Company typically has cash and cash equivalents that exceed the Federal Deposit Insurance Corporation (FDIC) coverage or may not be insured at all. Management believes that its credit risk with respect to cash and cash equivalents is minimal due to the relative financial strength of the financial institutions which maintain the Company's bank balances and the short-term nature of its investments.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from geographic regions, activities, or economic characteristics of its reinsurers. At December 31, 2015 and 2014, the Company's reinsurance recoverables consisted primarily of amounts due from the U.S. government and are therefore considered to have a low credit risk. The remainder of the Company's reinsurance recoverables are due from third parties that are rated consistent with companies that are considered to have the ability to meet their obligations. Credit risk relative to accounts receivable is minimal due to the nature of the receivables and due to the large number of policyholders.

Business Risks and Uncertainties. The Company's investments are primarily comprised of debt and equity securities. Significant changes in prevailing interest rates and market conditions may adversely affect the timing and amount of cash flows on such investments and their related values. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in values in the near-term could materially affect the Company's consolidated balance sheets and the amounts reported in the consolidated statements of operations.

The Company invests in mortgage backed securities (MBS) and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount on MBS is based on historical experience and estimates of future payments on the underlying mortgage loans. Actual prepayments will differ from the original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Reclassifications. Certain 2014 amounts have been reclassified to conform to 2015 presentation. The reclassifications had no effect on previously reported net loss.

Subsequent Events. Management evaluates events occurring subsequent to the date of the consolidated financial statements in determining the accounting for and disclosure of transactions and events that affect the consolidated financial statements. Subsequent events have been evaluated through May 27, 2016, which is the date the consolidated financial statements were available to be issued.
2. Investments

Investments by major class consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt securities</td>
<td>$87,473,805</td>
<td>$101,024,624</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>$27,500,892</td>
<td>$33,023,559</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>$3,871,738</td>
<td>$2,611,738</td>
</tr>
<tr>
<td>Other invested assets</td>
<td>$724,012</td>
<td>$877,423</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>$535,498</td>
<td>$684,714</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$120,105,945</strong></td>
<td><strong>$138,222,058</strong></td>
</tr>
</tbody>
</table>

**Investments in Debt and Equity Securities.** The Company classifies the following investments as available-for-sale and records them at fair value.

The cost and fair value of the investments at December 31, 2015 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Government debt securities</td>
<td>$20,080,975</td>
<td>$246,302</td>
<td>$(120,787)</td>
<td>$20,206,490</td>
</tr>
<tr>
<td>Mortgage/asset backed securities</td>
<td>$24,198,721</td>
<td>$307,671</td>
<td>$(315,592)</td>
<td>$24,190,800</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>$43,626,631</td>
<td>$548,216</td>
<td>$(1,098,332)</td>
<td>$43,076,515</td>
</tr>
<tr>
<td><strong>Total debt securities</strong></td>
<td><strong>$87,906,327</strong></td>
<td><strong>$1,102,189</strong></td>
<td><strong>$(1,534,711)</strong></td>
<td><strong>$87,473,805</strong></td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>$24,771,709</td>
<td>$3,252,114</td>
<td>$(522,931)</td>
<td>$27,500,892</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$112,678,036</strong></td>
<td><strong>$4,354,303</strong></td>
<td><strong>$(2,057,642)</strong></td>
<td><strong>$114,974,697</strong></td>
</tr>
</tbody>
</table>

Approximately $1.8 million of gross realized gains and $640 thousand of gross realized losses (including $300 thousand of bond impairment) were included in investment income on the consolidated statements of operations for 2015.

(Continued)
2. Investments (Continued)

The cost and fair value of the investments at December 31, 2014 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Government debt securities</td>
<td>$14,032,024 $297,918</td>
<td>$(24,002)</td>
<td>$14,305,940</td>
</tr>
<tr>
<td>Mortgage/asset backed securities</td>
<td>$28,800,237 $672,679</td>
<td>$(84,272)</td>
<td>$29,388,644</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>$56,365,000 $1,209,503</td>
<td>$(244,463)</td>
<td>$57,330,040</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>$99,197,261 $2,180,100</td>
<td>$(352,737)</td>
<td>$101,024,624</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>$28,948,079 $4,306,139</td>
<td>$(230,659)</td>
<td>$33,023,559</td>
</tr>
<tr>
<td>Total</td>
<td>$128,145,340 $6,486,239</td>
<td>$(583,396)</td>
<td>$134,048,183</td>
</tr>
</tbody>
</table>

Approximately $1.8 million of gross realized gains and $72 thousand of gross realized losses were included in investment income on the consolidated statements of operations for 2014.

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. Consideration is given to the length of time and the extent to which the fair value has been less than cost, the financial condition, and near-term prospects of the issuer and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in fair value. Based on this analysis, management determined that certain bonds were permanently impaired and recorded a loss of approximately $300 thousand during 2015.

The aggregate fair values of securities, by category, that had gross unrealized losses at December 31, 2015, and the securities that were in a loss position at December 31, 2014 that were still in a loss position at December 31, 2015, are as follows:

<table>
<thead>
<tr>
<th>Less than 12 Months</th>
<th>12 Months or More</th>
<th>Total</th>
<th>Gross Unrealized Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized Appreciation</td>
<td>Fair Value</td>
</tr>
<tr>
<td>Debt securities</td>
<td>$38,621,251</td>
<td>$(1,344,453)</td>
<td>$11,456,224</td>
</tr>
<tr>
<td>Equity securities</td>
<td>$4,268,380</td>
<td>$(161,180)</td>
<td>$3,179,007</td>
</tr>
<tr>
<td>Total</td>
<td>$42,889,631</td>
<td>$(1,505,633)</td>
<td>$14,635,231</td>
</tr>
</tbody>
</table>

As of December 31, 2015, the Company had 119 securities in an unrealized loss position. All of these securities had a percentage decline of less than 28%.

(Continued)
2. Investments (Continued)

At December 31, 2015, debt securities were scheduled to mature as follows:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Amortized Cost</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due in one year or less</td>
<td>$ 8,011,973</td>
<td>$ 8,003,084</td>
</tr>
<tr>
<td>Due in one to five years</td>
<td>39,591,674</td>
<td>39,948,228</td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>37,648,809</td>
<td>37,239,269</td>
</tr>
<tr>
<td>Due after ten years</td>
<td>6,525,609</td>
<td>6,154,962</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 91,778,065</td>
<td>$ 91,345,543</td>
</tr>
</tbody>
</table>

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

<table>
<thead>
<tr>
<th>Period</th>
<th>Amortized Cost/ Fair Value</th>
<th>Unrealized Appreciation</th>
<th>Tax Effect</th>
<th>Net Unrealized Appreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2015</td>
<td>$ 112,678,036 / $ 114,974,697</td>
<td>$ 2,296,403</td>
<td>$ (889,000)</td>
<td>$ 1,407,403</td>
</tr>
<tr>
<td>Less December 31, 2014</td>
<td>128,145,340 / 134,048,183</td>
<td>5,902,843</td>
<td>(2,241,000)</td>
<td>3,661,843</td>
</tr>
<tr>
<td><strong>Change in unrealized</strong></td>
<td></td>
<td><strong>(3,606,440)</strong></td>
<td></td>
<td><strong>(2,254,440)</strong></td>
</tr>
</tbody>
</table>

Investment expense was approximately $279,000 and $350,000 for the years ended December 31, 2015 and 2014, respectively.

**Other Invested Assets.** Other invested assets consist of investments in partnerships that are accounted for using the equity method. The percentage of the Company's ownership in each of these investments varies based upon total investment in the secondary market.
3. Accounts Receivable

Accounts receivable at December 31 consisted of the following:

<table>
<thead>
<tr>
<th>Account</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA reinsurance</td>
<td>18,433,007</td>
<td>19,207,012</td>
</tr>
<tr>
<td>Uncollected premiums from policyholders</td>
<td>15,612,910</td>
<td>8,530,969</td>
</tr>
<tr>
<td>Medicare risk score</td>
<td>8,830,000</td>
<td>13,132,000</td>
</tr>
<tr>
<td>Pharmacy rebates</td>
<td>6,870,009</td>
<td>3,544,823</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>6,140,000</td>
<td>7,027,590</td>
</tr>
<tr>
<td>ACA risk adjustment</td>
<td>6,028,854</td>
<td>2,293,491</td>
</tr>
<tr>
<td>Reinsurance recoverables</td>
<td>5,444,769</td>
<td>7,562,571</td>
</tr>
<tr>
<td>Amounts due from groups under administrative service contracts</td>
<td>3,674,075</td>
<td>3,135,575</td>
</tr>
<tr>
<td>ACA risk corridor</td>
<td>1,953,109</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>3,065,005</td>
<td>4,578,290</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>76,051,738</strong></td>
<td><strong>69,012,321</strong></td>
</tr>
</tbody>
</table>

4. Property

Major classes of property at December 31 consisted of the following:

<table>
<thead>
<tr>
<th>Account</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>3,994,140</td>
<td>3,172,078</td>
</tr>
<tr>
<td>Buildings</td>
<td>18,892,775</td>
<td>18,771,989</td>
</tr>
<tr>
<td>Furniture and fixtures</td>
<td>2,986,901</td>
<td>2,955,894</td>
</tr>
<tr>
<td>Office equipment</td>
<td>3,438,517</td>
<td>2,141,028</td>
</tr>
<tr>
<td>Software</td>
<td>13,733,396</td>
<td>12,264,352</td>
</tr>
<tr>
<td>Automobiles</td>
<td>103,897</td>
<td>73,505</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>1,483,286</td>
<td>1,483,286</td>
</tr>
<tr>
<td>Work-in-process</td>
<td>158,376</td>
<td>136,339</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44,791,288</strong></td>
<td><strong>40,998,471</strong></td>
</tr>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>15,235,653</td>
<td>8,869,434</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29,555,635</strong></td>
<td><strong>32,129,037</strong></td>
</tr>
</tbody>
</table>
5. **Intangible Assets**

Major classes of intangible assets at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer relationships</td>
<td>$6,083,630</td>
<td>$6,083,630</td>
</tr>
<tr>
<td>Contractual arrangements</td>
<td>$3,785,235</td>
<td>$3,785,235</td>
</tr>
<tr>
<td>Trade names and trademarks</td>
<td>-</td>
<td>$600,000</td>
</tr>
<tr>
<td>Other intangible assets</td>
<td>-</td>
<td>$125,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$9,868,865</td>
<td>$10,593,865</td>
</tr>
</tbody>
</table>

Intangible assets with finite lives are amortized using the straight-line method over their estimated useful lives, which range from ten to twenty years. Amortization expense is expected to be as follows for each of the succeeding five years: 2016, $819,870; 2017, $819,870; 2018, $819,870; 2019, $657,476; 2020, $430,129; and $2,790,812 thereafter.
6. Liability for Unpaid Claims and Claims Adjustment Expenses

The liability for unpaid claims and claims adjustment expenses is based on the estimated amount payable on claims reported prior to the consolidated balance sheets date that have not yet been settled, claims reported subsequent to the consolidated balance sheets date that have been incurred during the period then ended, and an estimate based on prior experience of incurred but unreported claims relating to such period.

Activity in the liability for unpaid claims and claims adjustment expenses is summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses, January 1</td>
<td>$96,185,220</td>
<td>$102,490,850</td>
</tr>
<tr>
<td>Less reinsurance receivable</td>
<td>(26,769,583)</td>
<td>(5,445,066)</td>
</tr>
<tr>
<td>Net balance</td>
<td>69,415,637</td>
<td>97,045,784</td>
</tr>
<tr>
<td>Incurred related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>1,111,592,010</td>
<td>1,071,422,703</td>
</tr>
<tr>
<td>Prior years</td>
<td>(7,662,463)</td>
<td>(7,485,019)</td>
</tr>
<tr>
<td>Total incurred</td>
<td>1,103,929,547</td>
<td>1,063,937,684</td>
</tr>
<tr>
<td>Paid related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>(989,393,293)</td>
<td>(996,562,000)</td>
</tr>
<tr>
<td>Prior years</td>
<td>(88,522,757)</td>
<td>(95,005,831)</td>
</tr>
<tr>
<td>Total paid</td>
<td>(1,077,916,050)</td>
<td>(1,091,567,831)</td>
</tr>
<tr>
<td>Net balance</td>
<td>95,429,134</td>
<td>69,415,637</td>
</tr>
<tr>
<td>Plus reinsurance receivable</td>
<td>23,877,776</td>
<td>26,769,583</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses, December 31</td>
<td>$119,306,910</td>
<td>$96,185,220</td>
</tr>
</tbody>
</table>

As a result of changes in estimates of insured events in prior years, the liability for unpaid claims, and claims adjustment expenses (net of reinsurance recoveries of $23,877,776) decreased by $7,662,463 in 2015. The liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $26,769,583) decreased by $7,485,019 in 2014. The Company records a liability for unpaid claims and claims adjustment expenses that includes an allowance for potential shock claims.
7. **Accrued Expenses**

Accrued expenses at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCO risk sharing</td>
<td>$18,704,433</td>
<td>$25,800,170</td>
</tr>
<tr>
<td>ACA reinsurance</td>
<td>7,917,044</td>
<td>12,754,984</td>
</tr>
<tr>
<td>Accrued payroll and taxes</td>
<td>6,613,646</td>
<td>4,874,929</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>2,877,319</td>
<td>2,883,076</td>
</tr>
<tr>
<td>Other</td>
<td>1,902,871</td>
<td>3,921,851</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$38,015,313</strong></td>
<td><strong>$50,235,010</strong></td>
</tr>
</tbody>
</table>

8. **Notes Payable**

Notes payable consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note payable to bank, due in monthly installments of $90,956 including interest at a fixed rate of 3.95% through June 2022 at which time it converts to a variable rate of the Federal Home Loan Fixed Advance Rate plus 2%, collateralized by real property and other business assets, balance due July 2025.</td>
<td>$13,801,592</td>
<td>$ -</td>
</tr>
<tr>
<td>Notes payable to individuals, due in monthly installments of $20,634, including interest at the prime rate plus 2% adjusted annually, not to be less than 7% or exceed 10% (effective rate of 7% at December 31, 2015), collateralized by business assets, matures March 2018.</td>
<td>513,804</td>
<td>717,508</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$14,315,396</strong></td>
<td><strong>$717,508</strong></td>
</tr>
</tbody>
</table>

The estimated aggregate amounts of principal payments on notes payable maturities are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$765,769</td>
</tr>
<tr>
<td>2017</td>
<td>805,441</td>
</tr>
<tr>
<td>2018</td>
<td>655,290</td>
</tr>
<tr>
<td>2019</td>
<td>618,633</td>
</tr>
<tr>
<td>2020</td>
<td>642,583</td>
</tr>
<tr>
<td>Thereafter</td>
<td>10,827,680</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$14,315,396</strong></td>
</tr>
</tbody>
</table>
9. Retirement Plans

The Company has a non-contributory pension plan and a participatory retirement plan (401(k)), both of which cover substantially all employees.

The non-contributory pension benefits are based on years of service and the employee's compensation during employment before the plan was frozen. The Company contributes at least the minimum funding required annually. Effective December 31, 2012, the benefits associated with the plan were frozen.

The following table sets forth the plan's funded status and amounts recognized in the Company's consolidated financial statements at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation for service rendered to date</td>
<td>$(31,457,623)</td>
<td>$(33,786,562)</td>
</tr>
<tr>
<td>Plan assets at fair value</td>
<td>$29,444,325</td>
<td>$31,352,385</td>
</tr>
<tr>
<td>Funded status</td>
<td>$(2,013,298)</td>
<td>$(2,434,177)</td>
</tr>
</tbody>
</table>

Change in projected benefit obligation:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation, beginning of year</td>
<td>$33,786,562</td>
<td>$28,877,813</td>
</tr>
<tr>
<td>Settlement gain</td>
<td>-</td>
<td>(227,667)</td>
</tr>
<tr>
<td>Interest cost</td>
<td>1,332,312</td>
<td>1,418,637</td>
</tr>
<tr>
<td>Settlement payments</td>
<td>-</td>
<td>(2,328,922)</td>
</tr>
<tr>
<td>Benefits paid and administrative expenses</td>
<td>(1,075,210)</td>
<td>(263,271)</td>
</tr>
<tr>
<td>Actuarial (gain) loss</td>
<td>(2,586,041)</td>
<td>6,309,972</td>
</tr>
</tbody>
</table>

Projected benefit obligation, end of year            | $31,457,623| $33,786,562|

Change in fair value of plan assets:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets, beginning of year</td>
<td>$31,352,385</td>
<td>$32,577,203</td>
</tr>
<tr>
<td>Actual return on plan assets</td>
<td>(832,850)</td>
<td>1,367,375</td>
</tr>
<tr>
<td>Settlement payments</td>
<td>-</td>
<td>(2,328,922)</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(1,075,210)</td>
<td>(263,271)</td>
</tr>
</tbody>
</table>

Fair value of plan assets, end of year                | $29,444,325| $31,352,385|

(Continued)
9. Retirement Plans (Continued)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net periodic benefit cost:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest cost</td>
<td>$1,332,312</td>
<td>$1,418,637</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(1,943,683)</td>
<td>(2,025,502)</td>
</tr>
<tr>
<td>Amortization of loss</td>
<td>706,794</td>
<td>37,573</td>
</tr>
<tr>
<td>Settlement loss</td>
<td>-</td>
<td>663,086</td>
</tr>
<tr>
<td>Total net periodic benefit cost</td>
<td>$95,423</td>
<td>$93,794</td>
</tr>
</tbody>
</table>

Amounts recognized in accumulated other comprehensive loss:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net loss</td>
<td>$9,103,347</td>
<td>$9,619,649</td>
</tr>
<tr>
<td>Total accumulated other comprehensive loss</td>
<td>$9,103,347</td>
<td>$9,619,649</td>
</tr>
</tbody>
</table>

Changes in other comprehensive loss:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net loss</td>
<td>$190,492</td>
<td>$6,733,075</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>(706,794)</td>
<td>(700,659)</td>
</tr>
<tr>
<td>Total recognized in other comprehensive loss</td>
<td>$(516,302)</td>
<td>$6,032,416</td>
</tr>
</tbody>
</table>

Accumulated benefit obligation, end of year

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$31,457,623</td>
<td>$33,786,562</td>
</tr>
</tbody>
</table>

The Company estimates net loss, prior service cost, and transition obligation for the defined benefit pension plan that will be amortized into periodic benefit cost in 2016 to be $684,780, $0 and $0, respectively.

The Company does not expect to make any contribution to its pension plan in 2016. Future anticipated benefit payments from the defined benefit pension plan are as follows: 2016, $1,135,433; 2017, $743,981; 2018, $841,894; 2019, $1,567,125; 2020, $2,296,531; and from 2021 to 2025, $8,540,579.

(Continued)
9. Retirement Plans (Continued)

Assumptions used in the accounting for the defined benefit pension plan were as follows at December 31:

<table>
<thead>
<tr>
<th>Assumptions used for net periodic benefit costs:</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate used in determining present values</td>
<td>4.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Annual increase in future compensation levels</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expected long-term rate of return on assets</td>
<td>6.4</td>
<td>6.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assumptions used to determine benefit obligation:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate used in determining present values</td>
<td>4.5%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Rate of compensation increase</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Measurement date</td>
<td>December 31</td>
<td>December 31</td>
</tr>
</tbody>
</table>

The plan assets are invested in the following asset classes:

<table>
<thead>
<tr>
<th>Asset Class</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity investments</td>
<td>63%</td>
<td>61%</td>
</tr>
<tr>
<td>Debt investments</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>Real estate</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

| Total                   | 100% | 100% |

The plan assets are invested in a variety of bond and equity mutual funds. The targeted composition is set by the Company and reallocated periodically. The Company's expected rate of return on plan assets is determined by the plan assets' historical long-term investment performance, current asset allocation, and estimates of future long-term returns by asset class.

The 401(k) plan provides for voluntary employee contributions with employer matching. The plan requires a 50% Company match on eligible elective deferrals. Elective deferrals in excess of 6% of eligible employee compensation are not eligible to receive a match. In both 2015 and 2014, in addition to the annual matching contributions, the Company made a 3% discretionary non-elective contribution for all eligible employees. Company contributions under the plan were $2,148,191 and $2,273,467 in 2015 and 2014, respectively.
10. Income Taxes

PacificSource files a consolidated federal income tax return with its subsidiaries on the basis of its annual GAAP financial statements adjusted for the tax regulations. The Company files state income tax returns based on the annual statements that are filed with the insurance regulatory authorities for PSHP and PCHP. The Company files on the basis of its annual GAAP financial statements adjusted for the state tax regulations for the remaining subsidiaries. The allocation methodology under the adopted tax allocation agreement applies the projected consolidated group income tax rate to the entities based on pre-tax net income. Federal income taxes are settled between PacificSource and its subsidiaries based on the tax sharing agreement.

The provision for income taxes consists of the following:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current income tax expense (benefit):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal</td>
<td>$10,134,012</td>
<td>$2,198,431</td>
</tr>
<tr>
<td>State</td>
<td>(541,500)</td>
<td>1,580,323</td>
</tr>
<tr>
<td>Total current income tax expense</td>
<td>$9,592,512</td>
<td>$3,778,754</td>
</tr>
<tr>
<td>Deferred tax expense</td>
<td>3,821,700</td>
<td>985,300</td>
</tr>
<tr>
<td>Total income tax expense</td>
<td>$13,414,212</td>
<td>$4,764,054</td>
</tr>
</tbody>
</table>

The reconciliation between federal taxes at the statutory rate and the Company's income taxes are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax expense (benefit) computed at statutory rate</td>
<td>$3,619,000</td>
<td>($1,150,000)</td>
</tr>
<tr>
<td>State tax expense (benefit), net of federal income tax benefit</td>
<td>511,000</td>
<td>($147,000)</td>
</tr>
<tr>
<td>Tax effect of health insurance provider fee</td>
<td>5,959,000</td>
<td>6,420,000</td>
</tr>
<tr>
<td>Prior year true-up and other permanent and temporary differences</td>
<td>3,325,212</td>
<td>($358,946)</td>
</tr>
<tr>
<td>Total income tax expense</td>
<td>$13,414,212</td>
<td>$4,764,054</td>
</tr>
</tbody>
</table>

(Continued)
10. Income Taxes (Continued)

Deferred income tax assets and liabilities at December 31 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deferred tax assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal and state net operating loss carryforwards</td>
<td>$ 1,921,000</td>
<td>$ 3,503,000</td>
</tr>
<tr>
<td>Accruals</td>
<td>2,138,000</td>
<td>1,470,000</td>
</tr>
<tr>
<td>Defined benefit pension plan</td>
<td>786,000</td>
<td>969,000</td>
</tr>
<tr>
<td>Partnership difference</td>
<td>777,000</td>
<td>815,000</td>
</tr>
<tr>
<td>Discount of claims provision</td>
<td>527,000</td>
<td>433,000</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>512,000</td>
<td>542,000</td>
</tr>
<tr>
<td>Alternative minimum tax credit carryforwards</td>
<td>-</td>
<td>2,001,700</td>
</tr>
<tr>
<td>Contribution carryforwards</td>
<td>-</td>
<td>787,000</td>
</tr>
<tr>
<td>Goodwill</td>
<td>-</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Total deferred tax assets</strong></td>
<td>$ 6,661,000</td>
<td>$10,524,700</td>
</tr>
<tr>
<td><strong>Deferred tax liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property</td>
<td>(4,409,000)</td>
<td>(4,068,000)</td>
</tr>
<tr>
<td>Prepaids</td>
<td>(2,060,000)</td>
<td>(2,069,000)</td>
</tr>
<tr>
<td>Unrealized gains</td>
<td>(770,000)</td>
<td>(2,241,000)</td>
</tr>
<tr>
<td>Subsidiary equity income</td>
<td>(72,000)</td>
<td>(67,000)</td>
</tr>
<tr>
<td><strong>Total deferred tax liabilities</strong></td>
<td>(7,311,000)</td>
<td>(8,445,000)</td>
</tr>
<tr>
<td><strong>Net deferred tax (liabilities) assets</strong></td>
<td>$ (650,000)</td>
<td>$ 2,079,700</td>
</tr>
</tbody>
</table>

As of December 31, 2015, the Company recognized a deferred tax asset of $1,921,000 for the anticipated utilization of federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $4,764,572 will expire in 2028, if not used before then. State net operating loss carryforwards of $5,543,829 will expire on various dates through 2034.

The Company is required to record a valuation allowance when it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of the deferred tax assets depends on the ability to generate sufficient taxable income in the future. Based on its profitable operating results in previous years, together with management's intention and active pursuit of strategies to remain successful in the health insurance industry, no valuation allowance has been recorded because it appears more likely than not that the full tax benefit of deferred tax assets will be realized.
11. Reinsurance

The Company was reinsured against inpatient hospital costs and ancillary outpatient services under the terms of an excess liability policy. The following is a summary of the coverage levels at December 31, 2015 in order of their application:

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10% up to $120,000</td>
<td>$800,000</td>
<td>$1,200,000 per member</td>
</tr>
<tr>
<td>Layer 2</td>
<td>10% up to $300,000</td>
<td>$2,000,000</td>
<td>$3,000,000 per member</td>
</tr>
<tr>
<td>Layer 3</td>
<td>$-</td>
<td>$5,000,000</td>
<td>$5,000,000 per member</td>
</tr>
<tr>
<td>Layer 4</td>
<td>$-</td>
<td>$10,000,000</td>
<td>$10,000,000 per member</td>
</tr>
<tr>
<td>Layer 5</td>
<td>$-</td>
<td>$20,000,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Premiums ceded under the terms of the non-ACA reinsurance policies were $7,544,695 and $7,790,136 in 2015 and 2014, respectively. Reinsurance recoveries were $6,164,981 and $13,278,509 in 2015 and 2014, respectively. The reinsurance contracts do not relieve the Company from its primary obligation to policyholders.
12. Leases

The Company leases office space in Springfield, Oregon; Portland, Oregon; Tigard, Oregon; Medford, Oregon; Hood River, Oregon; Boise, Idaho; Idaho Falls, Idaho; Helena, Montana; and Billings, Montana under general operating lease agreements with various expirations through May 2026. The Company is responsible for substantially all executory costs under the agreements. Certain agreements contain annual rent adjustments or other rent escalations which the Company is required to pay.

Minimum aggregate future lease payments under all non-cancelable operating leases as of December 31, 2015 are summarized as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$1,600,268</td>
</tr>
<tr>
<td>2017</td>
<td>1,537,054</td>
</tr>
<tr>
<td>2018</td>
<td>1,014,407</td>
</tr>
<tr>
<td>2019</td>
<td>1,004,555</td>
</tr>
<tr>
<td>2020</td>
<td>961,309</td>
</tr>
<tr>
<td>Thereafter</td>
<td>1,969,638</td>
</tr>
</tbody>
</table>

Total $8,087,231

Amounts charged to rent expense for the various leases were $1,273,791 and $1,249,995 for 2015 and 2014, respectively.

13. Commitments

In March 2010, the President of the United States signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. This legislation includes a number of provisions that impact the health insurance industry, including provisions on increasing the number of insured members, new rules on guaranteed issue contracts, elimination of lifetime annual maximum caps on policy payments, coverage of dependent children on the parents' policy until age 26, and many others. The Company has calculated expected costs as a result of the reform and has adjusted premium rates accordingly. In addition, this legislation created health insurance exchanges. In 2014, the Company began offering individual and small group products on the exchanges in Oregon, Idaho, and Montana.

(Continued)
13. Commitments (Continued)

The Company is subject to an annual fee under the ACA which is not deductible for tax purposes. This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. During 2015 and 2014, the Company paid $16,105,705 and $16,735,185 related to 2014 and 2013 net premiums written, respectively. As of December 31, 2015, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2016 and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2016 to be approximately $16 million.

14. Litigation and Contingent Liabilities

The Company, consistent with the insurance industry in general, is subject to litigation in the normal course of business. The Company's management does not believe that such litigation will have a material effect on its financial position.

15. Related Party Transactions

The board of trustees formed the PacificSource Foundation for Health Improvement (the Foundation). Certain trustees of the Company are also officers of the Foundation. As of December 31, 2015 and 2014, total assets (unaudited), consisting primarily of cash equivalents and marketable securities, were approximately $4,000,000 and $4,450,000, respectively. The Foundation is a public benefit corporation organized for the purpose of providing funds for the health and welfare of the poor and needy. It qualifies as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code. During 2015 and 2014, the Company made no contributions to the Foundation.
16. Fair Value of Financial Instruments

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2015. Valuation techniques utilized to determine fair value are consistently applied.

Investments in equity securities are classified as available-for-sale and are reported at fair value. These securities are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

Investments in debt securities are classified as available-for-sale and are reported at fair value. Investments in U.S. Government debt securities are traded in active markets and valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy. The fair value of all other debt instruments are estimated using recently executed transactions, market price quotations (where observable), bond spreads, or credit default swap spreads. The spread data used are for the same maturity as the bond. If the spread data does not reference the issuer, then data that references a comparable issuer is used. Where observable price quotations are not available, fair value is determined based on cash flow models with yield curves, bond or single-name credit default swap spreads and recovery rates based on collateral values as key inputs. They are generally categorized in Level Two of the fair value hierarchy.

(Continued)
16. Fair Value of Financial Instruments (Continued)

Fair values of assets and liabilities measured on a recurring basis are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th>Quoted Prices in Active Markets for Identical Assets (Level 1)</th>
<th>Significant Other Observable Inputs (Level 2)</th>
<th>Significant Unobservable Inputs (Level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government debt securities</td>
<td>$ 20,206,490</td>
<td>$ 20,206,490</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>24,190,800</td>
<td>-</td>
<td>24,190,800</td>
<td>-</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>43,076,515</td>
<td>-</td>
<td>43,076,515</td>
<td>-</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>87,473,805</td>
<td>20,206,490</td>
<td>67,267,315</td>
<td>-</td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>27,500,892</td>
<td>27,500,892</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>December 31, 2014</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. Government debt securities</td>
<td>$ 14,305,940</td>
<td>$ 14,305,940</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>29,388,644</td>
<td>-</td>
<td>29,388,644</td>
<td>-</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>57,330,040</td>
<td>-</td>
<td>57,330,040</td>
<td>-</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>101,024,624</td>
<td>14,305,940</td>
<td>86,718,684</td>
<td>-</td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>33,023,559</td>
<td>33,023,559</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(Continued)
16. Fair Value of Financial Instruments (Continued)

The following presents a summary of the Company's defined benefit plan investment assets measured at fair value:

<table>
<thead>
<tr>
<th>Description</th>
<th>Total</th>
<th>Fair Value Measurement</th>
<th>Quoted Prices in Active Markets for Identical Assets (Level 1)</th>
<th>Significant Other Observable Inputs (Level 2)</th>
<th>Significant Unobservable Inputs (Level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$7,873,616</td>
<td>$7,873,616 $</td>
<td>-</td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>9,780,871</td>
<td>9,780,871</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,334,291</td>
<td>6,334,291</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,669,029</td>
<td>3,669,029</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,786,518</td>
<td>1,786,518</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$29,444,325</td>
<td>$29,444,325</td>
<td>-</td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td><strong>December 31, 2014</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$8,964,714</td>
<td>$8,964,714 $</td>
<td>-</td>
<td>$</td>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>10,394,681</td>
<td>10,394,681</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,290,238</td>
<td>6,290,238</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,891,716</td>
<td>3,891,716</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Money market funds</td>
<td>84,604</td>
<td>84,604</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,726,432</td>
<td>1,726,432</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$31,352,385</td>
<td>$31,352,385</td>
<td>-</td>
<td>$</td>
<td>-</td>
</tr>
</tbody>
</table>

The following is a description of the valuation methodologies used for the Company's defined benefit plan investment assets measured at fair value.

Registered investment companies are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.
17. Statutory Financial Information

PSHP and PCHP, which are domiciled in Oregon, prepare their statutory basis financial statements in accordance with accounting principles and practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation. Oregon has adopted the NAIC's statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practices.

PSHP and PCHP follow the NAIC's SAP and do not have permitted practices that deviate from NAIC SAP. PSHP and PCHP's statutory capital and surplus were sufficient to satisfy regulatory requirements at December 31, 2015.

18. Subsequent Events

The Company signed a member substitution agreement with Billings Clinic to become a 35% member of New West Health Services (New West) as of April 1, 2016. New West is a Medicare Advantage plan in Montana, with approximately 15,000 members.

The Company has entered into a member acquisition agreement with Legacy Health (Legacy). As part of the agreement, PacificSource will create a new non-profit organization that will have a 50% member interest in the PacificSource Holding Company. Legacy will purchase the remaining 50% member interest. The Organization will have a Board of Directors made up of an equal number of members designated by PacificSource and Legacy, as well as three independent members from the community. As part of the transaction, Legacy will make a staged capital contribution of $247.5 million over the next five years. The anticipated closing of the transaction is mid-2016.
<table>
<thead>
<tr>
<th>Item</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$39,227,256</td>
<td>$35,872,846</td>
</tr>
<tr>
<td>Payroll taxes</td>
<td>3,327,165</td>
<td>3,274,937</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>7,828,719</td>
<td>7,631,659</td>
</tr>
<tr>
<td>Retirement plans</td>
<td>2,091,643</td>
<td>1,994,650</td>
</tr>
<tr>
<td>Administrative expense, net</td>
<td>1,050,102</td>
<td>1,169,861</td>
</tr>
<tr>
<td>Advertising</td>
<td>2,489,286</td>
<td>3,633,219</td>
</tr>
<tr>
<td>Auditing and tax services</td>
<td>603,695</td>
<td>482,391</td>
</tr>
<tr>
<td>Automobile expense</td>
<td>374,326</td>
<td>315,599</td>
</tr>
<tr>
<td>Banking charges</td>
<td>583,946</td>
<td>468,260</td>
</tr>
<tr>
<td>Board expenses</td>
<td>415,233</td>
<td>427,787</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>391,267</td>
<td>379,957</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>1,678,589</td>
<td>1,769,632</td>
</tr>
<tr>
<td>Contract labor</td>
<td>872,997</td>
<td>971,941</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>7,649,977</td>
<td>9,770,484</td>
</tr>
<tr>
<td>Education and training</td>
<td>282,070</td>
<td>218,730</td>
</tr>
<tr>
<td>Health insurance provider fee</td>
<td>16,105,705</td>
<td>16,735,185</td>
</tr>
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<td>Imaging expense</td>
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<td>Insurance</td>
<td>801,067</td>
<td>714,868</td>
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<td>Legal fees</td>
<td>361,210</td>
<td>407,014</td>
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<td>Meals and entertainment</td>
<td>506,010</td>
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<td>Office expenses and supplies</td>
<td>1,025,415</td>
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<tr>
<td>Postage</td>
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<td>Printing expense</td>
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<tr>
<td>Professional dues</td>
<td>318,586</td>
<td>299,921</td>
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<tr>
<td>Purchased services</td>
<td>5,932,106</td>
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<tr>
<td>Recruiting</td>
<td>220,574</td>
<td>294,559</td>
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<tr>
<td>Rent - equipment</td>
<td>102,696</td>
<td>92,390</td>
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<tr>
<td>Rent - regional offices</td>
<td>1,273,791</td>
<td>1,249,995</td>
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<tr>
<td>Repairs and maintenance</td>
<td>840,059</td>
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<td>Software licenses</td>
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<td>4,284,161</td>
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<td>Subscriptions</td>
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<tr>
<td>Surveys and studies</td>
<td>19,838</td>
<td>4,725</td>
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<tr>
<td>Taxes and licenses</td>
<td>660,472</td>
<td>987,711</td>
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<tr>
<td>Telephone</td>
<td>705,702</td>
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<tr>
<td>Travel</td>
<td>812,081</td>
<td>711,002</td>
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<td>Utilities</td>
<td>290,556</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$107,837,281</strong></td>
<td><strong>$111,776,217</strong></td>
</tr>
</tbody>
</table>
## Consolidating Balance Sheet

**December 31, 2015**

### ASSETS

<table>
<thead>
<tr>
<th>Description</th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments</td>
<td>$150,534,717</td>
<td>$171,628,262</td>
<td>$52,563,390</td>
<td>$12,486,991</td>
<td>$932,305</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (268,039,720)</td>
<td>$120,105,945</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$12,305,849</td>
<td>$11,945,589</td>
<td>$23,535,037</td>
<td>$50,417,556</td>
<td>$2,573,553</td>
<td>$2,050,338</td>
<td>$1,823,510</td>
<td>-</td>
<td>$104,651,432</td>
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<tr>
<td>Trust funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$3,850,868</td>
<td>$3,850,868</td>
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<tr>
<td>Accounts receivable</td>
<td>$20,305</td>
<td>$50,112,206</td>
<td>$20,798,844</td>
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<td>-</td>
<td>$107,070</td>
<td>$366,548</td>
<td>$76,051,738</td>
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<tr>
<td>Prepaid expenses and deposits</td>
<td>$9,795,081</td>
<td>$407,641</td>
<td>$1,472,985</td>
<td>-</td>
<td>$76,060</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$11,752,313</td>
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<tr>
<td>Prepaid income taxes</td>
<td>$13,416,198</td>
<td>$38,716</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$1,031</td>
<td>-</td>
<td>$13,455,945</td>
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<tr>
<td>Property, net</td>
<td>$29,555,635</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$29,555,635</td>
<td>-</td>
</tr>
<tr>
<td>Goodwill</td>
<td>-</td>
<td>$3,038,598</td>
<td>-</td>
<td>$9,087,214</td>
<td>$497,917</td>
<td>-</td>
<td>$3,026,641</td>
<td>-</td>
<td>$12,631,772</td>
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<tr>
<td>Intangible assets, net</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$6,338,027</td>
<td>-</td>
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<tr>
<td>Intercompany receivables</td>
<td>-</td>
<td>$1,135,193</td>
<td>$1,824,647</td>
<td>$50,710,472</td>
<td>$44,455</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$53,714,767</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$215,627,785</td>
<td>$238,306,205</td>
<td>$100,194,903</td>
<td>$127,348,998</td>
<td>$7,424,265</td>
<td>$2,158,439</td>
<td>$9,067,567</td>
<td>$378,373,675</td>
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### LIABILITIES AND FUND BALANCE

<table>
<thead>
<tr>
<th>Description</th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>$3,145,724</td>
<td>$1,591,188</td>
<td>$302,757</td>
<td>$211,432</td>
<td>$7,500</td>
<td>$1,031</td>
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<td>-</td>
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<tr>
<td>Accounts payable</td>
<td>$9,957,740</td>
<td>$8,464,806</td>
<td>$579,395</td>
<td>$19,003,968</td>
<td>-</td>
<td>$7,500</td>
<td>$1,031</td>
<td>-</td>
<td>$38,015,313</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>$2,013,298</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$2,013,298</td>
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<tr>
<td>Unearned premiums</td>
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<td>-</td>
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<td>Provider incentive compensation and withholds payable</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>$48,626,193</td>
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<tr>
<td>Accrued retro settlements</td>
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<td>$2,374,341</td>
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<td>-</td>
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<td>$2,374,341</td>
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<td>Collections for others</td>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>$3,850,868</td>
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<tr>
<td>Notes payable</td>
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<td>$513,804</td>
<td>$14,315,396</td>
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<tr>
<td>Deferred tax liabilities (assets)</td>
<td>$100,000</td>
<td>$(650,000)</td>
<td>$867,000</td>
<td>$(205,000)</td>
<td>$160,000</td>
<td>-</td>
<td>$378,000</td>
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<td>$650,000</td>
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<td>Intercompany payables</td>
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<td>$597,098</td>
<td>$208,955</td>
<td>-</td>
<td>-</td>
<td>$53,714,767</td>
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<tr>
<td><strong>Total</strong></td>
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<td>$40,705,154</td>
<td>$81,053,813</td>
<td>$168,333</td>
<td>$604,598</td>
<td>$5,543,735</td>
<td>$53,714,767</td>
<td>$244,051,422</td>
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### FUND BALANCE:

<table>
<thead>
<tr>
<th>Description</th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accumulated other comprehensive (loss) income</td>
<td>$(4,404,045)</td>
<td>$(1,139,303)</td>
<td>$(15,186)</td>
<td>$(2,326)</td>
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<td>-</td>
<td>$(1,121,791)</td>
<td>$(4,404,045)</td>
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<tr>
<td>Noncontrolling interests</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$621,537</td>
<td>$621,537</td>
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<td><strong>Total</strong></td>
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<td>$7,263,932</td>
<td>$1,553,841</td>
<td>$3,523,832</td>
<td>$134,322,253</td>
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<tr>
<td><strong>Total</strong></td>
<td>$215,627,785</td>
<td>$238,306,205</td>
<td>$100,194,903</td>
<td>$127,348,998</td>
<td>$7,424,265</td>
<td>$2,158,439</td>
<td>$9,067,567</td>
<td>$321,754,487</td>
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### CLAIMS EXPENSE:

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<th>Year Ended December 31, 2015</th>
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<tr>
<td><strong>PREMIUMS:</strong></td>
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<tr>
<td>Commercial</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
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</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td><strong>CLAIMS EXPENSE:</strong></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
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</tr>
<tr>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td><strong>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</strong></td>
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</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE REVENUES</strong></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GENERAL AND ADMINISTRATIVE EXPENSES</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UNDERWRITING GAIN (LOSS)</strong></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER INCOME (EXPENSE):</strong></td>
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</tr>
<tr>
<td>Investment income</td>
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<tr>
<td>Interest expense</td>
<td></td>
</tr>
<tr>
<td>Charitable contributions</td>
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<tr>
<td>Miscellaneous (expense) income</td>
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<tr>
<td>Income from subsidiaries</td>
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<tr>
<td><strong>CONSOLIDATED</strong></td>
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<td></td>
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</tbody>
</table>
Independent Auditors' Report
Consolidated Financial Statements and
Supplemental Information
Years Ended December 31, 2016 and 2015
# PACIFICSOURCE AND SUBSIDIARIES

## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDEPENDENT AUDITORS' REPORT</strong></td>
<td>1-2</td>
</tr>
<tr>
<td><strong>FINANCIAL STATEMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated balance sheets</td>
<td>3</td>
</tr>
<tr>
<td>Consolidated statements of operations</td>
<td>4</td>
</tr>
<tr>
<td>Consolidated statements of comprehensive loss</td>
<td>5</td>
</tr>
<tr>
<td>Consolidated statements of fund balance</td>
<td>6</td>
</tr>
<tr>
<td>Consolidated statements of cash flows</td>
<td>7-8</td>
</tr>
<tr>
<td>Notes to consolidated financial statements</td>
<td>9-36</td>
</tr>
<tr>
<td><strong>SUPPLEMENTAL INFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated schedules of general and administrative expenses</td>
<td>37</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
PacificSource and Subsidiaries:

We have audited the accompanying consolidated financial statements of PacificSource and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive loss, fund balance, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of PacificSource and Subsidiaries as of December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and related directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Kernutt Stokes LLP

Eugene, Oregon
April 20, 2017
## CONSOLIDATED BALANCE SHEETS

### ASSETS

<table>
<thead>
<tr>
<th>Asset</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments</td>
<td>$178,381,998</td>
<td>$120,105,945</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>128,797,867</td>
<td>104,651,432</td>
</tr>
<tr>
<td>Trust funds</td>
<td>5,931,542</td>
<td>3,850,868</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>74,186,247</td>
<td>76,051,738</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>12,592,742</td>
<td>11,752,313</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>7,215,210</td>
<td>13,455,945</td>
</tr>
<tr>
<td>Property, net</td>
<td>6,953,584</td>
<td>29,555,635</td>
</tr>
<tr>
<td>Goodwill</td>
<td>12,611,772</td>
<td>12,611,772</td>
</tr>
<tr>
<td>Intangible assets, net</td>
<td>5,518,158</td>
<td>6,338,027</td>
</tr>
<tr>
<td>Deferred tax assets</td>
<td>1,736,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$433,925,120</strong></td>
<td><strong>$378,373,675</strong></td>
</tr>
</tbody>
</table>

### LIABILITIES AND FUND BALANCE

#### LIABILITIES:

<table>
<thead>
<tr>
<th>Liability</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>$115,335,762</td>
<td>$119,306,910</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>5,990,994</td>
<td>5,251,434</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>42,319,383</td>
<td>38,015,313</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>4,237,759</td>
<td>2,013,298</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>15,092,691</td>
<td>9,647,669</td>
</tr>
<tr>
<td>Accrued medical incentive pools and withholds payable</td>
<td>41,451,858</td>
<td>48,626,193</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>1,488,462</td>
<td>2,374,341</td>
</tr>
<tr>
<td>Collections for others</td>
<td>5,931,542</td>
<td>3,850,868</td>
</tr>
<tr>
<td>Notes payable</td>
<td>295,375</td>
<td>14,315,396</td>
</tr>
<tr>
<td>Deferred tax liabilities</td>
<td>-</td>
<td>650,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>232,143,826</strong></td>
<td><strong>244,051,422</strong></td>
</tr>
</tbody>
</table>

#### FUND BALANCE:

| Fund balance, unrestricted                          | 206,023,215  | 138,104,761 |
| Accumulated other comprehensive loss                | (4,816,382)  | (4,404,045)  |
| Noncontrolling interests                             | 574,461      | 621,537     |
| **Total**                                             | **201,781,294** | **134,322,253** |

**Total**                                               | **$433,925,120** | **$378,373,675** |

See accompanying notes.
# CONSOLIDATED STATEMENTS OF OPERATIONS

**Year Ended December 31**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUMS:</td>
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<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$554,847,140</td>
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<tr>
<td>Medicare</td>
<td>345,466,471</td>
<td>301,577,532</td>
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<tr>
<td>Medicaid</td>
<td>328,343,402</td>
<td>340,997,255</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,228,657,013</strong></td>
<td><strong>1,213,976,659</strong></td>
</tr>
<tr>
<td>CLAIMS EXPENSE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>507,120,946</td>
<td>503,799,158</td>
</tr>
<tr>
<td>Medicare</td>
<td>324,340,673</td>
<td>288,280,340</td>
</tr>
<tr>
<td>Medicaid</td>
<td>281,674,358</td>
<td>295,113,012</td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>18,123,914</td>
<td>18,097,328</td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>5,405,447</td>
<td>9,188,549</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>-</td>
<td>(4,960,000)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,136,665,338</strong></td>
<td><strong>1,109,518,387</strong></td>
</tr>
<tr>
<td>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</td>
<td>91,991,675</td>
<td>104,458,272</td>
</tr>
<tr>
<td>ADMINISTRATIVE REVENUES</td>
<td>20,317,045</td>
<td>10,922,333</td>
</tr>
<tr>
<td>GENERAL AND ADMINISTRATIVE EXPENSES</td>
<td>116,616,541</td>
<td>107,837,281</td>
</tr>
<tr>
<td>UNDERWRITING (LOSS) GAIN</td>
<td>(4,307,821)</td>
<td>7,543,324</td>
</tr>
<tr>
<td>OTHER INCOME (EXPENSE):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment income</td>
<td>4,893,498</td>
<td>5,095,265</td>
</tr>
<tr>
<td>Interest expense</td>
<td>(438,489)</td>
<td>(306,921)</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(1,027,134)</td>
<td>(747,359)</td>
</tr>
<tr>
<td>Miscellaneous income (expense)</td>
<td>630,499</td>
<td>(1,237,470)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,058,374</strong></td>
<td><strong>2,803,515</strong></td>
</tr>
<tr>
<td>(LOSS) INCOME BEFORE INCOME TAXES</td>
<td>(249,447)</td>
<td>10,346,839</td>
</tr>
<tr>
<td>INCOME TAX EXPENSE</td>
<td>9,656,311</td>
<td>13,414,212</td>
</tr>
<tr>
<td><strong>TOTAL LOSS</strong></td>
<td>(9,955,758)</td>
<td>(3,067,373)</td>
</tr>
<tr>
<td>LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS</td>
<td>71,191</td>
<td>62,832</td>
</tr>
<tr>
<td><strong>NET LOSS</strong></td>
<td><strong>$9,976,949</strong></td>
<td><strong>$(3,130,205)</strong></td>
</tr>
</tbody>
</table>

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES

Consolidated Statements of Comprehensive Loss

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET LOSS</td>
<td>$ (9,976,949)</td>
<td>$ (3,130,205)</td>
</tr>
<tr>
<td>OTHER COMPREHENSIVE LOSS, NET OF TAXES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation of investments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation arising during year</td>
<td>840,246</td>
<td>(1,443,812)</td>
</tr>
<tr>
<td>(net of tax of $623,000 in 2016 and $(866,000) in 2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassification adjustment for gains and losses realized in net loss</td>
<td>(26,111)</td>
<td>(810,628)</td>
</tr>
<tr>
<td>(net of tax of $20,000 in 2016 and $486,000 in 2015), included in investment income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation and depreciation of investments, net</td>
<td>814,135</td>
<td>(2,254,440)</td>
</tr>
<tr>
<td>Defined benefit pension plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss arising during year (net of tax of $1,046,000 in 2016 and $96,000 in 2015), included in general and administrative expenses</td>
<td>(1,645,252)</td>
<td>(94,492)</td>
</tr>
<tr>
<td>Amortization of net loss (net of tax of $266,000 in 2016 and $356,000 in 2015), included in general and administrative expenses</td>
<td>418,780</td>
<td>350,794</td>
</tr>
<tr>
<td>Defined benefit pension plan, net</td>
<td>(1,226,472)</td>
<td>256,302</td>
</tr>
<tr>
<td>Total other comprehensive loss</td>
<td>(412,337)</td>
<td>(1,998,138)</td>
</tr>
<tr>
<td>COMPREHENSIVE LOSS</td>
<td>$ (10,389,286)</td>
<td>$ (5,128,343)</td>
</tr>
</tbody>
</table>

See accompanying notes.
## Consolidated Statements of Fund Balance

### Unrealized Appreciation and Depreciation

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Unrealized Appreciation on Investments</th>
<th>Defined Benefit Pension Plan</th>
<th>Noncontrolling Interests</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BALANCE, January 1, 2015</td>
<td>$141,234,966</td>
<td>$3,393,742</td>
<td>$(5,799,649)</td>
<td>$570,468</td>
</tr>
<tr>
<td>Net (loss) income</td>
<td>$(3,130,205)</td>
<td>-</td>
<td>-</td>
<td>62,832</td>
</tr>
<tr>
<td>Other comprehensive (loss) income</td>
<td>-</td>
<td>$(2,254,440)</td>
<td>256,302</td>
<td>-</td>
</tr>
<tr>
<td>Redemption of IPN common stock</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$(11,763)</td>
</tr>
<tr>
<td>BALANCE, December 31, 2015</td>
<td>$138,104,761</td>
<td>$1,139,302</td>
<td>$(5,543,347)</td>
<td>621,537</td>
</tr>
<tr>
<td>Net (loss) income</td>
<td>$(9,976,949)</td>
<td>-</td>
<td>-</td>
<td>71,191</td>
</tr>
<tr>
<td>Other comprehensive income (loss)</td>
<td>-</td>
<td>814,135</td>
<td>$(1,226,472)</td>
<td>-</td>
</tr>
<tr>
<td>Contribution</td>
<td>100,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dividends</td>
<td>$(22,104,597)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Redemption of IPN common stock</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$(118,267)</td>
</tr>
<tr>
<td>BALANCE, December 31, 2016</td>
<td>$206,023,215</td>
<td>$1,953,437</td>
<td>$(6,769,819)</td>
<td>574,461</td>
</tr>
</tbody>
</table>

See accompanying notes.
<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH FLOWS FROM OPERATING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums collected</td>
<td>$1,235,995,146</td>
<td>$1,208,588,533</td>
</tr>
<tr>
<td>Claims paid</td>
<td>(1,148,696,700)</td>
<td>(1,079,823,817)</td>
</tr>
<tr>
<td>General and administrative expenses paid</td>
<td>(108,517,590)</td>
<td>(118,679,844)</td>
</tr>
<tr>
<td>Investment income received</td>
<td>3,320,653</td>
<td>4,101,499</td>
</tr>
<tr>
<td>Other revenue received</td>
<td>20,317,045</td>
<td>10,922,333</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(439,763)</td>
<td>(308,109)</td>
</tr>
<tr>
<td>Income taxes paid</td>
<td>(5,624,576)</td>
<td>(13,583,310)</td>
</tr>
<tr>
<td>Net cash (used in) provided by operating activities</td>
<td>(3,645,785)</td>
<td>11,217,285</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM INVESTING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from sale of investments</td>
<td>87,073,944</td>
<td>89,600,671</td>
</tr>
<tr>
<td>Investments purchased</td>
<td>(140,703,190)</td>
<td>(74,097,232)</td>
</tr>
<tr>
<td>Property purchased</td>
<td>(4,440,246)</td>
<td>(3,792,817)</td>
</tr>
<tr>
<td>Net cash (used in) provided by investing activities</td>
<td>(58,069,492)</td>
<td>11,710,622</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CASH FLOWS FROM FINANCING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proceeds from contribution</td>
<td>100,000,000</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from notes payable</td>
<td>-</td>
<td>13,801,592</td>
</tr>
<tr>
<td>Payments on notes payable</td>
<td>(14,020,021)</td>
<td>(203,704)</td>
</tr>
<tr>
<td>Redemption of common stock</td>
<td>(118,267)</td>
<td>(11,763)</td>
</tr>
<tr>
<td>Net cash provided by financing activities</td>
<td>85,861,712</td>
<td>13,586,125</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHANGE IN CASH AND CASH EQUIVALENTS</strong></td>
<td>24,146,435</td>
<td>36,514,032</td>
</tr>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS, beginning of year</strong></td>
<td>104,651,432</td>
<td>68,137,400</td>
</tr>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS, end of year</strong></td>
<td>$128,797,867</td>
<td>$104,651,432</td>
</tr>
</tbody>
</table>

(Continued)

See accompanying notes.
Reconciliation of Net Loss to Net Cash
(Used in) Provided by Operating Activities

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET LOSS</td>
<td>$ (9,976,949)</td>
<td>$ (3,130,205)</td>
</tr>
</tbody>
</table>

ADJUSTMENTS TO RECONCILE NET LOSS TO
NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income attributable to noncontrolling interest</td>
<td>71,191</td>
<td>62,832</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>5,757,569</td>
<td>7,649,977</td>
</tr>
<tr>
<td>Deferred tax expense</td>
<td>(2,209,000)</td>
<td>3,821,700</td>
</tr>
<tr>
<td>Gain on sale of investments</td>
<td>(1,208,350)</td>
<td>(1,142,982)</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>-</td>
<td>(4,960,000)</td>
</tr>
<tr>
<td>Adjustments resulting from changes in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>1,893,111</td>
<td>(7,039,417)</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>(364,495)</td>
<td>149,216</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(840,429)</td>
<td>(4,175,903)</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>6,240,735</td>
<td>(3,990,798)</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>(3,971,148)</td>
<td>23,121,690</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>739,560</td>
<td>(208,722)</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>(2,619,623)</td>
<td>(12,219,697)</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>217,989</td>
<td>95,423</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>5,445,022</td>
<td>1,651,291</td>
</tr>
<tr>
<td>Accrued medical incentive pools payable</td>
<td>(7,174,335)</td>
<td>14,137,111</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>(885,879)</td>
<td>(2,604,231)</td>
</tr>
</tbody>
</table>

NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES  $ (3,645,785)   $ 11,217,285

Supplemental Schedule of Noncash Investing and Financing Activities

At December 31, 2016, there was an increase from December 31, 2015 in unrealized appreciation of investments, net of reclassification adjustments, of $1,417,135 with deferred taxes of $(603,000). At December 31, 2015, there was a decrease from December 31, 2014 in unrealized appreciation of investments, net of reclassification adjustments, of $(3,606,440) with deferred taxes of $1,352,000.

At December 31, 2016, there were defined benefit pension plan adjustments of $(2,006,472) with deferred taxes of $780,000. At December 31, 2015, there were defined benefit pension plan adjustments of $516,302 with deferred taxes of $(260,000).

During the year ended December 31, 2016, the Company distributed $22,104,597 of buildings and land to its parent company (Note 2).

At December 31, 2016, the Company recorded accounts receivable of $27,620 and accounts payable of $1,684,447 for unsettled purchases and sales of securities.
1. Organization and Summary of Significant Accounting Policies

PacificSource and its subsidiaries are organized as follows:

- PacificSource
  - PacificSource Health Plans (PSHP)
    - PacificSource Administrators, Inc. (PSA)
    - Primary Health, Inc. (PHI)
      - IPN, Inc. (60%) (IPN)
    - PacificSource Community Health Plans (PCHP)
      - PacificSource Community Solutions (PCS)

PacificSource is an Oregon not-for-profit holding company. PSHP is an independent, not-for-profit community health plan offering commercial medical and dental plans in Oregon, Idaho, Montana, and Washington.

PSA is a third-party administrator specializing in administration of self-funded employee health benefit plans, flexible spending accounts, health reimbursement arrangements, and COBRA administration based in Oregon.

PHI is a shell corporation which owns 60% of the outstanding shares of IPN, an Idaho based for-profit non-insurance entity. IPN is a physician contracting network.

PCHP is a not-for-profit health insurance company licensed in the states of Oregon, Idaho, and Montana. It offers Medicare Advantage and, through their subsidiary PCS, Medicaid plans. On December 31, 2016, PacificSource Community Solutions, Inc. merged into a newly formed not-for-profit corporation, PacificSource Community Solutions.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The relative proportion of gross revenue attributable to each entity for the years ended December 31 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource</td>
<td>$7,208,243</td>
<td>$449,002</td>
</tr>
<tr>
<td>PSHP</td>
<td>560,875,174</td>
<td>575,247,233</td>
</tr>
<tr>
<td>PCHP and subsidiary</td>
<td>673,810,464</td>
<td>642,577,383</td>
</tr>
<tr>
<td>PSA</td>
<td>4,501,895</td>
<td>4,161,700</td>
</tr>
<tr>
<td>PHI and subsidiary</td>
<td>2,578,282</td>
<td>2,463,674</td>
</tr>
<tr>
<td><strong>Gross revenue</strong></td>
<td><strong>$1,248,974,058</strong></td>
<td><strong>$1,224,898,992</strong></td>
</tr>
</tbody>
</table>

**Principles of Consolidation.** The accompanying consolidated financial statements of PacificSource are consolidated with PSHP and its subsidiaries (collectively the Company). All significant intercompany balances and transactions have been eliminated in the consolidation.

**Basis of Presentation.** The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) that differ from statutory accounting principles used by regulatory authorities.

**Investments.** Investments in debt securities, equity securities, and mutual funds are classified as available-for-sale and are reported at fair value. Realized gains and losses on investments are recognized on the specific identification basis and recorded using the original cost of the security. Changes in fair value of investments are recorded as unrealized depreciation or appreciation directly in the fund balance as other comprehensive income or loss and have no effect on net income or loss. Certificates of deposit that had a maturity of more than three months at the time of acquisition are carried at cost.

Investments in other invested assets are accounted for using the equity method. The equity method of accounting for investments requires the Company to recognize its pro-rata share of the income or loss and distributions of the investments and to increase or decrease the carrying value of the investment accordingly.

**Restricted Deposits.** PSHP, PCHP, and PCS maintain deposits as required by regulatory authorities. At December 31, 2016 and 2015, the Company had total restricted deposits that were included at fair value in investments on the consolidated balance sheets of $2,589,000 and $3,871,738, respectively. At December 31, 2016 and 2015, the Company had total restricted deposits included in cash and cash equivalents on the consolidated balance sheets of $9,497,815 and $7,205,524, respectively.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Cash Equivalents. For purposes of the consolidated statements of cash flows, the Company considers all highly liquid debt instruments purchased with maturities of three months or less at the time of acquisition to be cash equivalents. Substantially all of the cash and cash equivalents are maintained at various banks whose deposits exceed federally insured limits. The Company has not experienced any losses on such accounts.

Trust Funds. Under the terms of administrative agreements for self-insurance and third-party administrator services, the Company is required to maintain separate cash trust accounts for benefit administration services received for various employers.

Accounts Receivable. Accounts receivable consist primarily of uncollected premiums from policyholders, amounts due from groups under administrative service contracts for uninsured health plans, pharmacy rebates, claims refunds collectible from providers, insureds and third-parties, amounts due under the Patient Protection and Affordable Care Act (ACA) reinsurance, risk corridor and risk adjustment programs, and amounts due for contractual adjustments from the Centers for Medicare and Medicaid Services (CMS).

Management determines and evaluates past due balances on an account-by-account basis, and if amounts become uncollectible, they will be charged to operations when that determination is made. As of December 31, 2016 and 2015, management considered receivables to be fully collectible; accordingly, no allowance for doubtful accounts was considered necessary.

Health Care Reform. The ACA enacted significant reforms to various aspects of the U.S. health insurance industry including an annual premium-based health insurance provider fee and the establishment of federally-facilitated or state-based exchanges. The U.S. Department of Health and Human Services (HHS) pays a portion of the premium and a portion of the claim costs for low-income individual public exchange members. In addition, HHS administers three premium stabilization programs, as described more fully below.

ACA Reinsurance. The ACA established a temporary three-year reinsurance program, under which all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by HHS. Funds collected will be utilized to reimburse issuer's high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in claims expense - premium taxes and assessments, for all of the Company's insurance products with the exception of products associated with qualified individual members. At December 31, 2016 and 2015, the Company recorded an accrued expense for funding contribution fees under the program. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. The Company recorded a receivable and offset claims expense to reflect its estimate of these recoveries.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Premiums ceded under the terms of the ACA reinsurance program were $3,401,204 and $7,908,627 in 2016 and 2015, respectively. Reinsurance recoveries were $6,026,154 and $19,282,251 in 2016 and 2015, respectively. The ACA reinsurance program does not relieve the Company from its primary obligation to policyholders.

Risk Adjustment. The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment receivable and reflects the impact as an adjustment to premium revenue.

Risk Corridor. The ACA established a temporary three-year risk sharing program for qualified individual and small group insurance plans. Under this program, the Company makes (or receives) a payment to (or from) HHS based on the ratio of allowable costs to target costs. The Company records a risk corridor receivable or payable as an adjustment to premium revenue on a pro-rata, year-to-date basis based on its estimate of the ultimate risk sharing amount. The Company believes it is due a receivable of $7.2 million for the program year ended December 31, 2014; however, the Company did not record the full receivable because the collectability of those payments from HHS are deemed uncertain. At December 31, 2016 and 2015, the Company had a receivable recorded of approximately $980,000 and $1,950,000, respectively, related to the 2014 program year, which is expected to be paid by HHS from future collections under the remaining life of the risk corridor program. During 2016 and 2015, the Company collected approximately $290,000 and $778,000, respectively, under the 2014 program. Additionally, the Company wrote off approximately $680,000 that it no longer considered to be collectible in 2016. The Company also believes it is due receivables of $52 million for the program years ended December 31, 2015 and 2016; however, it did not record any risk corridor receivable for those program years because the collectability of those payments from HHS are deemed uncertain.

The Company will perform a final reconciliation and settlement with HHS of claims expense, ACA reinsurance, risk adjustment, and risk corridor during the subsequent years.

Medicare Part D. The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from an annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premium revenue for providing insurance coverage ratably over the term of its annual contract. CMS payments are subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, the Company is not at risk for amounts due for reinsurance, low-income cost subsidies, and certain discounts on brand name prescription drugs in the coverage gap. The Company expenses the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset claims expense when incurred.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require refunds to CMS for a portion of the premiums received. The Company records a receivable or payable at the contract level as an adjustment to claims expense based on the timing of expected settlement. The Company performs a reconciliation of the final risk-sharing, low-income subsidy, and catastrophic amounts after the end of each contract year.

Medicare Risk-Score Adjustment. CMS utilizes a risk-score adjustment model which apportions premiums paid to Medicare plans according to health severity. The risk-score adjustment model pays more for enrollees with predictably higher costs, allowing health plans to be paid appropriately based upon members' overall health. Under the risk-score adjustment methodology, new members are assigned a risk score upon enrollment based upon a variety of factors, including demographics and health history. The risk score is then used in an actuarial model to calculate the rates paid to a health plan. The Company estimates risk-score adjustment revenues based on a number of analyses, including retrospective chart reviews of its members performed by a third-party.

Property. Property is stated at cost. Depreciation is computed on the straight-line method based on the estimated useful lives of the assets. Property additions and improvements are capitalized, while repairs and maintenance are charged to expense as incurred.

Goodwill. The Company assesses goodwill for impairment annually and whenever events or changes in circumstances indicate it may be impaired. When an impairment is indicated, any excess of carrying value over fair value of goodwill is recorded as an operating loss. The Company completed annual tests for impairment at December 31, 2016 and 2015, and determined that the fair value of goodwill exceeded the carrying value, thus goodwill was not considered impaired.

Intangible Assets. Intangible assets with finite lives are amortized on a straight-line basis over their estimated useful lives. Customer relationships and contract arrangements are amortized over ten to twenty years. Estimated useful lives of intangible assets are periodically reviewed by management to determine if events or circumstances warrant a change in the remaining useful life of the asset.

The Company assesses the recoverability of intangibles whenever events or changes in circumstances indicate they may be impaired. When an impairment is indicated, any excess of carrying value over fair value of intangibles is recorded as an operating loss. The Company completed tests for impairment at December 31, 2016 and 2015 and determined that the fair value of intangibles exceeded the carrying value, thus intangibles were not considered impaired.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

**Liability for Unpaid Claims and Claims Adjustment Expenses.** The Company establishes a liability, based on actuarial models, for unpaid claims and related administrative costs. The Company does not discount its liability for unpaid claims. The liability is an estimate, and while the Company believes that the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The estimate is continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in the period in which the revisions are determined. Actual payments will differ from the original estimates and may result in material adjustments to claims expense recorded in future periods.

**Premium Deficiency Reserve.** The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or actuarial forecasts indicate probable future losses. The Company establishes a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceed related future premiums under contracts without consideration of investment income. For purposes of premium deficiency losses, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts and represents the Company's best estimate in a range of potential outcomes. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. The Company determined that no premium deficiency existed as of December 31, 2016 and 2015.

**Coordinated Care Organization Risk Sharing.** The Company was awarded the Coordinated Care Organization (CCO) contracts with the state of Oregon which cover the Central Oregon and Gorge regions. Under the terms of the CCO contracts, the Company is subject to various risk sharing targets. Based on an annual review of performance and utilization, the Company may remit amounts to contract participants following the end of the Company's fiscal year. Amounts due under these contract provisions are recorded as accrued expenses on the accompanying consolidated balance sheets.

**Accrued Medical Incentive Pools and Withholds Payable.** The Company contracts with certain medical provider groups to provide healthcare services to plan members that involve risk sharing arrangements. Under the terms of the contracts with participating providers, a percentage of their fees are retained by the Company in an incentive pool reserve. Based on an annual review of performance and utilization, pool surpluses are generally paid to providers and pool deficits are generally retained by the Company.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

*Income Taxes.* PacificSource is a taxable Oregon nonprofit public benefit corporation. Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred taxes. Deferred income taxes arise principally from temporary differences relating to the deferred compensation plan, defined benefit pension plan, unrealized appreciation and depreciation of investments, depreciation and amortization, certain accrued and prepaid expenses, group life insurance and annuity contracts, premium deficiency reserve, discounting of the claims provision, partnership differences, goodwill, bad debts, alternative minimum tax credit carryforwards, charitable contribution carryforwards, and federal and state net operating loss carryforwards. PacificSource files consolidated federal income tax returns with its subsidiaries in accordance with applicable tax law.

*Revenue Recognition.* Premiums are recognized on a monthly basis over the policy term. Administrative revenues are recognized over the period the service is provided and include the operations of the non-insurance subsidiaries and administrative service contract fees which are received in exchange for performing certain claims processing and member services.

*Reinsurance.* The Company seeks to limit its loss on any single insured risk and to recover a portion of benefits paid by ceding reinsurance to its reinsurer under excess coverage agreements. Reinsurance agreements do not relieve the Company from its primary obligation to the policyholders, but provide the Company with insurance for large claims. Reinsurance premiums and reinsurance recoveries are offset against claims incurred. Amounts recoverable under reinsurance agreements include such amounts due from the reinsurer for the reimbursement of amounts paid on claims in excess of the insurance risk transferred to the reinsurer.

*Assessments.* Assessments are accrued at the time the events occur on which assessments are expected to be based.

*Advertising.* Costs for advertising are expensed as incurred. Advertising expense was $4,439,359 and $2,489,286 for 2016 and 2015, respectively.

*Fair Value Measurements.* Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value framework requires the categorization of assets and liabilities into three levels based upon the ability to observe the assumptions (inputs) used to value the assets and liabilities. Level One provides the most reliable and observable measure of fair value, whereas Level Three generally requires significant judgment. When valuing assets or liabilities, GAAP requires the most observable inputs to be used.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The fair value hierarchy is categorized into three levels based on the inputs as follows:

- **Level One**: Unadjusted, quoted prices in active markets for identical assets and liabilities.
- **Level Two**: Observable inputs, other than those included in Level One. For example, quoted prices for similar assets or liabilities in active markets or quoted prices for identical assets or liabilities in inactive markets.
- **Level Three**: Unobservable inputs reflecting assumptions about the inputs used in pricing the asset or liability.

The fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

*Estimates.* The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

*Concentrations of Credit Risk.* The Company's financial instruments that are exposed to concentrations of credit risk consist primarily of debt securities, cash and cash equivalents, reinsurance receivables, and other accounts receivable. Credit risk related to investments varies depending on the nature of the investments. Management believes that its credit risk related to debt securities is limited due to the financial strength of the U.S. Government and supporting corporations securing such investments. Due to the Company's normal operating cash flow requirements, the Company typically has cash and cash equivalents that exceed the Federal Deposit Insurance Corporation (FDIC) coverage or may not be insured at all. Management believes that its credit risk with respect to cash and cash equivalents is minimal due to the relative financial strength of the financial institutions which maintain the Company's bank balances and the short-term nature of its investments.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from geographic regions, activities, or economic characteristics of its reinsurers. At December 31, 2016 and 2015, the Company's reinsurance recoverables consisted primarily of amounts due from the U.S. government and are therefore considered to have a low credit risk. The remainder of the Company's reinsurance recoverables are due from third-parties that are rated consistently with companies that are considered to have the ability to meet their obligations. Credit risk relative to accounts receivable is minimal due to the nature of the receivables and due to the large number of policyholders.

Business Risks and Uncertainties. The Company's investments are primarily comprised of debt and equity securities. Significant changes in prevailing interest rates and market conditions may adversely affect the timing and amount of cash flows on such investments and their related values. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in values in the near-term could materially affect the Company's consolidated balance sheets and the amounts reported in the consolidated statements of operations.

The Company invests in mortgage backed securities (MBS) and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount on MBS is based on historical experience and estimates of future payments on the underlying mortgage loans. Actual prepayments will differ from the original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Recently Issued Accounting Pronouncements. In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers. The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This standard also includes expanded disclosure requirements that result in an entity providing users of financial statements with comprehensive information about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. This standard will be effective for the Company for the year ending on December 31, 2019. While insurance contracts have been carved out of this standard, the Company is currently in the process of evaluating the impact of adopting the provisions of this ASU on their other revenue streams.

In February 2016, the FASB issued ASU 2016-02, Leases. The standard requires all leases with lease terms over 12 months to be capitalized as a right-of-use asset and lease liability on the consolidated balance sheet at the date of lease commencement. Leases will be classified as either finance or operating. This distinction will be relevant for the pattern of expense recognition in the income statement. This standard will be effective for the calendar year ending December 31, 2020. The Company is currently in the process of evaluating the impact of adoption of this ASU on the financial statements.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

   **Reclassifications.** Certain 2015 amounts have been reclassified to conform to 2016 presentation. The reclassifications had no effect on previously reported net loss.

   **Subsequent Events.** Management evaluates events occurring subsequent to the date of the consolidated financial statements in determining the accounting for and disclosure of transactions and events that affect the consolidated financial statements. Subsequent events have been evaluated through April 20, 2017, which is the date the consolidated financial statements were available to be issued.

2. Member Acquisition Agreement

On September 1, 2016, the Company entered into a member acquisition agreement with Legacy Health (Legacy). As part of the agreement, the Company created a non-profit organization, Pacific Health Associates (PHA), which has a 50% member interest in the Company. Legacy purchased the remaining 50% member interest. The Company has a Board of Directors made up of an equal number of members designated by PHA and Legacy, as well as three independent members from the community. As part of the transaction, Legacy will make a multi-year capital contribution of $247.5 million, with $100 million paid in 2016, and the remaining balance to be paid over the next five years as certain contract provisions are met. The Company distributed $22,104,597 of land and buildings to PHA during 2016.

3. Investments

   Investments by major class consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt securities</td>
<td>$ 147,176,658</td>
<td>$ 87,473,805</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>27,161,337</td>
<td>27,500,892</td>
</tr>
<tr>
<td>Certificates of deposit (restricted)</td>
<td>2,589,000</td>
<td>3,871,738</td>
</tr>
<tr>
<td>Other invested assets</td>
<td>555,010</td>
<td>724,012</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>899,993</td>
<td>535,498</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 178,381,998</strong></td>
<td><strong>$ 120,105,945</strong></td>
</tr>
</tbody>
</table>

(Continued)
3. Investments (Continued)

*Investments in Debt and Equity Securities.* The Company classifies the following investments as available-for-sale and records them at fair value.

The cost and fair value of the investments at December 31, 2016 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage/asset backed securities</td>
<td>40,104,560</td>
<td>252,972</td>
<td>$(405,076)</td>
<td>39,952,456</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>74,486,363</td>
<td>306,174</td>
<td>$(875,132)</td>
<td>73,917,405</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>147,973,616</td>
<td>789,361</td>
<td>$(1,586,319)</td>
<td>147,176,658</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>22,650,841</td>
<td>4,972,374</td>
<td>(461,878)</td>
<td>27,161,337</td>
</tr>
<tr>
<td>Total</td>
<td>$170,624,457</td>
<td>$5,761,735</td>
<td>$(2,048,197)</td>
<td>$174,337,995</td>
</tr>
</tbody>
</table>

Approximately $2.0 million of gross realized gains and $600,000 of gross realized losses (including $35,000 of bond impairment) were included in investment income on the consolidated statements of operations for 2016.

The cost and fair value of the investments at December 31, 2015 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. government debt securities</td>
<td>$20,081,233</td>
<td>$246,044</td>
<td>$(120,787)</td>
<td>20,206,490</td>
</tr>
<tr>
<td>Mortgage/asset backed securities</td>
<td>24,198,721</td>
<td>307,671</td>
<td>$(315,592)</td>
<td>24,190,800</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>43,626,631</td>
<td>548,216</td>
<td>$(1,098,332)</td>
<td>43,076,515</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>87,906,585</td>
<td>1,101,931</td>
<td>$(1,534,711)</td>
<td>87,473,805</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>24,771,709</td>
<td>3,252,114</td>
<td>(522,931)</td>
<td>27,500,892</td>
</tr>
<tr>
<td>Total</td>
<td>$112,678,294</td>
<td>$4,354,045</td>
<td>$(2,057,642)</td>
<td>$114,974,697</td>
</tr>
</tbody>
</table>

Approximately $1.8 million of gross realized gains and $640,000 of gross realized losses (including $300,000 of bond impairment) were included in investment income on the consolidated statements of operations for 2015.

(Continued)
3. Investments (Continued)

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. Consideration is given to the length of time and the extent to which the fair value has been less than cost, the financial condition, and near-term prospects of the issuer and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in fair value. Based on this analysis, management determined that certain bonds were permanently impaired and recorded a loss of approximately $35,000 and $300,000 during 2016 and 2015, respectively.

The following table presents the estimated fair value and gross unrealized losses of the Company's investments at December 31, 2016 and 2015, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th>12 Months or More</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
</tr>
<tr>
<td>Debt securities</td>
<td>$ 42,215,245</td>
<td>$ (1,101,462)</td>
<td>$ 15,036,158</td>
</tr>
<tr>
<td>Equity securities</td>
<td>2,468,489</td>
<td>(101,264)</td>
<td>3,897,019</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 44,683,734</strong></td>
<td><strong>$ (1,202,726)</strong></td>
<td><strong>$ 18,933,177</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th>12 Months or More</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
</tr>
<tr>
<td>Debt securities</td>
<td>$ 38,621,251</td>
<td>$ (1,344,453)</td>
<td>$ 11,456,224</td>
</tr>
<tr>
<td>Equity securities</td>
<td>4,268,380</td>
<td>(161,180)</td>
<td>3,179,007</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 42,889,631</strong></td>
<td><strong>$ (1,505,633)</strong></td>
<td><strong>$ 14,635,231</strong></td>
</tr>
</tbody>
</table>

As of December 31, 2016, the Company had 249 securities in an unrealized loss position. All of these securities had a percentage decline of less than 16%.

(Continued)
3. Investments (Continued)

At December 31, 2016, debt securities were scheduled to mature as follows:

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Amortized Cost</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due in one year or less</td>
<td>$ 6,592,879</td>
<td>$ 6,614,552</td>
</tr>
<tr>
<td>Due in one to five years</td>
<td>55,733,346</td>
<td>55,826,434</td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>81,082,264</td>
<td>80,421,295</td>
</tr>
<tr>
<td>Due after ten years</td>
<td>4,565,127</td>
<td>4,314,377</td>
</tr>
<tr>
<td>Total</td>
<td>$ 147,973,616</td>
<td>$ 147,176,658</td>
</tr>
</tbody>
</table>

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Fair Value</th>
<th>Unrealized Appreciation</th>
<th>Tax Effect</th>
<th>Net Unrealized Appreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2016</td>
<td>$ 170,624,457 / $ 174,337,995</td>
<td>$ 3,713,538</td>
<td>$(1,492,000)</td>
<td>$ 2,221,538</td>
</tr>
<tr>
<td>Less December 31, 2015</td>
<td>$ 112,678,294 / $ 114,974,697</td>
<td>$ 2,296,403</td>
<td>$(889,000)</td>
<td>$ 1,407,403</td>
</tr>
</tbody>
</table>

Change in unrealized appreciation

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Fair Value</th>
<th>Unrealized Appreciation</th>
<th>Tax Effect</th>
<th>Net Unrealized Appreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in unrealized appreciation</td>
<td>$ 1,417,135 / $ (603,000)</td>
<td>$ 814,135</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Investment expense was approximately $326,000 and $279,000 for the years ended December 31, 2016 and 2015, respectively.

Other Invested Assets. Other invested assets consist of an investment in a partnership that is accounted for using the equity method. The percentage of the Company's ownership in this investment varies based upon total investment in the secondary market.
4. Accounts Receivable

Accounts receivable at December 31 consisted of the following:

<table>
<thead>
<tr>
<th>Account</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy rebates</td>
<td>$15,120,841</td>
<td>$6,870,009</td>
</tr>
<tr>
<td>Medicare risk score</td>
<td>12,007,000</td>
<td>8,830,000</td>
</tr>
<tr>
<td>Uncollected premiums from policyholders</td>
<td>10,884,617</td>
<td>15,612,910</td>
</tr>
<tr>
<td>ACA risk adjustment</td>
<td>10,879,009</td>
<td>6,028,854</td>
</tr>
<tr>
<td>ACA reinsurance</td>
<td>8,263,775</td>
<td>18,433,007</td>
</tr>
<tr>
<td>Amounts due from groups under administrative service contracts</td>
<td>5,113,362</td>
<td>3,674,075</td>
</tr>
<tr>
<td>Reinsurance recoverable</td>
<td>4,647,219</td>
<td>5,444,769</td>
</tr>
<tr>
<td>ACA risk corridor</td>
<td>979,283</td>
<td>1,953,109</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>-</td>
<td>6,140,000</td>
</tr>
<tr>
<td>Other</td>
<td>6,291,141</td>
<td>3,065,005</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$74,186,247</strong></td>
<td><strong>$76,051,738</strong></td>
</tr>
</tbody>
</table>

5. Property

Major classes of property at December 31 consisted of the following:

<table>
<thead>
<tr>
<th>Account</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$ -</td>
<td>$3,994,140</td>
</tr>
<tr>
<td>Buildings</td>
<td>-</td>
<td>18,892,775</td>
</tr>
<tr>
<td>Furniture and fixtures</td>
<td>4,219,178</td>
<td>2,986,901</td>
</tr>
<tr>
<td>Office equipment</td>
<td>5,272,305</td>
<td>3,438,517</td>
</tr>
<tr>
<td>Software</td>
<td>15,045,846</td>
<td>13,733,396</td>
</tr>
<tr>
<td>Automobiles</td>
<td>103,897</td>
<td>103,897</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>344,895</td>
<td>1,483,286</td>
</tr>
<tr>
<td>Work-in-process</td>
<td>-</td>
<td>158,376</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$24,986,121</strong></td>
<td><strong>44,791,288</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Account</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less accumulated depreciation and amortization</td>
<td>18,032,537</td>
<td>15,235,653</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,953,584</strong></td>
<td><strong>$29,555,635</strong></td>
</tr>
</tbody>
</table>

During the year ended December 31, 2016, the Company distributed all of its land and buildings to PHA (Note 2).
6. Intangible Assets

Major classes of intangible assets at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer relationships</td>
<td>$6,083,630</td>
<td>$6,083,630</td>
</tr>
<tr>
<td>Contractual arrangements</td>
<td>$3,785,235</td>
<td>$3,785,235</td>
</tr>
<tr>
<td></td>
<td>$9,868,865</td>
<td>$9,868,865</td>
</tr>
<tr>
<td>Less accumulated amortization</td>
<td>$4,350,707</td>
<td>$3,530,838</td>
</tr>
<tr>
<td>Total</td>
<td>$5,518,158</td>
<td>$6,338,027</td>
</tr>
</tbody>
</table>

Intangible assets with finite lives are amortized using the straight-line method over their estimated useful lives, which range from ten to twenty years. Amortization expense is expected to be as follows for each of the succeeding five years: 2017, $819,870; 2018, $819,870; 2019, $657,476; 2020, $430,129; 2021, $430,129; and $2,360,684 thereafter.

7. Liability for Unpaid Claims and Claims Adjustment Expenses

The liability for unpaid claims and claims adjustment expenses is based on the estimated amount payable on claims reported prior to the consolidated balance sheets date that have not yet been settled, claims reported subsequent to the consolidated balance sheets date that have been incurred during the period then ended, and an estimate based on prior experience of incurred but unreported claims relating to such period.

(Continued)
7. Liability for Unpaid Claims and Claims Adjustment Expenses (Continued)

Activity in the liability for unpaid claims and claims adjustment expenses is summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses, January 1</td>
<td>$119,306,910</td>
<td>$96,185,220</td>
</tr>
<tr>
<td>Less reinsurance receivable</td>
<td>(23,877,776)</td>
<td>(26,769,583)</td>
</tr>
<tr>
<td>Net balance</td>
<td>95,429,134</td>
<td>69,415,637</td>
</tr>
<tr>
<td>Incurred related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>1,159,850,333</td>
<td>1,111,592,010</td>
</tr>
<tr>
<td>Prior years</td>
<td>(7,875,278)</td>
<td>(7,662,463)</td>
</tr>
<tr>
<td>Total incurred</td>
<td>1,151,975,055</td>
<td>1,103,929,547</td>
</tr>
<tr>
<td>Paid related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>(1,033,547,789)</td>
<td>(989,393,293)</td>
</tr>
<tr>
<td>Prior years</td>
<td>(111,431,632)</td>
<td>(88,522,757)</td>
</tr>
<tr>
<td>Total paid</td>
<td>(1,144,979,421)</td>
<td>(1,077,916,050)</td>
</tr>
<tr>
<td>Net balance</td>
<td>102,424,768</td>
<td>95,429,134</td>
</tr>
<tr>
<td>Plus reinsurance receivable</td>
<td>12,910,994</td>
<td>23,877,776</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses, December 31</td>
<td>$115,335,762</td>
<td>$119,306,910</td>
</tr>
</tbody>
</table>

As a result of changes in estimates of insured events in prior years, the liability for unpaid claims, and claims adjustment expenses (net of reinsurance recoveries of $12,910,994) decreased by $7,875,278 in 2016. The liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $23,877,776) decreased by $7,662,463 in 2015. The Company records a liability for unpaid claims and claims adjustment expenses that includes an allowance for potential shock claims.
8. Accrued Expenses

Accrued expenses at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCO risk sharing</td>
<td>$19,154,749</td>
<td>$18,704,433</td>
</tr>
<tr>
<td>Accrued payroll and taxes</td>
<td>6,435,594</td>
<td>6,613,646</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>5,570,000</td>
<td>-</td>
</tr>
<tr>
<td>ACA reinsurance</td>
<td>3,425,276</td>
<td>7,917,044</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>3,109,018</td>
<td>2,877,319</td>
</tr>
<tr>
<td>Securities payable</td>
<td>1,684,447</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>2,940,299</td>
<td>1,902,871</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$42,319,383</strong></td>
<td><strong>$38,015,313</strong></td>
</tr>
</tbody>
</table>

9. Notes Payable

Notes payable consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note payable to bank paid in full August 2016</td>
<td>$</td>
<td>$13,801,592</td>
</tr>
<tr>
<td></td>
<td>295,375</td>
<td>513,804</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$295,375</strong></td>
<td><strong>$14,315,396</strong></td>
</tr>
</tbody>
</table>

The estimated aggregate amounts of principal payments on notes payable maturities are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$234,350</td>
<td>$61,025</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$295,375</strong></td>
<td></td>
</tr>
</tbody>
</table>
10. Retirement Plans

The Company has a non-contributory pension plan and a participatory retirement plan (401(k)). The 401(k) plan covers substantially all employees.

The non-contributory pension benefits are based on years of service and the employee's compensation during employment before the plan was frozen. The Company contributes at least the minimum funding required annually. Effective December 31, 2012, the benefits associated with the plan were frozen.

The following table sets forth the defined benefit plan's funded status and amounts recognized in the Company's consolidated financial statements at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation for service rendered to date</td>
<td>$(34,474,251)</td>
<td>$(31,457,623)</td>
</tr>
<tr>
<td>Plan assets at fair value</td>
<td>30,236,492</td>
<td>29,444,325</td>
</tr>
<tr>
<td>Funded status</td>
<td>$(4,237,759)</td>
<td>$(2,013,298)</td>
</tr>
</tbody>
</table>

Change in projected benefit obligation:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation, beginning of year</td>
<td>$31,457,623</td>
<td>$33,786,562</td>
</tr>
<tr>
<td>Interest cost</td>
<td>1,384,765</td>
<td>1,332,312</td>
</tr>
<tr>
<td>Benefits paid and administrative expenses</td>
<td>(1,028,250)</td>
<td>(1,075,210)</td>
</tr>
<tr>
<td>Actuarial loss (gain)</td>
<td>2,660,113</td>
<td>(2,586,041)</td>
</tr>
</tbody>
</table>

Projected benefit obligation, end of year | $34,474,251 | $31,457,623 |

Change in fair value of plan assets:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets, beginning of year</td>
<td>$29,444,325</td>
<td>$31,352,385</td>
</tr>
<tr>
<td>Actual return on plan assets</td>
<td>1,820,417</td>
<td>(832,850)</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(1,028,250)</td>
<td>(1,075,210)</td>
</tr>
</tbody>
</table>

Fair value of plan assets, end of year | $30,236,492 | $29,444,325 |

(Continued)
10. Retirement Plans (Continued)

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net periodic benefit cost:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest cost</td>
<td>$1,384,765</td>
<td>$1,332,312</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(1,851,556)</td>
<td>(1,943,683)</td>
</tr>
<tr>
<td>Amortization of loss</td>
<td>684,780</td>
<td>706,794</td>
</tr>
<tr>
<td><strong>Total net periodic benefit cost</strong></td>
<td>$217,989</td>
<td>$95,423</td>
</tr>
</tbody>
</table>

| Amounts recognized in accumulated other comprehensive loss: |                  |                  |
| Net loss                                                      | $11,109,819      | $9,103,347       |
| **Total accumulated other comprehensive loss**               | $11,109,819      | $9,103,347       |

| Changes in other comprehensive loss:                         |                  |                  |
| Net loss                                                     | $2,691,252        | $190,492         |
| Amortization of net loss                                    | (684,780)        | (706,794)        |
| **Total recognized in other comprehensive loss**            | $2,006,472        | $(516,302)       |

| Accumulated benefit obligation, end of year                  | $34,474,251       | $31,457,623      |

The Company estimates net loss, prior service cost, and transition obligation for the defined benefit pension plan that will be amortized into periodic benefit cost in 2017 to be $898,288, $0, and $0, respectively.

The Company does not expect to make any contribution to its pension plan in 2017. Future anticipated benefit payments from the defined benefit pension plan are as follows: 2017, $2,243,420; 2018, $1,524,493; 2019, $2,042,439; 2020, $2,020,978; 2021, $2,113,657; and from 2022 to 2026, $7,945,232.

(Continued)
10. Retirement Plans (Continued)

Assumptions used in the accounting for the defined benefit pension plan were as follows at December 31:

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate used in determining present values</td>
<td>4.5%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Annual increase in future compensation levels</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expected long-term rate of return on assets</td>
<td>6.4%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

Assumptions used to determine benefit obligation:

<table>
<thead>
<tr>
<th>Assumptions</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate used in determining present values</td>
<td>4.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Rate of compensation increase</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Measurement date

December 31  December 31

The plan assets are invested in the following asset classes:

<table>
<thead>
<tr>
<th>Asset Class</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity investments</td>
<td>60%</td>
<td>63%</td>
</tr>
<tr>
<td>Debt investments</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>Real estate</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The plan assets are invested in a variety of bond and equity mutual funds. The targeted composition is set by the Company and reallocated periodically. The Company's expected rate of return on plan assets is determined by the plan assets' historical long-term investment performance, current asset allocation, and estimates of future long-term returns by asset class.

The 401(k) plan provides for voluntary employee contributions with employer matching. The plan requires a 50% Company match on eligible elective deferrals. Elective deferrals in excess of 6% of eligible employee compensation are not eligible to receive a match. In both 2016 and 2015, in addition to the annual matching contributions, the Company made a 3% discretionary non-elective contribution for all eligible employees. Company contributions under the plan were $2,859,809 and $2,462,682 in 2016 and 2015, respectively.
11. Income Taxes

PacificSource files a consolidated federal income tax return with its subsidiaries on the basis of its annual GAAP financial statements adjusted for the tax regulations. The Company files state income tax returns based on the annual statements that are filed with the insurance regulatory authorities for PSHP and PCHP. The Company files on the basis of its annual GAAP financial statements adjusted for the state tax regulations for the remaining subsidiaries. The allocation methodology under the adopted tax sharing agreement applies the projected consolidated group income tax rate to the entities based on pre-tax net income. Federal income taxes are settled between PacificSource and its subsidiaries based on the tax sharing agreement.

The provision for income taxes consists of the following:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current income tax expense (benefit):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal</td>
<td>$9,628,797</td>
<td>$10,134,012</td>
</tr>
<tr>
<td>State</td>
<td>2,236,514</td>
<td>(541,500)</td>
</tr>
<tr>
<td>Total current income tax expense</td>
<td>11,865,311</td>
<td>9,592,512</td>
</tr>
<tr>
<td>Deferred tax (benefit) expense</td>
<td>(2,209,000)</td>
<td>3,821,700</td>
</tr>
<tr>
<td>Total income tax expense</td>
<td>$9,656,311</td>
<td>$13,414,212</td>
</tr>
</tbody>
</table>

The reconciliation between federal taxes at the statutory rate and the Company's income taxes are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax (benefit) expense computed at statutory rate</td>
<td>$ (87,000)</td>
<td>$ 3,619,000</td>
</tr>
<tr>
<td>State tax (benefit) expense, net of federal income tax benefit</td>
<td>(12,000)</td>
<td>511,000</td>
</tr>
<tr>
<td>Tax effect of health insurance provider fee</td>
<td>5,687,000</td>
<td>5,959,000</td>
</tr>
<tr>
<td>Tax effect of distribution of property</td>
<td>3,967,000</td>
<td>-</td>
</tr>
<tr>
<td>Prior year true-ups and other permanent and temporary differences</td>
<td>101,311</td>
<td>3,325,212</td>
</tr>
<tr>
<td>Total income tax expense</td>
<td>$ 9,656,311</td>
<td>$13,414,212</td>
</tr>
</tbody>
</table>

(Continued)
11. Income Taxes (Continued)

Deferred income tax assets and liabilities at December 31 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deferred tax assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal and state net operating loss carryforwards</td>
<td>$1,882,000</td>
<td>$1,921,000</td>
</tr>
<tr>
<td>Accruals</td>
<td>2,604,000</td>
<td>2,138,000</td>
</tr>
<tr>
<td>Defined benefit pension plan</td>
<td>1,656,000</td>
<td>786,000</td>
</tr>
<tr>
<td>Partnership difference</td>
<td>831,000</td>
<td>777,000</td>
</tr>
<tr>
<td>Discount of claims provision</td>
<td>462,000</td>
<td>527,000</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>559,000</td>
<td>512,000</td>
</tr>
<tr>
<td><strong>Total deferred tax assets</strong></td>
<td>$7,994,000</td>
<td>$6,661,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deferred tax liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property</td>
<td>(3,039,000)</td>
<td>(4,409,000)</td>
</tr>
<tr>
<td>Prepaids</td>
<td>(1,661,000)</td>
<td>(1,941,000)</td>
</tr>
<tr>
<td>Unrealized gains</td>
<td>(1,492,000)</td>
<td>(889,000)</td>
</tr>
<tr>
<td>Subsidiary equity income</td>
<td>(66,000)</td>
<td>(72,000)</td>
</tr>
<tr>
<td><strong>Total deferred tax liabilities</strong></td>
<td>(6,258,000)</td>
<td>(7,311,000)</td>
</tr>
</tbody>
</table>

**Net deferred tax assets (liabilities)** | $1,736,000 | $(650,000) |

As of December 31, 2016, the Company recognized a deferred tax asset of $1,882,000 for the anticipated utilization of federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $4,495,772 will expire in 2028, if not used before then. State net operating loss carryforwards of $6,283,941 will expire on various dates through 2034.

The Company is required to record a valuation allowance when it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of the deferred tax assets depends on the ability to generate sufficient taxable income in the future. Based on its profitable operating results in previous years, together with management's intention and active pursuit of strategies to remain successful in the health insurance industry, no valuation allowance has been recorded because it appears more likely than not that the full tax benefit of deferred tax assets will be realized.
12. Reinsurance

The Company was reinsured against inpatient hospital costs and ancillary outpatient services under the terms of an excess liability policy. The following is a summary of the general coverage levels at December 31, 2016 in order of their application:

**Commercial**

<table>
<thead>
<tr>
<th>Layer</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10% up to $100,000</td>
<td>$1,000,000</td>
<td>$1,000,000 per member</td>
</tr>
<tr>
<td>Layer 2</td>
<td>10% up to $300,000</td>
<td>$2,000,000</td>
<td>$3,000,000 per member</td>
</tr>
<tr>
<td>Layer 3</td>
<td>$ -</td>
<td>$5,000,000</td>
<td>$5,000,000 per member</td>
</tr>
<tr>
<td>Layer 4</td>
<td>$ -</td>
<td>$10,000,000</td>
<td>$10,000,000 per member</td>
</tr>
<tr>
<td>Layer 5</td>
<td>$ -</td>
<td>$20,000,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**Medicare**

<table>
<thead>
<tr>
<th>Layer</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**Medicaid**

<table>
<thead>
<tr>
<th>Layer</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Premiums ceded under the terms of the non-ACA reinsurance policies were $8,190,011 and $7,544,695 in 2016 and 2015, respectively. Reinsurance recoveries were $6,842,251 and $6,164,981 in 2016 and 2015, respectively. The reinsurance contracts do not relieve the Company from its primary obligation to policyholders.
13. Leases

The Company leases office space at various locations in Oregon, Idaho, and Montana under general operating lease agreements with various expirations through 2028. The Company is responsible for substantially all executory costs under the agreements. Certain agreements contain annual rent adjustments or other rent escalations which the Company is required to pay.

Minimum aggregate future lease payments under all non-cancelable third-party operating leases as of December 31, 2016 are summarized as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$1,595,768</td>
</tr>
<tr>
<td>2018</td>
<td>1,074,583</td>
</tr>
<tr>
<td>2019</td>
<td>1,059,879</td>
</tr>
<tr>
<td>2020</td>
<td>1,009,126</td>
</tr>
<tr>
<td>2021</td>
<td>542,424</td>
</tr>
<tr>
<td>Thereafter</td>
<td>1,443,311</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,725,091</strong></td>
</tr>
</tbody>
</table>

The Company leases office space in Springfield, Oregon and Bend, Oregon from PHA with expirations in 2028. The Company is responsible for substantially all executory costs under the agreements. The agreements contain annual rent escalations which the Company is required to pay. Rent expense paid to PHA in 2016 totaled approximately $923,000.

Minimum aggregate future lease payments under all related-party operating leases as of December 31, 2016 are summarized as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$2,853,043</td>
</tr>
<tr>
<td>2018</td>
<td>2,938,634</td>
</tr>
<tr>
<td>2019</td>
<td>3,026,793</td>
</tr>
<tr>
<td>2020</td>
<td>3,117,597</td>
</tr>
<tr>
<td>2021</td>
<td>3,211,125</td>
</tr>
<tr>
<td>Thereafter</td>
<td>25,343,275</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$40,490,467</strong></td>
</tr>
</tbody>
</table>

Total amounts charged to rent expense for the various operating leases were $2,618,637 and $1,273,791 for 2016 and 2015, respectively.
14. Litigation and Commitments

The Company, consistent with the insurance industry in general, is subject to litigation in the normal course of business. The Company's management does not believe that such litigation will have a material effect on its financial position.

The Company is subject to an annual fee under the ACA which is not deductible for tax purposes. This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. During 2016 and 2015, the Company paid $15,369,132 and $16,105,705 related to 2015 and 2014 net premiums written, respectively. There is a moratorium on the annual health insurance industry fee for payment year 2017 and as such no amounts are due in 2017 related to the premiums written by the Company in 2016.

15. Related Party Transactions

The Company entered into an administrative service agreement with PHA whereby it will perform certain accounting and oversight functions on PHA's behalf in exchange for fees of approximately $62,500 per year. No amounts were paid or owed under this agreement as of December 31, 2016.

16. Fair Value of Financial Instruments

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2016. Valuation techniques utilized to determine fair value are consistently applied.

Investments in equity securities are classified as available-for-sale and are reported at fair value. These securities are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

(Continued)
16. Fair Value of Financial Instruments (Continued)

Investments in debt securities are classified as available-for-sale and are reported at fair value. Investments in U.S. government debt securities are traded in active markets and valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy. The fair value of all other debt instruments are estimated using recently executed transactions, market price quotations (where observable), bond spreads, or credit default swap spreads. The spread data used are for the same maturity as the bond. If the spread data does not reference the issuer, then data that references a comparable issuer is used. Where observable price quotations are not available, fair value is determined based on cash flow models with yield curves, bond or single-name credit default swap spreads, and recovery rates based on collateral values as key inputs. They are generally categorized in Level Two of the fair value hierarchy.

Fair values of assets and liabilities measured on a recurring basis are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Quoted Prices in Active Markets for Identical Assets (Level 1)</th>
<th>Significant Other Observable Inputs (Level 2)</th>
<th>Significant Unobservable Inputs (Level 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2016</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. government debt securities</td>
<td>$33,306,797</td>
<td>$33,306,797</td>
<td>-</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>39,952,456</td>
<td>-</td>
<td>39,952,456</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>73,917,405</td>
<td>73,917,405</td>
<td>-</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>147,176,658</td>
<td>33,306,797</td>
<td>113,869,861</td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>27,161,337</td>
<td>27,161,337</td>
<td>-</td>
</tr>
<tr>
<td><strong>December 31, 2015</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. government debt securities</td>
<td>$20,206,490</td>
<td>$20,206,490</td>
<td>-</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>24,190,800</td>
<td>-</td>
<td>24,190,800</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>43,076,515</td>
<td>43,076,515</td>
<td>-</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>87,473,805</td>
<td>20,206,490</td>
<td>67,267,315</td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>27,500,892</td>
<td>27,500,892</td>
<td>-</td>
</tr>
</tbody>
</table>

(Continued)
16. Fair Value of Financial Instruments (Continued)

The following presents a summary of the Company's defined benefit plan investment assets measured at fair value:

<table>
<thead>
<tr>
<th>Description</th>
<th>December 31, 2016</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quoted Prices</td>
<td>Significant</td>
<td>Significant</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>in Active Markets for Identical Assets (Level 1)</td>
<td>Other Observable Inputs (Level 2)</td>
<td>Unobservable Inputs (Level 3)</td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$ 8,403,416</td>
<td>$ 8,403,416</td>
<td>-</td>
<td>$ 8,403,416</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>10,067,157</td>
<td>10,067,157</td>
<td>-</td>
<td>10,067,157</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,105,712</td>
<td>6,105,712</td>
<td>-</td>
<td>6,105,712</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,553,588</td>
<td>3,553,588</td>
<td>-</td>
<td>3,553,588</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,513,505</td>
<td>1,513,505</td>
<td>-</td>
<td>1,513,505</td>
</tr>
<tr>
<td>Money market funds</td>
<td>593,114</td>
<td>593,114</td>
<td>-</td>
<td>593,114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 30,236,492</strong></td>
<td><strong>$ 30,236,492</strong></td>
<td>-</td>
<td><strong>$ 30,236,492</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>December 31, 2015</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quoted Prices</td>
<td>Significant</td>
<td>Significant</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>in Active Markets for Identical Assets (Level 1)</td>
<td>Other Observable Inputs (Level 2)</td>
<td>Unobservable Inputs (Level 3)</td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$ 7,873,616</td>
<td>$ 7,873,616</td>
<td>-</td>
<td>$ 7,873,616</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>9,780,871</td>
<td>9,780,871</td>
<td>-</td>
<td>9,780,871</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,334,291</td>
<td>6,334,291</td>
<td>-</td>
<td>6,334,291</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,669,029</td>
<td>3,669,029</td>
<td>-</td>
<td>3,669,029</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,786,518</td>
<td>1,786,518</td>
<td>-</td>
<td>1,786,518</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 29,444,325</strong></td>
<td><strong>$ 29,444,325</strong></td>
<td>-</td>
<td><strong>$ 29,444,325</strong></td>
</tr>
</tbody>
</table>

The following is a description of the valuation methodologies used for the Company's defined benefit plan investment assets measured at fair value.

Registered investment companies are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.
17. Statutory Financial Information

PSHP and PCHP, which are domiciled in Oregon, prepare their statutory basis financial statements in accordance with accounting principles and practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation. Oregon has adopted the NAIC's statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practices.

PSHP and PCHP follow the NAIC's SAP and do not have permitted practices that deviate from NAIC SAP. PSHP and PCHP’s statutory capital and surplus were sufficient to satisfy regulatory requirements at December 31, 2016.
SUPPLEMENTAL INFORMATION

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Attachment 12-Three Years of Audited Financial Reports
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Schedules of General and Administrative Expenses

<table>
<thead>
<tr>
<th>Item</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$43,609,780</td>
<td>$39,227,256</td>
</tr>
<tr>
<td>Payroll taxes</td>
<td>3,686,780</td>
<td>3,327,165</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>9,911,839</td>
<td>7,828,719</td>
</tr>
<tr>
<td>Retirement plans</td>
<td>2,498,591</td>
<td>2,091,643</td>
</tr>
<tr>
<td>Administrative expense, net</td>
<td>1,274,068</td>
<td>1,050,102</td>
</tr>
<tr>
<td>Advertising</td>
<td>4,439,359</td>
<td>2,489,286</td>
</tr>
<tr>
<td>Auditing and tax services</td>
<td>689,819</td>
<td>603,695</td>
</tr>
<tr>
<td>Automobile expense</td>
<td>404,953</td>
<td>374,326</td>
</tr>
<tr>
<td>Banking charges</td>
<td>600,241</td>
<td>583,946</td>
</tr>
<tr>
<td>Board expenses</td>
<td>389,413</td>
<td>415,233</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>465,970</td>
<td>391,267</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>2,158,211</td>
<td>1,678,589</td>
</tr>
<tr>
<td>Contract labor</td>
<td>1,436,245</td>
<td>872,997</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>5,757,569</td>
<td>7,649,977</td>
</tr>
<tr>
<td>Education and training</td>
<td>292,604</td>
<td>282,070</td>
</tr>
<tr>
<td>Health insurance provider fee</td>
<td>15,369,132</td>
<td>16,105,705</td>
</tr>
<tr>
<td>Imaging expense</td>
<td>287,992</td>
<td>295,707</td>
</tr>
<tr>
<td>Insurance</td>
<td>858,087</td>
<td>801,067</td>
</tr>
<tr>
<td>Legal fees</td>
<td>290,922</td>
<td>361,210</td>
</tr>
<tr>
<td>Meals and entertainment</td>
<td>614,150</td>
<td>506,010</td>
</tr>
<tr>
<td>Office expenses and supplies</td>
<td>1,866,705</td>
<td>1,025,415</td>
</tr>
<tr>
<td>Postage</td>
<td>2,375,948</td>
<td>2,449,965</td>
</tr>
<tr>
<td>Printing expense</td>
<td>1,405,904</td>
<td>1,508,498</td>
</tr>
<tr>
<td>Professional dues</td>
<td>316,121</td>
<td>318,586</td>
</tr>
<tr>
<td>Purchased services</td>
<td>3,888,526</td>
<td>5,932,106</td>
</tr>
<tr>
<td>Recruiting</td>
<td>314,082</td>
<td>220,574</td>
</tr>
<tr>
<td>Rent - equipment</td>
<td>115,284</td>
<td>102,696</td>
</tr>
<tr>
<td>Rent - regional offices</td>
<td>2,618,637</td>
<td>1,273,791</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>1,298,927</td>
<td>840,059</td>
</tr>
<tr>
<td>Software licenses</td>
<td>4,609,969</td>
<td>4,658,381</td>
</tr>
<tr>
<td>Subscriptions</td>
<td>121,547</td>
<td>82,591</td>
</tr>
<tr>
<td>Surveys and studies</td>
<td>21,336</td>
<td>19,838</td>
</tr>
<tr>
<td>Taxes and licenses</td>
<td>714,675</td>
<td>660,472</td>
</tr>
<tr>
<td>Telephone</td>
<td>698,705</td>
<td>705,702</td>
</tr>
<tr>
<td>Travel</td>
<td>936,747</td>
<td>812,081</td>
</tr>
<tr>
<td>Utilities</td>
<td>277,703</td>
<td>290,556</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$116,616,541</strong></td>
<td><strong>$107,837,281</strong></td>
</tr>
</tbody>
</table>
RFA OHA-4690-19-PacificSource Community Solutions-Central Oregon

PACIFICSOURCE AND SUBSIDIARIES

Consolidating Balance Sheet

December 31, 2016

<table>
<thead>
<tr>
<th></th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>$ 207,086,468 $</td>
<td>$ 167,155,757 $</td>
<td>$ 66,152,928 $</td>
<td>$ 22,819,277 $</td>
<td>$ 861,690 $</td>
<td>$ - $</td>
<td>$ - $</td>
<td>$ (285,694,122) $</td>
<td>$ 178,381,998 $</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$ 9,676,645</td>
<td>$ 29,221,648</td>
<td>$ 31,740,669</td>
<td>$ 54,711,296</td>
<td>$ 190,899</td>
<td>$ 1,659,070</td>
<td>$ 1,597,640</td>
<td>-</td>
<td>$ 128,797,867</td>
</tr>
<tr>
<td>Trust funds</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$ 5,931,542</td>
<td>$ 5,931,542</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>$ 3,634,560</td>
<td>$ 42,526,161</td>
<td>$ 22,399,766</td>
<td>$ 5,009,792</td>
<td>-</td>
<td>$ 131,963</td>
<td>$ 484,005</td>
<td>-</td>
<td>$ 74,186,247</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>$ 11,654,946</td>
<td>$ 842,585</td>
<td>-</td>
<td>$ 29,979</td>
<td>$ 65,232</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$ 12,592,742</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>$ 7,149,345</td>
<td>38,110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$ 27,755</td>
<td>-</td>
</tr>
<tr>
<td>Property, net</td>
<td>$ 6,953,584</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$ 6,953,584</td>
</tr>
<tr>
<td>Goodwill</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intangible assets, net</td>
<td>-</td>
<td>$ 2,461,631</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$ 5,518,158</td>
</tr>
<tr>
<td>Deferred tax assets (liabilities)</td>
<td>$ 881,000</td>
<td>$ 684,000</td>
<td>$ 216,000</td>
<td>$ 47,000</td>
<td>$ 128,000</td>
<td>-</td>
<td>$ (220,000)</td>
<td>-</td>
<td>$ 1,736,000</td>
</tr>
<tr>
<td>Intercompany receivables</td>
<td>-</td>
<td>$ 3,947,329</td>
<td>-</td>
<td>$ 24,592,941</td>
<td>$ 204,714</td>
<td>-</td>
<td>$ 17,267</td>
<td>-</td>
<td>(28,762,251)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 45,829,715</td>
<td>$ 246,877,221</td>
<td>$ 120,509,363</td>
<td>$ 68,652,711</td>
<td>-</td>
<td>$ 3,822,637</td>
<td>$ 6,777,352</td>
<td>-</td>
<td>$ 232,143,826</td>
</tr>
</tbody>
</table>

|                  | PS  | PSHP | PCHP | PCS | PHI | IPN | PSA | Eliminations | Total          |
| **LIABILITIES**  |     |      |      |     |     |     |     |               |                |
| Unpaid claims and claims adjustment expenses | $ - | $ 62,100,000 | $ 39,821,651 | $ 13,414,111 | $ - | $ - | $ - | $ - | $ 115,335,762 |
| Accounts payable | $ 2,271,487 | $ 1,902,898 | $ 1,816,609 | - | - | - | - | - | $ 5,990,994 |
| Accrued pension liability | $ 4,237,759 | - | - | - | - | - | - | - | $ 4,237,759 |
| Unearned premiums | - | $ 14,179,569 | $ 268,138 | $ 96,272 | - | - | $ 548,712 | - | $ 15,092,691 |
| Accrued medical incentive pools and withholds payable | - | $ 1,303,561 | $ 4,957,147 | $ 35,191,150 | - | - | - | - | $ 41,451,858 |
| Accrued retro settlements | - | $ 1,488,462 | - | - | - | - | - | $ 5,931,542 | - | $ 5,931,542 |
| Collections for others | - | - | - | - | - | - | - | $ 295,375 | - | $ 295,375 |
| Notes payable     | - | - | - | - | - | - | - | - | - | - |
| Intercompany payables | $ 27,598,120 | - | $ 784,244 | - | - | $ 379,887 | - | (28,762,251) | - | - |
| **Total**         | $ 45,829,715 | 85,050,619 | $ 54,213,043 | $ 68,652,711 | - | $ 3,822,637 | $ 6,777,352 | - | $ 232,143,826 |

|                  | PS  | PSHP | PCHP | PCS | PHI | IPN | PSA | Eliminations | Total          |
| **FUND BALANCE** |     |      |      |     |     |     |     |               |                |
| Fund balance, unrestricted | $ 206,023,215 | $ 159,767,854 | $ 66,182,990 | $ 47,503,654 | $ 5,004,979 | $ 861,690 | $ 4,059,743 | (283,380,910) | $ 206,023,215 |
| Accumulated other comprehensive (loss) income | (4,816,382) | $ 2,058,748 | $ 113,330 | $ 141,134 | - | - | - | (2,313,212) | (4,816,382) |
| Noncontrolling interests | - | - | - | - | - | - | $ 574,461 | - | - | $ 574,461 |
| **Total**         | $ 201,206,833 | $ 161,826,602 | $ 66,296,320 | $ 47,644,788 | $ 5,004,979 | $ 1,436,151 | $ 4,059,743 | (285,694,122) | $ 201,781,294 |

The financial statements omit substantially all of the disclosures and the statements of cash flows and comprehensive income required by accounting principles generally accepted in the United States of America, and no assurance is provided on these financial statements.

Attachment 12-Three Years of Audited Financial Reports

Page 83 of 127
## Net (Loss) Income

<table>
<thead>
<tr>
<th></th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>1,228,657,013</td>
</tr>
<tr>
<td><strong>Claims Expense</strong></td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Commercial</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medicare</td>
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<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Administrative Revenues</strong></td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Premiums and assessments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Excess of Premiums Over Claims Expense</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>General and Administrative Expenses</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td><strong>Underwriting Gain (Loss)</strong></td>
<td>12,201,969</td>
<td>(30,777,638)</td>
<td>(6,882,467)</td>
<td>20,487,025</td>
<td>(251,505)</td>
<td>254,254</td>
<td>460,541</td>
<td></td>
<td>- (4,307,821)</td>
</tr>
<tr>
<td><strong>Other Income (Expense):</strong></td>
<td>75,432</td>
<td>4,049,486</td>
<td>222,954</td>
<td>545,610</td>
<td>-</td>
<td>-</td>
<td>16</td>
<td></td>
<td>4,893,498</td>
</tr>
<tr>
<td>Investment income</td>
<td>1,275,148</td>
<td>(46,826)</td>
<td>-</td>
<td>914,067</td>
<td>(30,582)</td>
<td>-</td>
<td>-</td>
<td></td>
<td>438,489</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(951,719)</td>
<td>(75,415)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Miscellaneous (expense) income</td>
<td>(2,787,260)</td>
<td>3,447,536</td>
<td>(8,938)</td>
<td>(30,020)</td>
<td>551</td>
<td>-</td>
<td>8,630</td>
<td></td>
<td>630,499</td>
</tr>
<tr>
<td>(Loss) income from subsidiaries</td>
<td>(14,627,552)</td>
<td>7,455,016</td>
<td>11,206,145</td>
<td>106,786</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(4,140,395)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(19,566,247)</td>
<td>14,829,797</td>
<td>11,420,161</td>
<td>1,429,657</td>
<td>107,337</td>
<td>-</td>
<td>(21,936)</td>
<td>(4,140,395)</td>
<td>4,058,374</td>
</tr>
<tr>
<td><strong>Income Tax Expense (Benefit)</strong></td>
<td>2,612,667</td>
<td>(1,320,287)</td>
<td>(1,940,362)</td>
<td>10,710,537</td>
<td>(385,215)</td>
<td>76,276</td>
<td>(97,395)</td>
<td></td>
<td>9,656,311</td>
</tr>
<tr>
<td><strong>Total (Loss) Income</strong></td>
<td>(9,976,945)</td>
<td>(14,627,554)</td>
<td>6,678,056</td>
<td>11,206,145</td>
<td>241,047</td>
<td>177,978</td>
<td>535,910</td>
<td>(4,140,395)</td>
<td>(9,905,758)</td>
</tr>
<tr>
<td><strong>Less Income Attributable to Noncontrolling Interests</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>71,191</td>
<td>-</td>
<td>-</td>
<td></td>
<td>71,191</td>
</tr>
<tr>
<td><strong>Net (Loss) Income</strong></td>
<td>(9,976,945)</td>
<td>(14,627,554)</td>
<td>6,678,056</td>
<td>11,206,145</td>
<td>241,047</td>
<td>106,787</td>
<td>535,910</td>
<td>(4,140,395)</td>
<td>(9,905,758)</td>
</tr>
</tbody>
</table>

The financial statements omit substantially all of the disclosures and the statements of cash flows and comprehensive income required by accounting principles generally accepted in the United States of America, and no assurance is provided on these financial statements.
# PACIFICSOURCE AND SUBSIDIARIES

## CONTENTS

<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDEPENDENT AUDITORS' REPORT</strong></td>
<td>1-2</td>
</tr>
<tr>
<td><strong>FINANCIAL STATEMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated balance sheets</td>
<td>3</td>
</tr>
<tr>
<td>Consolidated statements of operations</td>
<td>4</td>
</tr>
<tr>
<td>Consolidated statements of comprehensive income (loss)</td>
<td>5</td>
</tr>
<tr>
<td>Consolidated statements of changes in fund balance</td>
<td>6</td>
</tr>
<tr>
<td>Consolidated statements of cash flows</td>
<td>7-9</td>
</tr>
<tr>
<td>Notes to consolidated financial statements</td>
<td>10-37</td>
</tr>
<tr>
<td><strong>SUPPLEMENTAL INFORMATION</strong></td>
<td></td>
</tr>
<tr>
<td>Consolidated schedules of general and administrative expenses</td>
<td>38</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
PacificSource and Subsidiaries:

We have audited the accompanying consolidated financial statements of PacificSource and Subsidiaries, which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations, comprehensive income (loss), changes in fund balance, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement. An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of PacificSource and Subsidiaries as of December 31, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidated schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and related directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Kernitt Stokes CPA

Eugene, Oregon
May 17, 2018
### Consolidated Balance Sheets

#### December 31  
**2017** | **2016**
---|---
**ASSETS** |  
Investments | $256,965,321 | $178,381,998
Cash and cash equivalents | $123,312,310 | $128,797,867
Trust funds | $6,257,746 | $5,931,542
Accounts receivable | $66,064,163 | $74,186,247
Prepaid expenses and deposits | $45,975,655 | $12,592,742
Prepaid income taxes | $18,429,285 | $7,215,210
Property, net | $8,879,804 | $6,953,584
Goodwill | $12,113,855 | $12,611,772
Intangible assets, net | $3,313,243 | $5,518,158
Deferred tax assets | - | $1,736,000

**Total** | **$541,311,382** | **$433,925,120**

#### LIABILITIES AND FUND BALANCE

**LIABILITIES:**

| Unpaid claims and claims adjustment expenses | $131,198,344 | $115,335,762
| Accounts payable | $22,255,889 | $5,990,994
| Accrued expenses | $42,817,229 | $42,319,383
| Accrued pension liability | $4,328,462 | $4,237,759
| Unearned premiums | $14,320,998 | $15,092,691
| Accrued medical incentive pools and withholds payable | $47,585,378 | $41,451,858
| Accrued retro settlements | $539,961 | $1,488,462
| Collections for others | $6,257,746 | $5,931,542
| Notes payable | $61,154 | $295,375
| Deferred tax liabilities | $8,277,000 | -
| **Total** | **277,642,161** | **232,143,826**

**FUND BALANCE:**

| Fund balance, unrestricted | $264,114,298 | $206,023,215
| Accumulated other comprehensive loss | $(1,094,180) | $(4,816,382)
| Noncontrolling interests | $649,103 | $574,461
| **Total** | **263,669,221** | **201,781,294**

**Total** | **$541,311,382** | **$433,925,120**

---

See accompanying notes.
## PacificSource and Subsidiaries
### Consolidated Statements of Operations

<table>
<thead>
<tr>
<th></th>
<th>Year Ended December 31</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2016</td>
<td></td>
</tr>
<tr>
<td><strong>PREMIUMS:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$ 704,949,785</td>
<td>$ 554,847,140</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>357,594,116</td>
<td>345,466,471</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>313,506,831</td>
<td>328,343,402</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,376,050,732</td>
<td>1,228,657,013</td>
<td></td>
</tr>
<tr>
<td><strong>CLAIMS EXPENSE:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>607,321,294</td>
<td>507,120,946</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>325,785,456</td>
<td>324,340,673</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>283,779,640</td>
<td>281,674,358</td>
<td></td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>20,746,112</td>
<td>18,123,914</td>
<td></td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>5,102,909</td>
<td>5,405,447</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,242,735,411</td>
<td>1,136,665,338</td>
<td></td>
</tr>
</tbody>
</table>

**EXCESS OF PREMIUMS OVER CLAIMS EXPENSE**

133,315,321
91,991,675

**ADMINISTRATIVE REVENUES**

18,936,454
20,317,045

**GENERAL AND ADMINISTRATIVE EXPENSES**

115,692,243
116,616,541

**UNDERWRITING GAIN (LOSS)**

36,559,532
(4,307,821)

**OTHER INCOME (EXPENSE):**

<table>
<thead>
<tr>
<th></th>
<th>Year Ended December 31</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment income</td>
<td>9,399,243</td>
<td>4,893,498</td>
<td></td>
</tr>
<tr>
<td>Interest expense</td>
<td>(59,365)</td>
<td>(438,489)</td>
<td></td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(670,874)</td>
<td>(1,027,134)</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous (expense) income</td>
<td>(4,299,491)</td>
<td>630,499</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,369,513</td>
<td>4,058,374</td>
<td></td>
</tr>
</tbody>
</table>

**INCOME (LOSS) BEFORE INCOME TAXES**

40,929,045
(249,447)

**INCOME TAX EXPENSE**

12,407,320
9,656,311

**TOTAL INCOME (LOSS)**

28,521,725
(9,905,758)

**LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS**

74,642
71,191

**NET INCOME (LOSS)**

$ 28,447,083
$ (9,976,949)

---

See accompanying notes.

Attachment 12 - Three Years of Audited Financial Reports
### Consolidated Statements of Comprehensive Income (Loss)

<table>
<thead>
<tr>
<th></th>
<th>Year Ended December 31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
</tr>
<tr>
<td><strong>NET INCOME (LOSS)</strong></td>
<td>$ 28,447,083</td>
</tr>
<tr>
<td><strong>OTHER COMPREHENSIVE INCOME (LOSS), NET OF TAXES:</strong></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation of investments:</td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation arising during year</td>
<td>3,449,236</td>
</tr>
<tr>
<td>(net of tax of $2,150,000 in 2017 and $623,000 in 2016)</td>
<td></td>
</tr>
<tr>
<td>Reclassification adjustment for gains and losses realized in net income (loss)</td>
<td>201,451</td>
</tr>
<tr>
<td>(net of tax of $125,000 in 2017 and $(20,000) in 2016), included in investment income</td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation of investments, net</td>
<td>3,650,687</td>
</tr>
<tr>
<td>Defined benefit pension plan:</td>
<td></td>
</tr>
<tr>
<td>Net loss arising during year (net of tax of $212,000 in 2017 and $1,046,000 in 2016), included in general and administrative expenses</td>
<td>(334,773)</td>
</tr>
<tr>
<td>Amortization of net loss (net of tax of $348,000 in 2017 and $266,000 in 2016), included in general and administrative expenses</td>
<td>550,288</td>
</tr>
<tr>
<td>Defined benefit pension plan, net</td>
<td>215,515</td>
</tr>
<tr>
<td>Total other comprehensive income (loss)</td>
<td>3,866,202</td>
</tr>
<tr>
<td><strong>COMPREHENSIVE INCOME (LOSS)</strong></td>
<td>$ 32,313,285</td>
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</table>

See accompanying notes.
### PACIFICSOURCE AND SUBSIDIARIES

#### Consolidated Statements of Changes in Fund Balance

<table>
<thead>
<tr>
<th></th>
<th>Fund Balance</th>
<th>Unrealized Appreciation on Investments</th>
<th>Defined Benefit Pension Plan</th>
<th>Noncontrolling Interests</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accumulated Other Comprehensive Income (Loss)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BALANCE, JANUARY 1, 2016</strong></td>
<td>$138,104,761</td>
<td>$1,139,302</td>
<td>$(5,543,347)</td>
<td>$621,537</td>
<td>$134,322,253</td>
</tr>
<tr>
<td>Net (loss) income</td>
<td>(9,976,949)</td>
<td>-</td>
<td>-</td>
<td>71,191</td>
<td>(9,905,758)</td>
</tr>
<tr>
<td>Other comprehensive income (loss)</td>
<td>-</td>
<td>814,135</td>
<td>(1,226,472)</td>
<td>-</td>
<td>(412,337)</td>
</tr>
<tr>
<td>Contribution</td>
<td>100,000,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100,000,000</td>
</tr>
<tr>
<td>Dividends</td>
<td>(22,104,597)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(22,104,597)</td>
</tr>
<tr>
<td>Redemption of IPN common stock</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(118,267)</td>
<td>(118,267)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67,918,454</td>
<td>814,135</td>
<td>(1,226,472)</td>
<td>(47,076)</td>
<td>67,459,041</td>
</tr>
<tr>
<td><strong>BALANCE, DECEMBER 31, 2016</strong></td>
<td>206,023,215</td>
<td>1,953,437</td>
<td>(6,769,819)</td>
<td>574,461</td>
<td>201,781,294</td>
</tr>
<tr>
<td>Net income</td>
<td>28,447,083</td>
<td>-</td>
<td>-</td>
<td>74,642</td>
<td>28,521,725</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td>-</td>
<td>3,650,687</td>
<td>215,515</td>
<td>-</td>
<td>3,866,202</td>
</tr>
<tr>
<td>Reclassification of tax effects (Note 1)</td>
<td>144,000</td>
<td>1,280,000</td>
<td>(1,424,000)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Contribution</td>
<td>29,500,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>29,500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>58,091,083</td>
<td>4,930,687</td>
<td>(1,208,485)</td>
<td>74,642</td>
<td>61,887,927</td>
</tr>
<tr>
<td><strong>BALANCE, DECEMBER 31, 2017</strong></td>
<td>$264,114,298</td>
<td>$6,884,124</td>
<td>$(7,978,304)</td>
<td>$649,103</td>
<td>$263,669,221</td>
</tr>
</tbody>
</table>

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Cash Flows

Change in Cash and Cash Equivalents

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH FLOWS FROM OPERATING ACTIVITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premiums collected</td>
<td>$ 1,383,401,765</td>
<td>$ 1,235,995,146</td>
</tr>
<tr>
<td>Claims paid</td>
<td>(1,221,687,810)</td>
<td>(1,148,696,700)</td>
</tr>
<tr>
<td>General and administrative expenses paid</td>
<td>(129,696,061)</td>
<td>(108,517,590)</td>
</tr>
<tr>
<td>Investment income received</td>
<td>7,849,162</td>
<td>3,320,653</td>
</tr>
<tr>
<td>Other revenue received</td>
<td>18,936,454</td>
<td>20,317,045</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(60,731)</td>
<td>(439,763)</td>
</tr>
<tr>
<td>Income taxes paid</td>
<td>(16,019,395)</td>
<td>(5,624,576)</td>
</tr>
<tr>
<td><strong>Net cash provided by (used in) operating activities</strong></td>
<td><strong>42,723,384</strong></td>
<td><strong>(3,645,785)</strong></td>
</tr>
</tbody>
</table>

| **CASH FLOWS FROM INVESTING ACTIVITIES:** |                 |                 |
| Proceeds from sale of investments | 161,018,891     | 87,073,944      |
| Investments purchased           | (233,215,910)  | (140,703,190)  |
| Proceeds from sale of property   | 6,937           | -               |
| Property purchased              | (5,284,638)    | (4,440,246)     |
| **Net cash used in investing activities** | **(77,474,720)** | **(58,069,492)** |

| **CASH FLOWS FROM FINANCING ACTIVITIES:** |                 |                 |
| Proceeds from contribution       | 29,500,000      | 100,000,000     |
| Payments on notes payable        | (234,221)       | (14,020,021)    |
| Redemption of common stock       | -               | (118,267)       |
| **Net cash provided by financing activities** | **29,265,779** | **85,861,712** |

| **CHANGE IN CASH AND CASH EQUIVALENTS** | (5,485,557) | 24,146,435 |
| **CASH AND CASH EQUIVALENTS, beginning of year** | 128,797,867 | 104,651,432 |
| **CASH AND CASH EQUIVALENTS, end of year** | $ 123,312,310 | $ 128,797,867 |

(Continued)

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Cash Flows (Continued)

Reconciliation of Net Income (Loss) to Net Cash Provided by (Used in) Operating Activities

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>NET INCOME (LOSS)</td>
<td>$28,447,083</td>
<td>$(9,976,949)</td>
</tr>
<tr>
<td>ADJUSTMENTS TO RECONCILE NET INCOME (LOSS) TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income attributable to noncontrolling interest</td>
<td>74,642</td>
<td>71,191</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>6,044,537</td>
<td>5,757,569</td>
</tr>
<tr>
<td>Deferred tax expense (benefit)</td>
<td>7,602,000</td>
<td>(2,209,000)</td>
</tr>
<tr>
<td>Gain on sale of investments</td>
<td>(1,235,896)</td>
<td>(1,208,350)</td>
</tr>
<tr>
<td>Loss on disposal of property and intangible assets</td>
<td>9,776</td>
<td>-</td>
</tr>
<tr>
<td>Adjustments resulting from changes in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>8,122,726</td>
<td>1,893,111</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>(314,185)</td>
<td>(364,495)</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(33,382,913)</td>
<td>(840,429)</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>(11,214,075)</td>
<td>6,240,735</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>15,862,582</td>
<td>(3,971,148)</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>16,264,895</td>
<td>739,560</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>1,586,668</td>
<td>2,619,623</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>442,218</td>
<td>217,989</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>(771,693)</td>
<td>5,445,022</td>
</tr>
<tr>
<td>Accrued medical incentive pools payable</td>
<td>6,133,520</td>
<td>(7,174,335)</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>(948,501)</td>
<td>(885,879)</td>
</tr>
<tr>
<td>NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES</td>
<td>$42,723,384</td>
<td>$(3,645,785)</td>
</tr>
</tbody>
</table>

(Continued)

See accompanying notes.
At December 31, 2017, there was an increase from December 31, 2016 in unrealized appreciation of investments, net of reclassification adjustments, of $5,925,687 with deferred taxes of $(2,275,000). At December 31, 2016, there was an increase from December 31, 2015 in unrealized appreciation of investments, net of reclassification adjustments, of $1,417,135 with deferred taxes of $(603,000).

At December 31, 2017, there were defined benefit pension plan adjustments of $351,515 with deferred taxes of $(136,000). At December 31, 2016, there were defined benefit pension plan adjustments of $(2,006,472) with deferred taxes of $780,000.

At December 31, 2017, the Company recorded accounts receivable of $642 and accrued expenses of $1,088,822 for unsettled purchases and sales of securities. At December 31, 2016, the Company recorded accounts receivable of $27,620 and accounts payable of $1,684,447 for unsettled purchases and sales of securities.

During 2017, the Company reclassified $144,000 from accumulated other comprehensive loss to fund balance (Note 1).

During the year ended December 31, 2016, the Company distributed $22,104,597 of buildings and land to its parent company (Note 2).

See accompanying notes.
1. Organization and Summary of Significant Accounting Policies

PacificSource and its subsidiaries are organized as follows:

- PacificSource
  - PacificSource Health Plans (PSHP)
    - PacificSource Administrators, Inc. (PSA)
    - Primary Health, Inc. (PHI)
    - IPN, Inc. (60%) (IPN)
  - PacificSource Community Health Plans (PCHP)
    - PacificSource Community Solutions (PCS)

PacificSource is an Oregon not-for-profit holding company. PSHP is an independent not-for-profit community health plan offering commercial medical and dental plans in Oregon, Idaho, Montana, and Washington.

PSA is a third-party administrator specializing in administration of flexible spending accounts, health reimbursement arrangements, and COBRA based in Oregon.

PHI is a shell corporation which owns 60% of the outstanding shares of IPN, an Idaho based for-profit non-insurance entity. IPN is a physician contracting network.

PCHP is a not-for-profit health insurance company licensed in the states of Oregon, Idaho, Montana, and Washington. It offers Medicare Advantage and, through their subsidiary PCS, Medicaid plans. On December 31, 2016, PacificSource Community Solutions, Inc. merged into a newly formed not-for-profit corporation, PacificSource Community Solutions.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The relative proportion of gross revenue attributable to each entity for the years ended December 31 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource</td>
<td>593,439</td>
<td>7,208,243</td>
</tr>
<tr>
<td>PSHP</td>
<td>716,520,244</td>
<td>560,875,174</td>
</tr>
<tr>
<td>PCHP and subsidiary</td>
<td>671,100,947</td>
<td>673,810,464</td>
</tr>
<tr>
<td>PSA</td>
<td>4,079,059</td>
<td>4,501,895</td>
</tr>
<tr>
<td>PHI and subsidiary</td>
<td>2,693,497</td>
<td>2,578,282</td>
</tr>
<tr>
<td><strong>Gross revenue</strong></td>
<td><strong>$1,394,987,186</strong></td>
<td><strong>$1,248,974,058</strong></td>
</tr>
</tbody>
</table>

*Principles of Consolidation.* The accompanying consolidated financial statements of PacificSource are consolidated with PSHP and its subsidiaries (collectively the Company). All significant intercompany balances and transactions have been eliminated in the consolidation.

*Basis of Presentation.* The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) that differ from statutory accounting principles used by regulatory authorities.

*Investments.* Investments in debt securities, equity securities, and mutual funds are classified as available-for-sale and are reported at fair value. Realized gains and losses on investments are recognized on the specific identification basis and recorded using the original cost of the security. Changes in fair value of investments are recorded as unrealized depreciation or appreciation directly in the fund balance as other comprehensive income or loss and have no effect on net income or loss. Certificates of deposit that had a maturity of more than three months at the time of acquisition are carried at cost.

Investments in other invested assets consist of an investment in a partnership and are accounted for using the equity method. The equity method of accounting for investments requires the Company to recognize its pro-rata share of the income or loss and distributions of the investments and to increase or decrease the carrying value of the investment accordingly.

*Restricted Deposits.* PSHP, PCHP, and PCS maintain deposits as required by regulatory authorities. At December 31, 2017 and 2016, the Company had total restricted deposits that were included at fair value in investments on the consolidated balance sheets of $271,000 and $2,589,000, respectively. At December 31, 2017 and 2016, the Company had total restricted deposits included in cash and cash equivalents on the consolidated balance sheets of $10,824,722 and $9,497,815, respectively.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Cash Equivalents. For purposes of the consolidated statements of cash flows, the Company considers all highly liquid debt instruments purchased with maturities of three months or less at the time of acquisition to be cash equivalents. Substantially all of the cash and cash equivalents are maintained at various banks whose deposits exceed federally insured limits. The Company has not experienced any losses on such accounts.

Trust Funds. Under the terms of administrative agreements for self-insurance and third-party administrator services, the Company is required to maintain separate cash trust accounts for benefit administration services received for various employers.

Accounts Receivable. Accounts receivable consist primarily of uncollected premiums from policyholders, amounts due from groups under administrative service contracts for uninsured health plans, pharmacy rebates, claims refunds collectible from providers, insureds and third-parties, amounts due under the Patient Protection and Affordable Care Act (ACA) reinsurance, risk corridor and risk adjustment programs, and amounts due for contractual adjustments from the Centers for Medicare and Medicaid Services (CMS).

Management determines and evaluates past due balances on an account-by-account basis, and if amounts become uncollectible, they will be charged to operations when that determination is made. As of December 31, 2017 and 2016, management considered receivables to be fully collectible; accordingly, no allowance for doubtful accounts was considered necessary.

Health Care Reform. The ACA enacted significant reforms to various aspects of the U.S. health insurance industry including an annual premium-based health insurance provider fee and the establishment of federally-facilitated or state-based exchanges. The U.S. Department of Health and Human Services (HHS) pays a portion of the premium and a portion of the claim costs for low-income individual public exchange members. In addition, HHS administers three premium stabilization programs, as described more fully below.

Risk Adjustment. The ACA established a permanent risk adjustment program to transfer funds from qualified individual and small group insurance plans with below average risk scores to plans with above average risk scores. Based on the risk of the Company's qualified plan members relative to the average risk of members of other qualified plans in comparable markets, the Company estimates its ultimate risk adjustment payable or receivable and reflects the impact as an adjustment to premium revenue.

The Company will perform a final reconciliation and settlement with HHS of claims expense and the ACA risk adjustment program during subsequent years.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

**ACA Reinsurance.** The ACA established a temporary three-year reinsurance program, which ended in 2016, under which all issuers of major medical commercial insurance products and self-insured plan sponsors are required to contribute funding in amounts set by HHS. Funds collected will be utilized to reimburse issuer's high claims costs incurred for qualified individual members. The expense related to this required funding is reflected in claims expense - premium taxes and assessments. When annual claim costs incurred by the Company's qualified individual members exceed a specified attachment point, the Company is entitled to certain reimbursements from this program. In 2016, the Company recorded an accrued expense for funding contribution fees under the program. The Company recorded a receivable and offset claims expense to reflect its estimate of these recoveries. There was no expense recorded in 2017 related to the Company's estimated contribution for the funding of the ACA's reinsurance program, as the program expired at the end of 2016.

Premiums ceded under the terms of the ACA reinsurance program were $0 and $3,401,204 in 2017 and 2016, respectively. Reinsurance recoveries were $584,023 and $6,026,154 in 2017 and 2016, respectively. The ACA reinsurance program does not relieve the Company from its primary obligation to policyholders.

**Risk Corridor.** The ACA established a temporary risk sharing program that expired at the end of 2016 for qualified individual and small group insurance plans. Under this program, the Company made (or received) a payment to (or from) HHS based on the ratio of allowable costs to target costs (as defined by the ACA). The Company recorded a risk corridor receivable or payable as an adjustment to premium revenue on a pro-rata year-to-date basis based on its estimate of the ultimate risk sharing amount for that calendar year. At December 31, 2017 and 2016, the Company recorded a receivable of approximately $63,000 and $980,000, respectively, related to the 2014 program year, which is expected to be paid by HHS. The Company did not record any ACA risk corridor receivables related to the 2016 or 2015 program years or any amount in excess of HHS's announced pro-rated funding amount for the 2014 program year because payments from HHS are uncertain.

**Medicare Part D.** The Company covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments received monthly from CMS and members, which are determined from an annual bid, represent amounts for providing prescription drug insurance coverage. The Company recognizes premium revenue for providing insurance coverage ratably over the term of its annual contract. CMS payments are subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, the Company is not at risk for amounts due for reinsurance, low-income cost subsidies, and certain discounts on brand name prescription drugs in the coverage gap. The Company expenses the cost of covered prescription drugs as incurred. Costs associated with low-income Medicare beneficiaries and the catastrophic drug costs paid in advance by CMS are recorded as a liability and offset claims expense when incurred.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The risk corridor provisions compare costs targeted in the Company's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or require refunds to CMS for a portion of the premiums received. The Company records a receivable or payable at the contract level as an adjustment to claims expense based on the timing of expected settlement. The Company performs a reconciliation of the final risk-sharing, low-income subsidy, and catastrophic amounts after the end of each contract year.

Medicare Risk-Score Adjustment. CMS utilizes a risk-score adjustment model which apportions premiums paid to Medicare plans according to health severity. The risk-score adjustment model pays more for enrollees with predictably higher costs, allowing health plans to be paid appropriately based upon members' overall health. Under the risk-score adjustment methodology, new members are assigned a risk score upon enrollment based upon a variety of factors, including demographics and health history. The risk score is then used in an actuarial model to calculate the rates paid to a health plan. The Company estimates risk-score adjustment revenues based on a number of analyses, including retrospective chart reviews of its members performed by a third-party.

Property. Property is stated at cost. Depreciation is computed on the straight-line basis based on the estimated useful lives of the assets. Property additions and improvements are capitalized, while repairs and maintenance are charged to expense as incurred.

Goodwill. The Company assesses goodwill for impairment annually and whenever events or changes in circumstances indicate it may be impaired. When an impairment is indicated, any excess of carrying value over fair value of goodwill is recorded as an operating loss. The Company completed annual tests for impairment at December 31, 2017 and 2016, and determined that the fair value of goodwill exceeded the carrying value, thus goodwill was not considered impaired.

Intangible Assets. Intangible assets with finite lives are amortized on a straight-line basis over their estimated useful lives. Customer relationships and contract arrangements are amortized over two to twelve years. Estimated useful lives of intangible assets are periodically reviewed by management to determine if events or circumstances warrant a change in the remaining useful life of the asset.

The Company assesses the recoverability of intangibles whenever events or changes in circumstances indicate they may be impaired. When an impairment is indicated, any excess of carrying value over fair value of intangibles is recorded as an operating loss. The Company completed tests for impairment at December 31, 2017 and 2016 and determined that the fair value of intangibles exceeded the carrying value, thus intangibles were not considered impaired.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

**Liability for Unpaid Claims and Claims Adjustment Expenses.** The Company establishes a liability, based on actuarial models, for unpaid claims and related administrative costs. The Company does not discount its liability for unpaid claims. The liability is an estimate, and while the Company believes that the amount is adequate, the ultimate liability may be in excess of or less than the amount provided. The estimate is continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in the period in which the revisions are determined. Actual payments will differ from the original estimates and may result in material adjustments to claims expense recorded in future periods.

In May 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2015-09, *Financial Services - Insurance: Disclosures about Short-Duration Contracts*. This update requires new and expanded disclosure related to the liability for unpaid claims and claims adjustment expenses for short-duration insurance contracts. The Company adopted the ASU for the reporting period ending December 31, 2017. The adoption of the ASU did not have a significant impact on the Company's consolidated financial position, results of operations, or cash flows; however, it did require new disclosures in the consolidated financial statements.

**Premium Deficiency Reserve.** The Company reassesses the profitability of its contracts for providing insurance coverage to its members when current operating results or actuarial forecasts indicate probable future losses. The Company establishes a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceed related future premiums under contracts without consideration of investment income. For purposes of premium deficiency losses, contracts are grouped in a manner consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts and represents the Company's best estimate in a range of potential outcomes. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. The Company determined that no premium deficiency existed as of December 31, 2017 and 2016.

**Coordinated Care Organization Risk Sharing.** The Company was awarded the Coordinated Care Organization (CCO) contracts with the state of Oregon which cover the Central Oregon and Gorge regions. Under the terms of the CCO contracts, the Company is subject to various risk sharing targets. Based on an annual review of performance and utilization, the Company may remit amounts to contract participants following the end of the Company's fiscal year. Amounts due under these contract provisions are recorded as accrued expenses on the accompanying consolidated balance sheets.

**Accrued Medical Incentive Pools and Withholds Payable.** The Company contracts with certain medical provider groups to provide healthcare services to plan members that involve risk sharing arrangements. Under the terms of the contracts with participating providers, a percentage of their fees are retained by the Company. Based on an annual review of performance and utilization, surpluses are generally paid to providers and deficits are generally retained by the Company.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Income Taxes. PacificSource is a taxable Oregon nonprofit public benefit corporation. Income taxes are provided for the tax effects of transactions reported in the financial statements and consist of taxes currently due plus deferred taxes. Deferred income taxes arise principally from temporary differences relating to the deferred compensation plan, defined benefit pension plan, unrealized appreciation and depreciation of investments, depreciation and amortization, certain accrued and prepaid expenses, group life insurance and annuity contracts, discounting of the claims provision, partnership differences, goodwill, alternative minimum tax credit carryforwards, charitable contribution carryforwards, and federal and state net operating loss carryforwards. PacificSource files consolidated federal income tax returns with its subsidiaries in accordance with applicable tax law.

On December 22, 2017, congress enacted the Tax Cuts and Jobs Act (the Tax Act) which, among other things, reduced the U.S. federal corporate tax rate from 35% to 21%, eliminated the corporate alternative minimum tax (AMT) and changed how existing AMT credits can be realized, beginning in 2018. As a result of the newly enacted rates, deferred tax assets and liabilities have been remeasured using the expected effective rates at the time each deferred tax asset or liability is expected to reverse in the future, which is generally 21%. Accounting standards require the effects of remeasuring deferred tax balances as a result of newly enacted rates to be recognized as a component of income tax expense in the period in which the legislation is enacted.

As a result of the Tax Act passed by congress, the FASB issued ASU 2018-02, Addressing Stranded Tax Effects Resulting from U.S. Tax Reform. The standard allows the Company to elect to reclassify the income tax effects of the Tax Act on items in accumulated other comprehensive income to fund balance. The Company has elected to adopt this ASU for 2017. As a result of the adoption of ASU 2018-02, the Company has reclassified deferred taxes of $144,000, net, from accumulated other comprehensive loss to fund balance.

Revenue Recognition. Premiums are recognized on a monthly basis over the policy term. Administrative revenues are recognized over the period the service is provided and include the operations of the non-insurance subsidiaries and administrative service contract fees which are received in exchange for performing certain claims processing and member services.

Reinsurance. The Company seeks to limit its loss on any single insured risk and to recover a portion of benefits paid by ceding reinsurance to its reinsurer under excess coverage agreements. Reinsurance agreements do not relieve the Company from its primary obligation to the policyholders, but provide the Company with insurance for large claims. Reinsurance premiums and reinsurance recoveries are offset against claims incurred. Amounts recoverable under reinsurance agreements include such amounts due from the reinsurer for the reimbursement of amounts paid on claims in excess of the insurance risk transferred to the reinsurer.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

Assessments. Assessments are accrued at the time the events occur on which assessments are expected to be based.

Fair Value Measurements. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The fair value framework requires the categorization of assets and liabilities into three levels based upon the ability to observe the assumptions (inputs) used to value the assets and liabilities. Level One provides the most reliable and observable measure of fair value, whereas Level Three generally requires significant judgment. When valuing assets or liabilities, GAAP requires the most observable inputs to be used.

The fair value hierarchy is categorized into three levels based on the inputs as follows:

- **Level One** - Unadjusted, quoted prices in active markets for identical assets and liabilities.
- **Level Two** - Observable inputs, other than those included in Level One. For example, quoted prices for similar assets or liabilities in active markets or quoted prices for identical assets or liabilities in inactive markets.
- **Level Three** - Unobservable inputs reflecting assumptions about the inputs used in pricing the asset or liability.

The fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Estimates. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Concentrations of Credit Risk. The Company's financial instruments that are exposed to concentrations of credit risk consist primarily of debt securities, cash and cash equivalents, reinsurance receivables, and other accounts receivable. Credit risk related to investments varies depending on the nature of the investments. Management believes that its credit risk related to debt securities is limited due to the financial strength of the U.S. Government and supporting corporations securing such investments. Due to the Company's normal operating cash flow requirements, the Company typically has cash and cash equivalents that exceed the Federal Deposit Insurance Corporation (FDIC) coverage or may not be insured at all. Management believes that its credit risk with respect to cash and cash equivalents is minimal due to the relative financial strength of the financial institutions which maintain the Company's bank balances and the short-term nature of its investments.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

The Company evaluates the financial condition of its reinsurers and monitors concentrations of credit risk arising from geographic regions, activities, or economic characteristics of its reinsurers. The Company's reinsurance recoverables are primarily due from third-parties that are rated consistently with companies that are considered to have the ability to meet their obligations. The remainder of the Company's reinsurance recoverables consisted of amounts due from the U.S. government and are therefore considered to have a low credit risk. Credit risk relative to accounts receivable is minimal due to the nature of the receivables and due to the large number of policyholders.

*Business Risks and Uncertainties.* The Company's investments are primarily comprised of debt and equity securities. Significant changes in prevailing interest rates and market conditions may adversely affect the timing and amount of cash flows on such investments and their related values. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is at least reasonably possible that changes in values in the near-term could materially affect the Company's consolidated balance sheets and the amounts reported in the consolidated statements of operations.

The Company invests in mortgage backed securities (MBS) and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount on MBS is based on historical experience and estimates of future payments on the underlying mortgage loans. Actual prepayments will differ from the original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

*Recently Issued Accounting Pronouncements.* In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers.* The standard's core principle is that a company will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. This standard also includes expanded disclosure requirements that result in an entity providing users of financial statements with comprehensive information about the nature, amount, timing, and uncertainty of revenue and cash flows arising from the entity's contracts with customers. This standard will be effective for the Company for the year ending on December 31, 2019. While insurance contracts have been carved out of this standard, the Company is currently in the process of evaluating the impact of adopting the provisions of this ASU on their other revenue streams.

In February 2016, the FASB issued ASU 2016-02, *Leases.* The standard requires all leases with lease terms over 12 months to be capitalized as a right-of-use asset and lease liability on the consolidated balance sheets at the date of lease commencement. Leases will be classified as either finance or operating. This distinction will be relevant for the pattern of expense recognition in the income statement. This standard will be effective for the calendar year ending December 31, 2020. The Company is currently in the process of evaluating the impact of adoption of this ASU on the consolidated financial statements.

(Continued)
1. Organization and Summary of Significant Accounting Policies (Continued)

In January 2016, the FASB issued ASU 2016-01, Recognition and Measurement of Financial Assets and Financial Liabilities. The standard requires equity investments (except those accounted for under the equity method of accounting or those that result in consolidation of the investee) to be measured at fair value with changes recognized in income. The standard will be effective for the Company for the year ending December 31, 2019. Other portions of the ASU were previously adopted by the Company for the year ended December 31, 2015.

Reclassifications. Certain 2016 amounts have been reclassified to conform to 2017 presentation. The reclassifications had no effect on previously reported net loss.

Subsequent Events. Management evaluates events occurring subsequent to the date of the consolidated financial statements in determining the accounting for and disclosure of transactions and events that affect the consolidated financial statements. Subsequent events have been evaluated through May 17, 2018, which is the date the consolidated financial statements were available to be issued.

2. Member Acquisition Agreement

On September 1, 2016, the Company entered into a member acquisition agreement with Legacy Health (Legacy). As part of the agreement, the Company created a not-for-profit organization, Pacific Health Associates (PHA), which has a 50% member interest in the Company. Legacy purchased the remaining 50% member interest. The Company has a Board of Directors made up of an equal number of members designated by PHA and Legacy, as well as three independent members from the community. As part of the transaction, Legacy will make a multi-year capital contribution of $247.5 million, with $100 million paid in 2016, and the remaining balance to be paid over the next five years as certain contract provisions are met. During 2017, Legacy contributed capital of $29.5 million. The Company distributed $22,104,597 of land and buildings to PHA during 2016.

3. Investments

Investments by major class consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debt securities</td>
<td>$ 203,057,165</td>
<td>$ 147,176,658</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>51,932,136</td>
<td>27,161,337</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>1,214,178</td>
<td>899,993</td>
</tr>
<tr>
<td>Other invested assets</td>
<td>490,842</td>
<td>555,010</td>
</tr>
<tr>
<td>Certificates of deposit (restricted)</td>
<td>271,000</td>
<td>2,589,000</td>
</tr>
<tr>
<td>Total</td>
<td>$ 256,965,321</td>
<td>$ 178,381,998</td>
</tr>
</tbody>
</table>

(Continued)
### 3. Investments (Continued)

**Investments in Debt and Equity Securities.** The Company classifies the following investments as available-for-sale and records them at fair value.

The cost and fair value of investments at December 31, 2017 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. government debt securities</td>
<td>$32,693,732</td>
<td>$113,764</td>
<td>$(260,898)</td>
<td>$32,546,598</td>
</tr>
<tr>
<td>Mortgage/asset backed securities</td>
<td>54,830,892</td>
<td>308,288</td>
<td>$(342,819)</td>
<td>54,796,361</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>115,188,390</td>
<td>925,081</td>
<td>$(399,265)</td>
<td>115,714,206</td>
</tr>
<tr>
<td><strong>Total debt securities</strong></td>
<td>202,713,014</td>
<td>1,347,133</td>
<td>$(1,002,982)</td>
<td>203,057,165</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>42,637,062</td>
<td>9,491,962</td>
<td>$(196,888)</td>
<td>51,932,136</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$245,350,076</td>
<td>$10,839,095</td>
<td>$(1,199,870)</td>
<td>$254,989,301</td>
</tr>
</tbody>
</table>

Approximately $2.1 million of gross realized gains and $540,000 of gross realized losses were included in investment income on the consolidated statements of operations for 2017.

The cost and fair value of investments at December 31, 2016 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Cost</th>
<th>Gross Unrealized Appreciation</th>
<th>Gross Unrealized Depreciation</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage/asset backed securities</td>
<td>40,104,560</td>
<td>252,972</td>
<td>$(405,076)</td>
<td>39,952,456</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>74,486,363</td>
<td>306,174</td>
<td>$(875,132)</td>
<td>73,917,405</td>
</tr>
<tr>
<td><strong>Total debt securities</strong></td>
<td>147,973,616</td>
<td>789,361</td>
<td>$(1,586,319)</td>
<td>147,176,658</td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>22,650,841</td>
<td>4,972,374</td>
<td>$(461,878)</td>
<td>27,161,337</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$170,624,457</td>
<td>$5,761,735</td>
<td>$(2,048,197)</td>
<td>$174,337,995</td>
</tr>
</tbody>
</table>

Approximately $2.0 million of gross realized gains and $600,000 of gross realized losses (including $35,000 of bond impairment) were included in investment income on the consolidated statements of operations for 2016.

(Continued)
3. Investments (Continued)

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. Consideration is given to the length of time and the extent to which the fair value has been less than cost, the financial condition, and near-term prospects of the issuer and the intent and ability of the Company to retain its investment for a period of time sufficient to allow for any anticipated recovery in fair value. Based on this analysis, management determined that certain bonds were permanently impaired and recorded a loss of approximately $35,000 during 2016. No bonds were impaired during 2017.

The following table presents the estimated fair value and gross unrealized losses of the Company's investments at December 31, 2017 and 2016, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position:

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th></th>
<th>12 Months or More</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
</tr>
<tr>
<td>Debt securities</td>
<td>$83,650,918</td>
<td>$ (540,497)</td>
<td>$26,270,921</td>
<td>(462,485)</td>
<td>$109,921,839</td>
<td>(1,002,982)</td>
</tr>
<tr>
<td>Equity securities</td>
<td>4,371,305</td>
<td>(136,913)</td>
<td>1,549,864</td>
<td>(59,975)</td>
<td>5,921,169</td>
<td>(196,888)</td>
</tr>
<tr>
<td></td>
<td>$88,022,223</td>
<td>(677,410)</td>
<td>$27,820,785</td>
<td>(522,460)</td>
<td>$115,843,008</td>
<td>(1,199,870)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th></th>
<th>12 Months or More</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
<td>Fair Value</td>
<td>Gross Unrealized Depreciation</td>
</tr>
<tr>
<td>Debt securities</td>
<td>$42,215,245</td>
<td>(1,101,462)</td>
<td>$15,036,158</td>
<td>(484,857)</td>
<td>$57,251,403</td>
<td>(1,586,319)</td>
</tr>
<tr>
<td>Equity securities</td>
<td>2,468,489</td>
<td>(101,264)</td>
<td>3,897,019</td>
<td>(360,614)</td>
<td>6,365,508</td>
<td>(461,878)</td>
</tr>
<tr>
<td></td>
<td>$44,683,734</td>
<td>(1,202,726)</td>
<td>$18,933,177</td>
<td>(845,471)</td>
<td>$63,616,911</td>
<td>(2,048,197)</td>
</tr>
</tbody>
</table>

As of December 31, 2017, the Company had 231 securities in an unrealized loss position. All of these securities had a percentage decline of less than 15%.

At December 31, 2017, debt securities were scheduled to mature as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due in one year or less</td>
<td>$17,854,583</td>
<td>$17,862,046</td>
</tr>
<tr>
<td>Due in one to five years</td>
<td>85,542,166</td>
<td>85,471,008</td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>93,351,052</td>
<td>93,769,586</td>
</tr>
<tr>
<td>Due after ten years</td>
<td>5,965,213</td>
<td>5,954,525</td>
</tr>
<tr>
<td>Total</td>
<td>$202,713,014</td>
<td>$203,057,165</td>
</tr>
</tbody>
</table>

(Continued)
3. Investments (Continued)

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amortized Cost/ Fair Value</th>
<th>Unrealized Appreciation</th>
<th>Tax Effect</th>
<th>Net Unrealized Appreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2017</td>
<td>$245,350,076 $254,989,301</td>
<td>$9,639,225</td>
<td>$(2,487,000)</td>
<td>$7,152,225</td>
</tr>
<tr>
<td>Less December 31, 2016</td>
<td>170,624,457 174,337,995</td>
<td>3,713,538</td>
<td>(1,492,000)</td>
<td>2,221,538</td>
</tr>
<tr>
<td>Change in unrealized appreciation</td>
<td></td>
<td>$5,925,687</td>
<td>$(995,000)</td>
<td>$4,930,687</td>
</tr>
</tbody>
</table>

Investment expense was approximately $497,000 and $326,000 for the years ended December 31, 2017 and 2016, respectively.

*Other Invested Assets.* Other invested assets consist of an investment in a partnership that is accounted for using the equity method. The percentage of the Company's ownership in this investment varies based upon total investment in the secondary market.

4. Accounts Receivable

Accounts receivable at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncollected premiums from policyholders</td>
<td>$16,874,824</td>
<td>$10,884,617</td>
</tr>
<tr>
<td>Pharmacy rebates</td>
<td>15,134,591</td>
<td>15,120,841</td>
</tr>
<tr>
<td>Medicare risk score</td>
<td>14,171,000</td>
<td>12,007,000</td>
</tr>
<tr>
<td>Amounts due from groups under administrative service contracts</td>
<td>8,634,846</td>
<td>5,113,362</td>
</tr>
<tr>
<td>Other</td>
<td>5,660,003</td>
<td>6,291,141</td>
</tr>
<tr>
<td>Reinsurance recoverable</td>
<td>4,590,186</td>
<td>4,647,219</td>
</tr>
<tr>
<td>ACA reinsurance</td>
<td>936,181</td>
<td>8,263,775</td>
</tr>
<tr>
<td>ACA risk corridor</td>
<td>62,532</td>
<td>979,283</td>
</tr>
<tr>
<td>ACA risk adjustment</td>
<td>-</td>
<td>10,879,009</td>
</tr>
<tr>
<td>Total</td>
<td>$66,064,163</td>
<td>$74,186,247</td>
</tr>
</tbody>
</table>
5. Property

Major classes of property at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture and fixtures</td>
<td>$4,916,451</td>
<td>$4,219,178</td>
</tr>
<tr>
<td>Office equipment</td>
<td>7,282,271</td>
<td>5,272,305</td>
</tr>
<tr>
<td>Software</td>
<td>15,936,950</td>
<td>15,045,846</td>
</tr>
<tr>
<td>Automobiles</td>
<td>131,065</td>
<td>103,897</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>353,110</td>
<td>344,895</td>
</tr>
<tr>
<td>Construction-in-process</td>
<td>1,146,127</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>29,765,974</td>
<td>24,986,121</td>
</tr>
<tr>
<td>Less accumulated depreciation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20,886,170</td>
<td>18,032,537</td>
</tr>
<tr>
<td>Total</td>
<td>$8,879,804</td>
<td>$6,953,584</td>
</tr>
</tbody>
</table>

During the year ended December 31, 2016, the Company distributed all of its land and buildings to PHA (Note 2).

6. Intangible Assets

Major classes of intangible assets at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer relationships</td>
<td>$6,083,630</td>
<td>$6,083,630</td>
</tr>
<tr>
<td>Contractual arrangements</td>
<td>3,785,235</td>
<td>3,785,235</td>
</tr>
<tr>
<td></td>
<td>9,868,865</td>
<td>9,868,865</td>
</tr>
<tr>
<td>Less accumulated amortization</td>
<td>6,555,622</td>
<td>4,350,707</td>
</tr>
<tr>
<td>Total</td>
<td>$3,313,243</td>
<td>$5,518,158</td>
</tr>
</tbody>
</table>

Intangible assets with finite lives are amortized using the straight-line method over their estimated useful lives, which range from two to twelve years. Amortization expense is expected to be as follows for each of the succeeding five years: 2018, $2,204,914; 2019, $514,257; 2020, $286,910; 2021, $286,910; and 2022, $20,252.
7. Liability for Unpaid Claims and Claims Adjustment Expenses

The liability for unpaid claims and claims adjustment expenses is based on the estimated amount payable on claims reported prior to the consolidated balance sheets date that have not yet been settled, claims reported subsequent to the consolidated balance sheets date that have been incurred during the period then ended, and an estimate based on prior experience of incurred but unreported claims relating to such period. Claim frequency is not used in the calculation of the liability, as it is impracticable to gather such information.

Incurred and cumulative paid claims developments as of December 31, 2017, net of reinsurance, is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incurred claims:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>$1,152,600,830</td>
<td>$1,148,088,203</td>
</tr>
<tr>
<td>2017</td>
<td>1,242,063,019</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$2,390,151,222</td>
</tr>
<tr>
<td>Cumulative paid claims:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>$(1,037,265,068)</td>
<td>$(1,147,886,974)</td>
</tr>
<tr>
<td>2017</td>
<td>(1,111,065,904)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$(2,258,952,878)</td>
</tr>
<tr>
<td>All outstanding liabilities before 2016, net of reinsurance</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total unpaid claims and claims adjustment expenses</td>
<td>$131,198,344</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
7. Liability for Unpaid Claims and Claims Adjustment Expenses (Continued)

Activity in the liability for unpaid claims and claims adjustment expenses is summarized as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unpaid claims and claims adjustment expenses, January 1</td>
<td>$115,335,762</td>
<td>$119,306,910</td>
</tr>
<tr>
<td>Less reinsurance receivable</td>
<td>(12,910,994)</td>
<td>(23,877,776)</td>
</tr>
<tr>
<td>Net balance</td>
<td>102,424,768</td>
<td>95,429,134</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incurred related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>1,249,447,646</td>
<td>1,163,567,612</td>
</tr>
<tr>
<td>Prior years</td>
<td>(4,512,627)</td>
<td>(7,875,278)</td>
</tr>
<tr>
<td>Total incurred</td>
<td>1,244,935,019</td>
<td>1,155,692,334</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid related to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current year</td>
<td>(1,111,065,904)</td>
<td>(1,037,265,068)</td>
</tr>
<tr>
<td>Prior years</td>
<td>(110,621,906)</td>
<td>(111,431,632)</td>
</tr>
<tr>
<td>Total paid</td>
<td>(1,221,687,810)</td>
<td>(1,148,696,700)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net balance</td>
<td>125,671,977</td>
<td>102,424,768</td>
</tr>
<tr>
<td>Plus reinsurance receivable</td>
<td>5,526,367</td>
<td>12,910,994</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses, December 31</td>
<td>$131,198,344</td>
<td>$115,335,762</td>
</tr>
</tbody>
</table>

At December 31, 2017, total unpaid claims and claims adjustment expenses plus expected development on reported claims totaled approximately $131,198,344. Substantially all of the total unpaid claims plus expected development on reported claims at December 31, 2017 related to the current year. As a result of changes in estimates of insured events in prior years, the liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $5,526,367) decreased by $4,512,627 in 2017. The liability for unpaid claims and claims adjustment expenses (net of reinsurance recoveries of $12,910,994) decreased by $7,875,278 in 2016. The Company records a liability for unpaid claims and claims adjustment expenses that include an allowance for potential shock claims.
8. Accrued Expenses

Accrued expenses at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCO risk sharing</td>
<td>$16,578,049</td>
<td>$19,154,749</td>
</tr>
<tr>
<td>Accrued payroll and taxes</td>
<td>7,900,190</td>
<td>6,435,594</td>
</tr>
<tr>
<td>ACA risk adjustment</td>
<td>6,646,790</td>
<td>-</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>3,697,653</td>
<td>3,109,018</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>3,660,000</td>
<td>5,570,000</td>
</tr>
<tr>
<td>Other</td>
<td>3,738,922</td>
<td>2,940,299</td>
</tr>
<tr>
<td>Securities payable</td>
<td>595,625</td>
<td>1,684,447</td>
</tr>
<tr>
<td>ACA reinsurance</td>
<td>-</td>
<td>3,425,276</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$42,817,229</strong></td>
<td><strong>$42,319,383</strong></td>
</tr>
</tbody>
</table>

9. Notes Payable

Notes payable consisted of the following at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notes payable to individuals, due in monthly installments of $20,634, including interest at the prime rate plus 2% adjusted annually, not to be less than 7% or exceed 10% (effective rate of 7% at December 31, 2017), collateralized by business assets, matures March 2018.</td>
<td>$61,154</td>
<td>$295,375</td>
</tr>
</tbody>
</table>

The estimated aggregate principal payments on notes payable maturities is $61,154 in 2018.
10. Retirement Plans

The Company has a non-contributory pension plan (defined benefit plan) and a participatory retirement plan (401(k)). The 401(k) plan covers substantially all employees.

The defined benefit plan benefits are based on years of service and the employee's compensation during employment before the plan was frozen. The Company contributes at least the minimum funding required annually. Effective December 31, 2012, the benefits associated with the plan were frozen.

The following table sets forth the defined benefit plan's funded status and amounts recognized in the Company's consolidated financial statements at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation for service rendered to date</td>
<td>$ (37,974,509)</td>
<td>$ (34,474,251)</td>
</tr>
<tr>
<td>Plan assets at fair value</td>
<td>33,646,047</td>
<td>30,236,492</td>
</tr>
<tr>
<td>Funded status</td>
<td>$ (4,328,462)</td>
<td>$ (4,237,759)</td>
</tr>
</tbody>
</table>

Change in projected benefit obligation:

- Projected benefit obligation, beginning of year $34,474,251 $31,457,623
- Interest cost 1,411,304 1,384,765
- Benefits paid and administrative expenses (1,000,772) (1,028,250)
- Actuarial loss 3,089,726 2,660,113

Projected benefit obligation, end of year $37,974,509 $34,474,251

Change in fair value of plan assets:

- Fair value of plan assets, beginning of year $30,236,492 $29,444,325
- Actual return on plan assets 4,410,327 1,820,417
- Benefits paid (1,000,772) (1,028,250)

Fair value of plan assets, end of year $33,646,047 $30,236,492

(Continued)
10. Retirement Plans (Continued)

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net periodic benefit cost:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest cost</td>
<td>$ 1,411,304</td>
<td>$ 1,384,765</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(1,867,374)</td>
<td>(1,851,556)</td>
</tr>
<tr>
<td>Amortization of loss</td>
<td>898,288</td>
<td>684,780</td>
</tr>
<tr>
<td><strong>Total net periodic benefit cost</strong></td>
<td>$ 442,218</td>
<td>$ 217,989</td>
</tr>
<tr>
<td><strong>Amounts recognized in accumulated other comprehensive loss:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss</td>
<td>$ 10,758,304</td>
<td>$ 11,109,819</td>
</tr>
<tr>
<td><strong>Total accumulated other comprehensive loss</strong></td>
<td>$ 10,758,304</td>
<td>$ 11,109,819</td>
</tr>
<tr>
<td><strong>Changes in other comprehensive loss:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss</td>
<td>$ 546,773</td>
<td>$ 2,691,252</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>(898,288)</td>
<td>(684,780)</td>
</tr>
<tr>
<td><strong>Total recognized in other comprehensive loss</strong></td>
<td>$ (351,515)</td>
<td>$ 2,006,472</td>
</tr>
<tr>
<td><strong>Accumulated benefit obligation, end of year</strong></td>
<td>$ 37,974,509</td>
<td>$ 34,474,251</td>
</tr>
</tbody>
</table>

The Company estimates net loss, prior service cost, and transition obligation for the defined benefit plan that will be amortized into periodic benefit cost in 2018 to be $838,657, $0, and $0, respectively.

The Company does not expect to make any contribution to its defined benefit plan in 2018. Future anticipated benefit payments from the defined benefit pension plan are as follows: 2018, $2,625,977; 2019, $1,927,451; 2020, $2,095,846; 2021, $2,238,355; 2022, $2,087,923; and from 2023 to 2027, $7,740,040.

(Continued)
10. Retirement Plans (Continued)

Assumptions used in the accounting for the defined benefit pension plan were as follows at December 31:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assumptions used for net periodic benefit costs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discount rate used in determining present values</td>
<td>4.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Annual increase in future compensation levels</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expected long-term rate of return on assets</td>
<td>6.4%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

| Assumptions used to determine benefit obligation: |      |      |
| Discount rate used in determining present values | 3.7% | 4.2% |
| Rate of compensation increase | N/A  | N/A  |

Measurement date

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31</td>
<td>December 31</td>
<td></td>
</tr>
</tbody>
</table>

The plan assets are invested in the following asset classes:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity investments</td>
<td>66%</td>
<td>60%</td>
</tr>
<tr>
<td>Debt investments</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>Real estate</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

| Total            | 100% | 100% |

The plan assets are invested in a variety of bond and equity mutual funds. The targeted composition is set by the Company and reallocated periodically. The Company's expected rate of return on plan assets is determined by the plan assets' historical long-term investment performance, current asset allocation, and estimates of future long-term returns by asset class.

The 401(k) plan provides for voluntary employee contributions with employer matching. The plan requires a 50% Company match on eligible elective deferrals. Elective deferrals in excess of 6% of eligible employee compensation are not eligible to receive a match. In both 2017 and 2016, in addition to the annual matching contributions, the Company made a 3% discretionary non-elective contribution for all eligible employees. Company contributions under the plan were $3,294,951 and $2,859,809 in 2017 and 2016, respectively.
11. Income Taxes

PacificSource files a consolidated federal income tax return with its subsidiaries on the basis of its annual GAAP financial statements adjusted for the tax regulations. PacificSource files state income tax returns based on the annual statements that are filed with the insurance regulatory authorities for PSHP and PCHP. The Company files on the basis of its annual GAAP financial statements adjusted for the state tax regulations for the remaining subsidiaries. The allocation methodology under the adopted tax sharing agreement applies the projected consolidated group income tax rate to the entities based on pre-tax net income. Federal income taxes are settled between PacificSource and its subsidiaries based on the tax sharing agreement.

The provision for income taxes consists of the following:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current income tax expense:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal</td>
<td>$3,623,574</td>
<td>$9,628,797</td>
</tr>
<tr>
<td>State</td>
<td>1,181,746</td>
<td>2,236,514</td>
</tr>
<tr>
<td><strong>Total current income tax expense</strong></td>
<td><strong>4,805,320</strong></td>
<td><strong>11,865,311</strong></td>
</tr>
<tr>
<td>Deferred tax expense (benefit)</td>
<td>7,602,000</td>
<td>(2,209,000)</td>
</tr>
<tr>
<td><strong>Total income tax expense</strong></td>
<td><strong>$12,407,320</strong></td>
<td><strong>$9,656,311</strong></td>
</tr>
</tbody>
</table>

The reconciliation between federal taxes at the statutory rate and the Company's income taxes are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax expense (benefit) computed at statutory rate</td>
<td>$14,325,000</td>
<td>$(87,000)</td>
</tr>
<tr>
<td>State tax expense (benefit), net of federal income tax benefit</td>
<td>2,022,000</td>
<td>(12,000)</td>
</tr>
<tr>
<td>Prior year true-ups and other permanent differences</td>
<td>126,320</td>
<td>101,311</td>
</tr>
<tr>
<td>Change in rates due to tax law</td>
<td>(4,066,000)</td>
<td>-</td>
</tr>
<tr>
<td>Tax effect of health insurance provider fee</td>
<td>-</td>
<td>5,687,000</td>
</tr>
<tr>
<td>Tax effect of distribution of property</td>
<td>-</td>
<td>3,967,000</td>
</tr>
<tr>
<td><strong>Total income tax expense</strong></td>
<td><strong>$12,407,320</strong></td>
<td><strong>$9,656,311</strong></td>
</tr>
</tbody>
</table>

(Continued)
11. Income Taxes (Continued)

Deferred income tax assets and liabilities at December 31 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deferred tax assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accruals</td>
<td>$ 2,243,000</td>
<td>$ 2,604,000</td>
</tr>
<tr>
<td>Federal and state net operating loss carryforwards</td>
<td>1,263,000</td>
<td>1,882,000</td>
</tr>
<tr>
<td>Defined benefit pension plan</td>
<td>1,117,000</td>
<td>1,656,000</td>
</tr>
<tr>
<td>Partnership difference</td>
<td>503,000</td>
<td>831,000</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>476,000</td>
<td>559,000</td>
</tr>
<tr>
<td>Discount of claims provision</td>
<td>327,000</td>
<td>462,000</td>
</tr>
<tr>
<td>Deferred rent</td>
<td>181,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total deferred tax assets</strong></td>
<td><strong>6,110,000</strong></td>
<td><strong>7,994,000</strong></td>
</tr>
<tr>
<td><strong>Deferred tax liabilities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepaids</td>
<td>(9,611,000)</td>
<td>(1,661,000)</td>
</tr>
<tr>
<td>Unrealized gains</td>
<td>(2,487,000)</td>
<td>(1,492,000)</td>
</tr>
<tr>
<td>Property</td>
<td>(1,876,000)</td>
<td>(3,039,000)</td>
</tr>
<tr>
<td>Rebate guarantee</td>
<td>(364,000)</td>
<td>-</td>
</tr>
<tr>
<td>Subsidiary equity income</td>
<td>(49,000)</td>
<td>(66,000)</td>
</tr>
<tr>
<td><strong>Total deferred tax liabilities</strong></td>
<td><strong>(14,387,000)</strong></td>
<td><strong>(6,258,000)</strong></td>
</tr>
<tr>
<td><strong>Net deferred tax (liabilities) assets</strong></td>
<td><strong>$ (8,277,000)</strong></td>
<td><strong>$ 1,736,000</strong></td>
</tr>
</tbody>
</table>

As of December 31, 2017, the Company recognized a deferred tax asset of $1,263,000 for the anticipated utilization of federal and state net operating loss carryforwards. Federal net operating loss carryforwards of $4,226,972 will expire in 2028, if not used before then. State net operating loss carryforwards of $6,366,582 will expire on various dates through 2034.

The Company is required to record a valuation allowance when it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of the deferred tax assets depends on the ability to generate sufficient taxable income in the future. Based on its profitable operating results in previous years, together with management's intention and active pursuit of strategies to remain successful in the health insurance industry, no valuation allowance has been recorded because it appears more likely than not that the full tax benefit of deferred tax assets will be realized.
12. Reinsurance

The Company was reinsured against inpatient hospital costs and ancillary outpatient services under the terms of an excess liability policy. The following is a summary of the general coverage levels at December 31, 2017 in order of their application:

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10% up to $100,000</td>
<td>$1,000,000</td>
<td>$1,000,000 per member</td>
</tr>
<tr>
<td>Layer 2</td>
<td>10% up to $300,000</td>
<td>$2,000,000</td>
<td>$3,000,000 per member</td>
</tr>
<tr>
<td>Layer 3</td>
<td>$ -</td>
<td>$5,000,000</td>
<td>$5,000,000 per member</td>
</tr>
<tr>
<td>Layer 4</td>
<td>$ -</td>
<td>Unlimited</td>
<td>$10,000,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Retention</th>
<th>Deductible</th>
<th>Aggregate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Layer 1</td>
<td>10%</td>
<td>$400,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Premiums ceded under the terms of the non-ACA reinsurance policies were $7,964,808 and $8,190,011 in 2017 and 2016, respectively. Reinsurance recoveries were $4,613,571 and $6,842,251 in 2017 and 2016, respectively. The reinsurance contracts do not relieve the Company from its primary obligation to policyholders.
13. Leases

The Company leases office space at various locations in Oregon, Idaho, and Montana under general operating lease agreements with various expirations through 2029. The Company is responsible for substantially all executory costs under the agreements. Certain agreements contain annual rent adjustments or other rent escalations which the Company is required to pay.

Minimum aggregate future lease payments under all non-cancelable third-party operating leases as of December 31, 2017 are summarized as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$ 2,245,974</td>
</tr>
<tr>
<td>2019</td>
<td>2,289,458</td>
</tr>
<tr>
<td>2020</td>
<td>2,208,983</td>
</tr>
<tr>
<td>2021</td>
<td>1,572,494</td>
</tr>
<tr>
<td>2022</td>
<td>1,298,778</td>
</tr>
<tr>
<td>Thereafter</td>
<td>6,586,724</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 16,202,411</strong></td>
</tr>
</tbody>
</table>

The Company leases office space in Springfield, Oregon and Bend, Oregon from PHA with expirations in 2028. The Company is responsible for substantially all executory costs under the agreements. The agreements contain annual rent escalations which the Company is required to pay. Rent expense paid to PHA totaled approximately $2,853,000 and $923,000 in 2017 and 2016, respectively.

Minimum aggregate future lease payments under all related-party operating leases as of December 31, 2017 are summarized as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$ 2,938,634</td>
</tr>
<tr>
<td>2019</td>
<td>3,026,793</td>
</tr>
<tr>
<td>2020</td>
<td>3,117,597</td>
</tr>
<tr>
<td>2021</td>
<td>3,211,125</td>
</tr>
<tr>
<td>2022</td>
<td>3,307,458</td>
</tr>
<tr>
<td>Thereafter</td>
<td>22,035,816</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 37,637,423</strong></td>
</tr>
</tbody>
</table>

Total amounts charged to rent expense for the various operating leases were $5,731,621 and $2,618,637 for 2017 and 2016, respectively.
14. Litigation and Commitments

The Company, consistent with the insurance industry in general, is subject to litigation in the normal course of business. The Company's management does not believe that such litigation will have a material effect on its financial position.

The Company is subject to an annual fee under the ACA which is not deductible for tax purposes. This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. During 2016, the Company paid $15,369,132 related to 2015 net premiums written. There was a moratorium on the annual health insurance industry fee for payment year 2017 and, as such, no amounts were due in 2017 related to the premiums written by the Company in 2016. As the moratorium on the annual health insurance industry fee ended after payment year 2017, the Company estimates their payment due in 2018 related to premiums written in 2017 will be approximately $15,000,000.

15. Related Party Transactions

The Company entered into an administrative service agreement with PHA whereby it performs certain accounting and oversight functions on PHA's behalf. Total amounts collected under this agreement in 2017 were approximately $83,000. No amounts were collected in 2016.

16. Fair Value of Financial Instruments

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2017. Valuation techniques utilized to determine fair value are consistently applied.

Investments in equity securities are classified as available-for-sale and are reported at fair value. These securities are traded in active markets and are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.

(Continued)
16. Fair Value of Financial Instruments (Continued)

Investments in debt securities are classified as available-for-sale and are reported at fair value. Investments in U.S. government debt securities are traded in active markets and valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy. The fair value of all other debt instruments are estimated using recently executed transactions, market price quotations (where observable), bond spreads, or credit default swap spreads. The spread data used are for the same maturity as the bond. If the spread data does not reference the issuer, then data that references a comparable issuer is used. Where observable price quotations are not available, fair value is determined based on cash flow models with yield curves, bond or single-name credit default swap spreads, and recovery rates based on collateral values as key inputs. They are generally categorized in Level Two of the fair value hierarchy.

Fair values of assets and liabilities measured on a recurring basis are as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Fair Value Measurement</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Quoted Prices in Active Markets for Identical Assets</td>
<td>Significant Other Observable Inputs</td>
<td>Significant Unobservable Inputs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Level One)</td>
<td>(Level Two)</td>
<td>(Level Three)</td>
<td></td>
</tr>
<tr>
<td>December 31, 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. government debt securities</td>
<td>$32,546,589</td>
<td>$32,546,589</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>54,796,361</td>
<td></td>
<td>-</td>
<td>54,796,361</td>
<td></td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>115,714,206</td>
<td></td>
<td>-</td>
<td>115,714,206</td>
<td></td>
</tr>
<tr>
<td>Total debt securities</td>
<td>203,057,156</td>
<td>32,546,589</td>
<td>170,510,567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>51,932,136</td>
<td>51,932,136</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 31, 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale debt securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>U.S. government debt securities</td>
<td>$33,306,797</td>
<td>$33,306,797</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>39,952,456</td>
<td></td>
<td>-</td>
<td>39,952,456</td>
<td></td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>73,917,405</td>
<td></td>
<td>-</td>
<td>73,917,405</td>
<td></td>
</tr>
<tr>
<td>Total debt securities</td>
<td>147,176,658</td>
<td>33,306,797</td>
<td>113,869,861</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>27,161,337</td>
<td>27,161,337</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
16. Fair Value of Financial Instruments (Continued)

The following presents a summary of the Company's defined benefit plan investment assets measured at fair value:

<table>
<thead>
<tr>
<th>Description</th>
<th>Fair Value Measurement</th>
<th>December 31, 2017</th>
<th>December 31, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Quoted Prices in Active Markets for Identical Assets (Level One)</td>
<td>Significant Other Observable Inputs (Level Two)</td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$ 8,221,619</td>
<td>$ 8,221,619</td>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>12,330,581</td>
<td>12,330,581</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>7,340,551</td>
<td>7,340,551</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>4,154,931</td>
<td>4,154,931</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,598,365</td>
<td>1,598,365</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$ 33,646,047</td>
<td>$ 33,646,047</td>
<td>-</td>
</tr>
</tbody>
</table>

The following is a description of the valuation methodologies used for the Company's defined benefit plan investment assets measured at fair value.

Registered investment companies are valued at quoted market prices. They are generally categorized in Level One of the fair value hierarchy.
17. Statutory Financial Information

PSHP and PCHP, which are domiciled in Oregon, prepare their statutory basis financial statements in accordance with accounting principles and practices prescribed or permitted by the State of Oregon, Department of Consumer and Business Services, Division of Financial Regulation. Oregon has adopted the National Association of Insurance Commissioners statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practices.

PSHP and PCHP follow NAIC SAP and do not have permitted practices that deviate from NAIC SAP. PSHP and PCHP's statutory capital and surplus were sufficient to satisfy regulatory requirements at December 31, 2017.
<table>
<thead>
<tr>
<th>Item</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries</td>
<td>$50,747,510</td>
<td>$43,609,780</td>
</tr>
<tr>
<td>Payroll taxes</td>
<td>4,439,432</td>
<td>3,686,780</td>
</tr>
<tr>
<td>Employee benefits</td>
<td>11,595,275</td>
<td>9,911,839</td>
</tr>
<tr>
<td>Retirement plans</td>
<td>3,075,256</td>
<td>2,498,591</td>
</tr>
<tr>
<td>Administrative expense, net</td>
<td>842,587</td>
<td>1,274,066</td>
</tr>
<tr>
<td>Advertising</td>
<td>4,456,797</td>
<td>4,439,359</td>
</tr>
<tr>
<td>Auditing and tax services</td>
<td>591,702</td>
<td>689,819</td>
</tr>
<tr>
<td>Automobile expense</td>
<td>456,747</td>
<td>404,953</td>
</tr>
<tr>
<td>Banking charges</td>
<td>968,019</td>
<td>600,241</td>
</tr>
<tr>
<td>Board expenses</td>
<td>419,549</td>
<td>389,413</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>349,132</td>
<td>465,970</td>
</tr>
<tr>
<td>Consultant fees</td>
<td>1,995,033</td>
<td>2,158,211</td>
</tr>
<tr>
<td>Contract labor</td>
<td>1,157,298</td>
<td>1,436,245</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>6,044,537</td>
<td>5,757,569</td>
</tr>
<tr>
<td>Education and training</td>
<td>296,189</td>
<td>292,604</td>
</tr>
<tr>
<td>Health insurance provider fee</td>
<td>-</td>
<td>15,369,132</td>
</tr>
<tr>
<td>Imaging expense</td>
<td>298,865</td>
<td>287,992</td>
</tr>
<tr>
<td>Insurance</td>
<td>1,146,509</td>
<td>858,087</td>
</tr>
<tr>
<td>Legal fees</td>
<td>273,831</td>
<td>290,922</td>
</tr>
<tr>
<td>Meals and entertainment</td>
<td>662,337</td>
<td>614,150</td>
</tr>
<tr>
<td>Office expenses and supplies</td>
<td>1,254,390</td>
<td>1,866,705</td>
</tr>
<tr>
<td>Postage</td>
<td>2,780,917</td>
<td>2,375,948</td>
</tr>
<tr>
<td>Printing expense</td>
<td>1,959,286</td>
<td>1,405,904</td>
</tr>
<tr>
<td>Professional dues</td>
<td>305,972</td>
<td>316,121</td>
</tr>
<tr>
<td>Purchased services</td>
<td>4,081,671</td>
<td>3,888,526</td>
</tr>
<tr>
<td>Recruiting</td>
<td>183,351</td>
<td>314,082</td>
</tr>
<tr>
<td>Rent - equipment</td>
<td>101,680</td>
<td>115,284</td>
</tr>
<tr>
<td>Rent - regional offices</td>
<td>5,731,621</td>
<td>2,618,637</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>681,250</td>
<td>1,298,927</td>
</tr>
<tr>
<td>Software licenses</td>
<td>5,895,084</td>
<td>4,609,969</td>
</tr>
<tr>
<td>Subscriptions</td>
<td>72,930</td>
<td>121,547</td>
</tr>
<tr>
<td>Surveys and studies</td>
<td>9,016</td>
<td>21,336</td>
</tr>
<tr>
<td>Taxes and licenses</td>
<td>784,498</td>
<td>714,675</td>
</tr>
<tr>
<td>Telephone</td>
<td>718,814</td>
<td>698,705</td>
</tr>
<tr>
<td>Travel</td>
<td>1,034,917</td>
<td>936,747</td>
</tr>
<tr>
<td>Utilities</td>
<td>280,241</td>
<td>277,703</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$115,692,243</strong></td>
<td><strong>$116,616,541</strong></td>
</tr>
</tbody>
</table>
The financial statements omit substantially all of the disclosures and the statements of cash flows and comprehensive income required by accounting principles generally accepted in the United States of America, and no assurance is provided on these financial statements.
Consolidating Statement of Operations
Year Ended December 31, 2017

<table>
<thead>
<tr>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
<th>Eliminations</th>
<th>Consolidated Total</th>
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<tr>
<td><strong>PREMIUMS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$ -</td>
<td>$ 70,494,785</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
<td>$ 70,494,785</td>
</tr>
<tr>
<td>Medicare</td>
<td>-</td>
<td>-</td>
<td>357,594,116</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>357,594,116</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>313,506,831</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>313,506,831</td>
</tr>
<tr>
<td><strong>CLAIMS EXPENSE:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>-</td>
<td>607,611,592</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(290,298)</td>
</tr>
<tr>
<td>Medicare</td>
<td>-</td>
<td>-</td>
<td>325,785,456</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>325,785,456</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>283,779,640</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>283,779,640</td>
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<tr>
<td>Commissions on premiums</td>
<td>-</td>
<td>16,129,117</td>
<td>4,616,995</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20,746,112</td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>-</td>
<td>5,102,909</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5,102,909</td>
</tr>
<tr>
<td><strong>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</strong></td>
<td>-</td>
<td>76,106,167</td>
<td>27,191,665</td>
<td>29,727,191</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>290,298</td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE REVENUES</strong></td>
<td>4,794,045</td>
<td>11,570,459</td>
<td>-</td>
<td>-</td>
<td>2,983,795</td>
<td>4,079,059</td>
<td>(4,490,904)</td>
<td>18,936,454</td>
</tr>
<tr>
<td><strong>UNDERWRITING GAIN (LOSS)</strong></td>
<td>4,794,045</td>
<td>20,411,589</td>
<td>3,230,740</td>
<td>9,013,676</td>
<td>(1,536,865)</td>
<td>266,579</td>
<td>379,768</td>
<td>-</td>
</tr>
<tr>
<td><strong>OTHER INCOME (EXPENSE):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment income</td>
<td>1,507,760</td>
<td>4,088,010</td>
<td>1,709,319</td>
<td>2,094,148</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>9,399,243</td>
</tr>
<tr>
<td>Interest expense (income)</td>
<td>(920,404)</td>
<td>(45,245)</td>
<td>-</td>
<td>920,404</td>
<td>-</td>
<td>-</td>
<td>(14,120)</td>
<td>(59,365)</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(557,164)</td>
<td>(113,710)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(670,874)</td>
<td>-</td>
</tr>
<tr>
<td>Miscellaneous (expense) income</td>
<td>(2,471,220)</td>
<td>(1,194,942)</td>
<td>(63,564)</td>
<td>(77,346)</td>
<td>(497,917)</td>
<td>-</td>
<td>5,498</td>
<td>(4,299,491)</td>
</tr>
<tr>
<td>Income from subsidiaries</td>
<td>26,882,908</td>
<td>10,557,354</td>
<td>7,515,545</td>
<td>-</td>
<td>111,963</td>
<td>-</td>
<td>-</td>
<td>(45,067,770)</td>
</tr>
<tr>
<td><strong>INCOME (LOSS) BEFORE INCOME TAXES</strong></td>
<td>24,441,880</td>
<td>13,291,467</td>
<td>9,161,300</td>
<td>29,727,191</td>
<td>2,937,206</td>
<td>385,954</td>
<td>(8,816)</td>
<td>(45,067,770)</td>
</tr>
<tr>
<td><strong>INCOME TAX EXPENSE (BENEFIT)</strong></td>
<td>29,235,925</td>
<td>33,703,056</td>
<td>12,392,040</td>
<td>29,727,191</td>
<td>(1,922,819)</td>
<td>266,579</td>
<td>371,152</td>
<td>(45,067,770)</td>
</tr>
<tr>
<td><strong>TOTAL INCOME (LOSS)</strong></td>
<td>4,794,045</td>
<td>6,820,148</td>
<td>7,515,545</td>
<td>(1,469,425)</td>
<td>186,605</td>
<td>348,270</td>
<td>-</td>
<td>45,067,770</td>
</tr>
<tr>
<td><strong>LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>NET INCOME (LOSS)</strong></td>
<td>28,447,083</td>
<td>26,882,908</td>
<td>11,678,509</td>
<td>7,515,545</td>
<td>(1,469,425)</td>
<td>111,963</td>
<td>348,270</td>
<td>(45,067,770)</td>
</tr>
</tbody>
</table>

The financial statements omit substantially all of the disclosures and the statements of cash flows and comprehensive income required by accounting principles generally accepted in the United States of America, and no assurance is provided on these financial statements.
Attachment 13 — Attestations

Applicant Name: PacificSource Community Solutions
Authorizing Signature: 
Printed Name: Kenneth P. Provencher

Instructions: For each attestation, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no.” Applicant must respond to all attestations. If an attestation has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract
   a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?
      ☑ Yes ☐ No
      If “no” please provide explanation:
   b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?
      ☑ Yes ☐ No
      If “no” please provide explanation:

2. Subcontracts
   a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?
      ☑ Yes ☐ No
      If “no” please provide explanation:
   b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?
      ☑ Yes ☐ No
      If “no” please provide explanation:
   c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?
      ☑ Yes ☐ No
      If “no” please provide explanation:
3. Third Party Liability and Personal Injury Lien
   a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member’s Third Party Liability?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ______________________________

   b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ______________________________

   c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ______________________________

   d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ______________________________

4. Oversight and Governance
   a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ______________________________

B. Provider Participation and Operations Attestations (Attachment 7)
   1. General Questions
      a. Will Applicant have an individual accountable for each of the operational functions described below?
         • Contract administration
         • Outcomes and evaluation
         • Performance measurement
         • Health management and Care Coordination activities
         • System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
         • Behavioral Health (mental health and addictions) coordination and system management
         • Communications management to Providers and Members
         • Provider relations and network management, including credentialing
• Health information technology and medical records
• Privacy officer
• Compliance officer
• Quality Performance Improvement
• Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
• Traditional Health Workers Liaison

☑ Yes    ☐ No
If “no” please provide explanation: ____________________________

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?
☑ Yes    ☐ No
If “no” please provide explanation: ____________________________

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?
☑ Yes    ☐ No
If “no” please provide explanation: ____________________________

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary’s equivalent has been ineffective in the treatment or the formulary’s drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?
☑ Yes    ☐ No
If “no” please provide explanation: ____________________________

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?
☑ Yes    ☐ No
If “no” please provide explanation: ____________________________

Attachment 13-Attestations
f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒ Yes ☐ No

If “no” please provide explanation:

________________________


g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒ Yes ☐ No

If “no” please provide explanation:

________________________


h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒ Yes ☐ No

If “no” please provide explanation:

________________________


i. Will Applicant’s contracts for administrative and management services contain the OHA required Contract provisions?

☒ Yes ☐ No

If “no” please provide explanation:

________________________


j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒ Yes ☐ No

If “no” please provide explanation:

________________________


k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If “no” please provide explanation:

________________________


l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If “no” please provide explanation:

________________________
m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?
☑ Yes ☐ No
If “no” please provide explanation: ________________________________

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority’s comprehensive local plan for the delivery of mental health services (ORS 430.630)?
☑ Yes ☐ No
If “no” please provide explanation: ________________________________

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO’s Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?
• Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
• The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
• Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
• Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
• Addressing diverse patient populations in a linguistically diverse and culturally competent manner.
☑ Yes ☐ No
If “no” please provide explanation: ________________________________

p. Will Applicant establish policies, procedures, and standards that:
• Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
• Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
• Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
• Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.
  ☑ Yes  ☐ No
  If "no" please provide explanation:

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?
  ☑ Yes  ☐ No
  If "no" please provide explanation:

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?
  ☑ Yes  ☐ No
  If "no" please provide explanation:

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].
  ☑ Yes  ☐ No
  If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).
  ☑ Yes  ☐ No
  If "no" please provide explanation:
u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☐ Yes  ☒ No

If "no" please provide explanation: CaremarkPCS Health, LLC, a subcontractor, is an international company involved in a variety of inquiries and litigation matters, some of which may include allegations of inappropriate conduct that involves federal funds.

2. Network Adequacy
   a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

      ☒ Yes  ☐ No

      If "no" please provide explanation: ____________________________

   b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

      ☒ Yes  ☐ No

      If "no" please provide explanation: ____________________________

   c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

      ☒ Yes  ☐ No

      If "no" please provide explanation: ____________________________

   d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

      ☒ Yes  ☐ No

      If "no" please provide explanation: ____________________________

   e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

      ☒ Yes  ☐ No

      If "no" please provide explanation: ____________________________

   f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

      ☒ Yes  ☐ No
g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?
   ☑ Yes  ☐ No

3. Fraud, Waste and Abuse Compliance
   a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________

   b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________

C. Value-Based Payment (VBP) Attestations (Attachment 8)
   1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________

   2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________

   3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017” (https://hcp­lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________
4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network’s (LAN’s) “Alternative Payment Model Framework White Paper Refreshed 2017” (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific provider.)

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO’s VBP Provider contracts for common Provider types and specialties?

☐ Yes  ☐ No
If “no” please provide explanation: ____________________________________________
10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts? 
☐ Yes ☐ No
If “no” please provide explanation: ____________________________

D. Health Information Technology (HIT) Attestations (Attachment 9)
1. HIT Roadmap
   a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval? 
      ☐ Yes ☐ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA? 
      ☐ Yes ☐ No
      If “no” please provide explanation: ____________________________

2. HIT Partnership
   a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following: 
      • Maintaining an active, signed HIT Commons MOU and adhering to its terms,
      • Paying annual HIT Commons assessments, and
      • Serving, if elected, on the HIT Commons Governance Board or one of its committees?
      ☐ Yes ☐ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant agree to participate in OHA’s HIT Advisory Group, (HITAG), at least once annually? 
      ☐ Yes ☐ No
      If “no” please provide explanation: ____________________________

3. Support for EHR Adoption
   a. Will Applicant support EHR adoption for its contracted physical health Providers? 
      ☐ Yes ☐ No
      If “no” please provide explanation: ____________________________
b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   c. Will Applicant support EHR adoption for its contracted oral health Providers?
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.
   - Yes □ No
   If “no” please provide explanation:

   ____________________________

   ____________________________
h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☐ Yes ☐ No
If “no” please provide explanation: __________________________________________

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☐ Yes ☐ No
If “no” please provide explanation: __________________________________________

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☐ Yes ☐ No
If “no” please provide explanation: __________________________________________

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☐ Yes ☐ No
If “no” please provide explanation: __________________________________________

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☐ Yes ☐ No
If “no” please provide explanation: __________________________________________
d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?
   ☑ Yes ☐ No
   If “no” please provide explanation: ______________________________
k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes □ No
   If “no” please provide explanation: _______________________

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes □ No
   If “no” please provide explanation: _______________________

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?
   ☑ Yes □ No
   If “no” please provide explanation: _______________________

   a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?
      ☑ Yes □ No
      If “no” please provide explanation: _______________________

   b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?
      ☑ Yes □ No
      If “no” please provide explanation: _______________________

   c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?
      ☑ Yes □ No
      If “no” please provide explanation: _______________________

   d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?
      ☑ Yes □ No
      If “no” please provide explanation: _______________________
e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?
   ☑ Yes ☐ No
   If “no” please provide explanation:

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?
   ☑ Yes ☐ No
   If “no” please provide explanation:

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?
   ☑ Yes ☐ No
   If “no” please provide explanation:

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership
   a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?
      ☑ Yes ☐ No
      If “no” please provide explanation:
c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO’s Community Health Improvement Plan?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☑ Yes □ No

If “no” please provide explanation: __________________________________________

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☑ Yes □ No

If “no” please provide explanation: __________________________________________
4. Health Equity Assessment and Health Equity Plan
   a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant’s organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

   b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

   c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board’s Health Equity Committee?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

   d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

   e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

   f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________

5. Traditional Health Workers (THW) Utilization and Integration
   a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?
      ☒ Yes ☐ No
      If “no” please provide explanation: __________________________
b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?
   ☒ Yes ☐ No
   If “no” please provide explanation: ________________________________

   c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________

   d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________

   e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________

   f. Is Applicant willing to engage THWs during the development of the CHA and CHP?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________

   g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________

6. Community Health Assessment and Community Health Improvement Plan
   a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?
      ☒ Yes ☐ No
      If “no” please provide explanation: ________________________________
b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?
   ☒ Yes  ☐ No
   If “no” please provide explanation: ________________________________

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?
   ☒ Yes  ☐ No
   If “no” please provide explanation: ________________________________

d. Is Applicant willing to develop and fully implement a community engagement plan?
   ☒ Yes  ☐ No
   If “no” please provide explanation: ________________________________

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit
   a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?
      ☒ Yes  ☐ No
      If “no” please provide explanation: ________________________________

   d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.
      ☒ Yes  ☐ No
      If “no” please provide explanation: ________________________________
e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?
☑ Yes □ No
If “no” please provide explanation: ____________________________

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?
☑ Yes □ No
If “no” please provide explanation: ____________________________

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?
☑ Yes □ No
If “no” please provide explanation: ____________________________

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?
☑ Yes □ No
If “no” please provide explanation: ____________________________

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?
☑ Yes □ No
If “no” please provide explanation: ____________________________

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?
☑ Yes □ No
If “no” please provide explanation: ____________________________

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?
☑ Yes □ No
If “no” please provide explanation: ____________________________
I. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☐ Yes  ☐ No
If “no” please provide explanation: ________________________________
r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

s. Will Applicant ensure Applicant’s staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant’s network as the BHHs qualify in Applicant’s Region?
   ☑ Yes       ☐ No
   If “no” please provide explanation: ________________________________________
y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ____________________________________________

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ____________________________________________

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?
   ☑ Yes  ☐ No
   If “no” please provide explanation: ____________________________________________

2. MOU with Community Mental Health Program (CMHP)
   a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant’s Region by beginning of CY 2020, in accordance with ORS 414.153?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________________________

   b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant’s Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________________________

   c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630
      ☑ Yes  ☐ No
      If “no” please provide explanation: ____________________________________________
3. **Provisions of Covered Services – Behavioral Health**

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR § 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

[ ] Yes [ ] No

If “no” please provide explanation: ________________________________

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontact, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontact, with timeline to be determined by OHA?

[ ] Yes [ ] No

If “no” please provide explanation: ________________________________

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

[ ] Yes [ ] No

If “no” please provide explanation: ________________________________

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

[ ] Yes [ ] No

If “no” please provide explanation: ________________________________

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

[ ] Yes [ ] No

If “no” please provide explanation: ________________________________
4. Covered Services Component – Behavioral Health
   a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
   b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
   c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
   d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
   e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
   f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?
     ☒ Yes ☐ No
     If “no” please provide explanation: ________________________________
g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?
☐ Yes ☐ No
If “no” please provide explanation:

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?
☐ Yes ☐ No
If “no” please provide explanation:

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?
☐ Yes ☐ No
If “no” please provide explanation:

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?
☐ Yes ☐ No
If “no” please provide explanation:

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?
☐ Yes ☐ No
If “no” please provide explanation:
I. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?  
☒ Yes ☐ No  
If “no” please provide explanation: ___________________________  

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?  
☒ Yes ☐ No  
If “no” please provide explanation: ___________________________  

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?  
☒ Yes ☐ No  
If “no” please provide explanation: ___________________________  

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?  
☒ Yes ☐ No  
If “no” please provide explanation: ___________________________  

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?  
☒ Yes ☐ No  
If “no” please provide explanation: ___________________________
q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs and the individual’s informed choice?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member’s rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________
w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals’ immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual’s housing assessment?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________________________

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________________________

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________________________

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________________________

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________________________
bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual’s treatment goals, clinical needs, and the individual’s informed choice?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member’s diagnosis and needs?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member’s housing needs?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________

e.e. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________

ffe. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☐ Yes ☐ No

If “no” please provide explanation: ______________________________________
hh. Will Applicant, when ten (10) or more of Applicant’s adult Members with SPMI in Applicant’s Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member’s participation?

☑ Yes ☐ No
If “no” please provide explanation: ________________________________
II. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member’s self-identified needs, and ways that ACT can enhance a Member’s care and support independent Community living?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________
ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☑ Yes ☐ No
If "no" please provide explanation: ____________________________

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☑ Yes ☐ No
If "no" please provide explanation: ____________________________

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☑ Yes ☐ No
If "no" please provide explanation: ____________________________

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☑ Yes ☐ No
If "no" please provide explanation: ____________________________

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☑ Yes ☐ No
If "no" please provide explanation: ____________________________

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☑ Yes ☐ No
If "no" please provide explanation: ____________________________
yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?
☐ Yes ☐ No
If “no” please provide explanation: ____________________________________________

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?
☐ Yes ☐ No
If “no” please provide explanation: ____________________________________________

5. Children and Youth
a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?
☐ Yes ☐ No
If “no” please provide explanation: ____________________________________________

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?
☐ Yes ☐ No
If “no” please provide explanation: ____________________________________________

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?
☐ Yes ☐ No
If “no” please provide explanation: ____________________________________________
d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?
   ☒ Yes ☐ No
   If “no” please provide explanation: _______________________________________

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (POTS) and/or Intensive Outpatient Services and Supports?
   ☒ Yes ☐ No
   If “no” please provide explanation: _______________________________________

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?
   ☒ Yes ☐ No
   If “no” please provide explanation: _______________________________________

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?
   ☒ Yes ☐ No
   If “no” please provide explanation: _______________________________________

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?
   ☒ Yes ☐ No
   If “no” please provide explanation: _______________________________________
j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________ 

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________ 

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________ 

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________ 

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________ 

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?  
☑ Yes ☐ No  
If “no” please provide explanation: ___________________________
p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?
   ☒ Yes ☐ No
   If “no” please provide explanation: ____________________________

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?
   ☒ Yes ☐ No
   If “no” please provide explanation: ____________________________

G. Cost and Financial Attestations (Attachment 12)

1. Rates
   Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?
   ☒ Yes ☐ No
   If “no” please provide explanation: ____________________________

2. Evaluate CCO performance to inform CCO-specific profit margin
   a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?
      ☒ Yes ☐ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?
      ☒ Yes ☐ No
      If “no” please provide explanation: ____________________________

   c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?
      ☒ Yes ☐ No
      If “no” please provide explanation: ____________________________

   d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?
      ☒ Yes ☐ No
      If “no” please provide explanation: ____________________________
3. **Qualified Directed Payments to Providers**
   
a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

4. **Quality Pool Operations and Reporting**
   
a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?
   - [ ] Yes
   - [ ] No
   If “no” please provide explanation:
d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

5. Transparency in Pharmacy Benefit Management Contracts
a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 6. If not, please answer parts b-f of this question.
☐ Yes ☑ No
If “no” please provide explanation: Our PBM Contract will meet all CCO 2.0 requirements, including the requirements detailed in parts b-f of this question.

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost pass-through at 100% and pass back 100% of rebates received to Applicant?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?
☑ Yes ☐ No
If “no” please provide explanation: ____________________________
6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria
   a. Will Applicant partner with OHA on the goal of increasing the alignment
      of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set
      every year by OHA?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   b. Will Applicant align its PDL in any and all categories of drugs as
      recommended by the P&T committee and as required by OHA?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   c. Will Applicant post online in a publicly accessible manner the Applicant’s
      specific PDL with coverage and Prior Authorization criteria in a format
      designated by OHA and update the posting concurrently or before any
      changes to the PDL or coverage/PA criteria become effective?
      ☑ Yes ☐ No
      If “no” please provide explanation:

7. Financial Reporting Tools and Requirements
   a. Is Applicant willing to partake of all financial, legal and technological
      requirements of the National Association of Insurance Commissioners
      (NAIC) in whatever capacity necessary to file its financial information
      with OHA under NAIC standards?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   b. Will Applicant report its required financial information to OHA on the
      NAIC’s Health Quarterly and Annual Statement blank (“Orange Blank”)
      through the NAIC website as described in this RFA, under NAIC
      standards and instructions?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   c. Will Applicant report its financial information to OHA using Statutory
      Accounting Principles (SAP), subject to possible exemption from SAP for
      2020 as described in this RFA?
      ☑ Yes ☐ No
      If “no” please provide explanation:

   d. Will Applicant file the financial reports described in this RFA, including
      Contract Exhibit L and supplemental schedules with the instructions
      referenced in this RFA?
      ☑ Yes ☐ No
      If “no” please provide explanation:
e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant’s Service Area?
   ☒ Yes       ☐ No
   If “no” please provide explanation: ____________________________

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?
   ☒ Yes       ☐ No
   If “no” please provide explanation: ____________________________

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?
   ☒ Yes       ☐ No
   If “no” please provide explanation: ____________________________

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?
   ☒ Yes       ☐ No
   If “no” please provide explanation: ____________________________

i. If Applicant’s estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?
   ☒ Yes       ☐ No
   If “no” please provide explanation: ____________________________

8. Accountability to Oregon’s Sustainable Growth Targets
   a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?
      ☒ Yes       ☐ No
      If “no” please provide explanation: ____________________________

   b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?
      ☒ Yes       ☐ No
      If “no” please provide explanation: ____________________________
c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

   d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?
   ☒ Yes   ☐ No
   If “no” please provide explanation:

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?
   ☒ Yes   ☐ No
   If “no” please provide explanation:
c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?
   ☒ Yes   ☐ No
   If “no” please provide explanation: ________________________________

   d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?
      ☒ Yes   ☐ No
      If “no” please provide explanation: ________________________________

   e. Will Applicant maintain the required restricted reserve account per Contract?
      ☒ Yes   ☐ No
      If “no” please provide explanation: ________________________________

11. Encounter Data Validation Study
   a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?
      ☒ Yes   ☐ No
      If “no” please provide explanation: ________________________________

   b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?
      ☒ Yes   ☐ No
      If “no” please provide explanation: ________________________________

H. Member Transition Plan (Attachment 16)
   1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?
      ☒ Yes   ☐ No
      If “no” please provide explanation: ________________________________
Instructions: Assurances focus on the Applicant’s compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check “yes,” or “no.” A “yes” answer is normal, and an explanation will be furnished if Applicant’s response is “no”. Applicant must respond to all assurances. If an assurance has more than one question and Applicant’s answer is “no” to any question, check “no” and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Emergency and Urgent Care Services. Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140)
   Yes   No

   If “no” please provide explanation:

2. Continuity of Care. Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.208 and OAR 410-141-3160)
   Yes   No

   If “no” please provide explanation:

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant’s Primary Care and
Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

☐ Yes ☐ No

If "no" please provide explanation: 

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☐ Yes ☐ No

If "no" please provide explanation: 

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to their benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☐ Yes ☐ No

If "no" please provide explanation: 

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☐ Yes ☐ No

If "no" please provide explanation: 

Attachment 14-Assurances
7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☑ Yes ☐ No

If “no” please provide explanation:

8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; and OAR 410-141-3300]

☑ Yes ☐ No

If “no” please provide explanation:

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☑ Yes ☐ No

If “no” please provide explanation:

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state’s 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☑ Yes ☐ No
11. Will Applicant maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant and its Providers or Subcontractors will not hold Members responsible for debt incurred by the Applicant or by Providers if the entity becomes insolvent? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 447.46]

[ ] Yes [ ] No

If “no” please provide explanation: ____________________________________________

12. Will Applicant participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards? Has Applicant executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

[ ] Yes [ ] No

If “no” please provide explanation: ____________________________________________

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers’ compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

[ ] Yes [ ] No

If “no” please provide explanation: ____________________________________________

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the
operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]
☑ Yes ☐ No

If “no” please provide explanation:

15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a “managed care organization” in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

PSCS complies with each Medicaid requirement set forth in Item 15. Consistent with our strong results on the OHA evaluation of our 2017 DSN report, we have a proven track record for meeting these standards, monitoring our performance, and taking action to ensure our managed care activities meet state and federal requirements. We can leverage our solid foundation and history of compliance to scale successfully. Below, we set forth a brief narrative to describe how PSCS meets the standards and complies with Medicaid requirements.

PSCS complies with the Medicaid requirements set forth in 42 § CFR 438.206, as described in more detail in our narrative in response to Attachment 7, Section 12 (a-g). In brief, PSCS has adopted a Network Availability Standards Policy, which outlines how PSCS defines network adequacy. We base time and distance standards on requirements outlined in the Exhibit G of the CCO contract and applicable state and federal law. We produce a “Practitioner Availability Analysis” as a holistic evaluation of the delivery system network. The Provider Network and PSCS leadership review the evaluation and any opportunities identified in this report and act to ensure services are available. This evaluation utilizes Quest Analytics with geocoding and mapping to compare the network to membership distribution. We analyze transportation adequacy outside of the Quest Analytics tool through capacity reporting and grievance system monitoring. Leadership reviews the evaluation to identify and execute on opportunities for improvement.

Members can obtain information on how to access services through the CCO member handbooks, located online: https://communitysolutions.pacificsource.com/Member. This includes information for the member to use the provider directory, call our Customer Service team, and work with their primary care provider.
PSCS has established contractual standards that require subcontractors to comply with OHA expectations. We conduct provider workshops throughout the year and offer training and education opportunities for providers to stay informed and ask questions. Our Provider Manual, located online at https://communitysolutions.pacificsource.com/Documents/706, also sets forth access requirements. We send out regular provider newsletters to reinforce access standards and help increase the visibility of the standards. PSCS also distributes quarterly access to care surveys to assess provider compliance with these standards. The Provider Service Department follows up with providers that indicate that they are unable to comply with these standards for education and corrective action, as needed, along with changes in member assignment. We analyze this information to identify trends in barriers to care, as well as to identify any non-compliant providers. Providers that are unable to meet access to care standards may face remedial action up to and including termination of their contract. PSCS has also recently deployed an updated member-facing access survey. Results are pending. The surveys are being returned to PSCS from members and the responses are tracked by PSCS for evaluation upon conclusion of the pilot.

PSCS monitors the performance of network providers in various ways, including, but not limited to the use of surveys, site visits, monitoring, annual audits, grievance and appeals trending, and utilization trending. The data collected is compiled and analyzed to determine if providers are meeting contractual requirements related to access. If any issues are identified in performance monitoring, a corrective action plan may be necessary. Our Access Policy describes our process for working with the provider to remedy the identified deficiency.

PSCS outlines clear expectations for culturally and linguistically competent and appropriate care in our Provider Manual, provider contracts, and policies and procedures. Provider service representatives assess this information through site visits. PSCS saves this information in a document repository. We consider this information during the credentialing and re-credentialing processes. In addition, the Provider Operations Department sends regular letters to participating providers requesting this information for inclusion in the provider directory. We are also using this information to make changes to our patient assignment methodology.

PSCS invests in advancing Culturally and Linguistically Appropriate Standards (CLAS) throughout the entire organization and within our provider network. We hired a Health Equity and Diversity Strategist and have engaged in technical assistance from the OHA to assess health disparities. We have also invested in staff participation in the Developing Equity Leadership through Training and Action (DELTA) program through the OHA Office of Equity and Inclusion. These staff have been leading efforts to develop a culture of health equity at PSCS while also conducting outreach to community partners and provider groups. This provides additional education, support, and monitoring of CLAS among providers in our network. PSCS has prioritized improvements in cultural competence by making changes in staffing, recruiting, and employee training, most notably in outreach and recruitment of local bilingual and bicultural employees from
regional educational institutions. We have also expanded efforts to address health literacy, including partnering to co-sponsor the Legacy Health Literacy Conference for the past two years and making significant changes to member-facing materials. We are committed to integrating these efforts as part of a cohesive set of culturally attuned practices.

b. Medicaid Assurance #2 - 42 CFR § 438.207 Assurances of adequate capacity and services.

PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.207, as described in more detail in our narrative in response to Attachment 7, Section 11 and 12(a). In brief, PSCS analyzes all provider types for changes in utilization, performance, access to out-of-network providers, and grievances specific to member access for covered services. We use a combination of analytics and ongoing monitoring (including monthly network monitoring) to evaluate the adequacy of our network. We use Quest Analytics for geocoding/mapping and various other network adequacy tools. Our staff review these results to consider time and distance travelled, and we review this information against time and distance requirements. We review grievances on a monthly basis and trend them from quarter to quarter to identify areas of improvement or opportunity. PSCS also reviews and pre-authorizes requests for services and referrals that would require members to use out-of-network providers. Using a variety of reports and analytical platforms, staff immediately address any access deficiencies we identify. This may include additional contracting and reviewing changes in service area referral patterns.

PSCS maintains accessibility policies that pertain to all care types to ensure members have adequate access to services. Accessibility policies outline procedures to monitor capacity and access. PSCS’s Network Availability Standards Policy demonstrates monitoring of travel distances for members to provider offices and also the member-to-provider ratios. This Policy addresses the entirety of the CCO benefit package and imposes standards on benefit types even where applicable law is silent. We apply this Policy in conjunction with oversight activities of each contracted service provider’s access to care standards, network access policies, monitoring systems, and availability. We perform oversight and monitoring activities throughout the year and annually to ensure that providers meet the required standards and members have access to services.

Annually, PSCS conducts a comprehensive quantitative analysis of our network when we complete the Delivery System Network (DSN) report (all provider types) to identify network strengths and deficiencies. We will transition to quarterly DSN reporting in 2020 and intend to build our system capabilities to test more frequent reporting in 2019. We use results in a variety of ways, including to inform provider contracting. We leverage contracting and value-based reimbursement to ensure sufficient access for all provider types. Our contracts apply state and federal access standards across the CCO benefit package or our access standards where applicable law is silent on standards that apply to a particular benefit. These requirements reflect the guidelines outlined in Oregon Administrative Rules.
c. **Medicaid Assurance #3 - 42 CFR § 438.208 Coordination and continuity of care.**
PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.208, as described in more detail in our narrative in response to Attachment 7, Section 6 (a-d). In brief, PSCS has a robust program for care coordination and continuity of care. We support members through intensive care coordination and with a broad set of programs. Notably, we have developed sophisticated systems to support community health workers, and we recruit and train bilingual, bicultural staff to provide care coordination and management in a culturally appropriate way. Nurse Care Managers assess complex health issues, chronic conditions, dental care, behavioral health, and other special health care needs. Member Support Specialists provide assistance for members who have needs specifically involving service access or barriers to social determinants of health. Additionally, Behavioral Health Specialists are available and work in integrated care teams to offer consults for behavioral health issues that affect members with special health care needs. The Care Management team members contact and incorporate other specialist input in care planning and interventions as appropriate, such as in consultation with dental care managers and providers, and provide coordination for transportation needs through the Non-Emergent Medical Transportation or flexible service benefits.

We develop care plans with participation from members and/or family/member representatives, whenever possible. Our team frequently receives referrals when members are not engaged with appropriate health services, so member participation may not be feasible; however, whenever possible, their preferences are considered and incorporated into the care plan.

PSCS uses best efforts to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful. Member Support Specialists and Nurse Care Managers conduct telephonic screenings of referred or identified members regarding care coordination, cultural factors, and social determinates of health needs. Nurse Care Managers assess complex health issues, chronic conditions, behavioral health, and other special health care needs. Member Support Specialists provide assistance for members who have needs specifically involving service access and/or barriers to social determinants of health. We also conduct new member welcome calls for all new CCO members and do warm hand-offs between Customer Service and Case Management to support members with care coordination needs.

PSCS Care Managers create individualized care plans for members who are eligible for ICC service, those with special health care needs, or those who need long-term services and supports. We coordinate and share care planning with providers and specialists to ensure consideration is given to incorporate unique needs, including cultural and linguistic factors, as appropriate, and in compliance with applicable privacy requirements. We re-review and revise care plans for enrollees with special health care needs and ICC members on a regular basis, when the member’s circumstances or needs change, or when the member requests it.
PSCS allows direct access to specialty care for members with special health care needs or those eligible for ICC. These requirements are set forth in our policies and procedures, the Provider Manual, the member handbook, and in contractual language with providers. We monitor direct access to specialty care through methods that include provider surveys, provider oversight, member surveys, and health assessments.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.
PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.210, as described in more detail in our narrative in response to Attachment 7, Section 6(d), 12 (f-g). In brief, each year, our Medicaid Medical Director and representatives from the Pharmacy, Behavioral Health, Claims, Appeals & Grievances, and Utilization Management teams meet to review data from the prior year regarding utilization, costs, and decision status. This data helps to inform which services should require, or not require, a preapproval for the next coverage year. In addition, at the time of release, we review newly developed state coverage guidelines and CPT-HCPCS codes with subject matter experts to determine authorization requirements. The Pharmacy Department reviews all newly approved FDA drugs no later than 180 days post launch. We review updates against guidelines, requirements of coverage, and cost. The Pharmacy and Therapeutics Committee reviews recommendations for approval or modification.

PSCS regularly reviews updated OHP requirements and coverage materials to ensure that services are furnished in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services furnished to beneficiaries enrolled in OHP fee-for-service coverage. PSCS ensures that medically necessary services are delivered in a manner that is no more restrictive than that used in the OHP fee-for-service system, including quantitative and non-quantitative treatment limits. Our commitment is evidenced by our strong Mental Health Parity Assessment results, finalized by the OHA in December 2018.

PSCS uses several methods to demonstrate consistent application of criteria used in making service authorization decisions (including decisions made by delegated entities and subcontractors), including interrater reliability testing, timeliness reporting, policies, daily workflows (including huddles), auditing templates, monitoring and auditing of decisions, and education to delegates, subcontractors, and staff.

PSCS has processes in place for monitoring authorizations. Our work includes daily huddles, workflows and routine reporting, oversight and auditing, root-cause analysis, and education, as applicable. We report notices of adverse benefit decisions (NOABDs) to the OHA quarterly and upon request. We analyze and report data from delegates and subcontractors. We assign clinical staff, monitor work queues and respond to expedited requests over long weekends. The Pharmacy Department audits coverage determinations on a monthly basis for accuracy and consistency.

For those decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, processes are in place to ensure these decisions are made by individuals who have appropriate expertise in treating the
enrollee’s condition or disease. PSCS has various teams with clinical expertise and contracts with consultants to ensure we use appropriate review processes. If necessary, PSCS will consult with panel physicians, members of the Clinical Quality and Utilization Management committee, or with outside consultants. PSCS adheres to OHA-mandated requirements for decision-making processes. Members are notified in writing regarding their rights and what services have been approved or denied. For denied services, we provide a specific explanation of the denial reason. In addition to the written notification through the NOABD, we make an oral notification attempt to the member if the request is urgent or expedited. We ensure our compliance with making a verbal notification attempt to the member by tracking our work in the health management IT system called Dynamo, which has mandatory fields to prompt for verbal notification prior to the user completing a service request.

PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.214, as described in more detail in our narrative in response to Attachment 7, Section 12 (a). In brief, PSCS makes every effort to contract with highly qualified practitioners by using strict credentialing standards. The Credentialing Department performs credentialing and recredentialing activities. In addition, the Medicaid Medical Director and the Credentialing Committee participate in credentialing activities. The Credentialing Department promulgates and maintains robust policies and procedures. All credentialing activities are performed in accordance with these policies and procedures, whether the process is performed by the PSCS credentialing staff or delegated to an external entity. PSCS Credentialing Staff and the Chief Medical Officer review the credentialing and recredentialing policies and procedures, at a minimum, on an annual basis. They submit any revisions to the Credentialing Committee for review and final approval.

Practitioners are required to submit an Oregon Practitioner Recredentialing Application or an application approved by PSCS if the provider practices outside of the state of Oregon. If the application is incomplete, staff will send the application directly back to the practitioner with an explanation stating what was omitted from the original submission and informing the practitioner that the process will not begin until all information is received. Once a practitioner has completed the initial credentialing process, all participating practitioners will be recredentialed at a minimum of every three years. If the provider cannot be recredentialed within the three-year timeframe, due to the provider being on active military assignment, maternity leave, or sabbatical, the reason for leave is documented in the provider file, and the provider is recredentialed within sixty days of returning to practice.

PSCS Credentialing staff perform ongoing monitoring of providers, including review of license sanctions, patient complaints, Medicare or Medicaid sanctions, adverse events, quality concerns, site visit results, and medical record reviews. Other departments also provide information that we use during the credentialing and recredentialing process, such as quality of care or service complaints. Our policies are designed to ensure that we will neither employ, nor contract with, providers excluded from federal health care programs.
We take a variety of steps to ensure that participating providers who serve high-risk or costly populations are not discriminated against in the selection process and when considering reimbursement and indemnification. PSCS does not consider patient populations or risk-associated stratification when extending participating provider agreements or determining reimbursement. We review provider terminations regularly to ensure we follow non-discriminatory practices. In addition, our Credentialing Committee member agreements state that when making credentialing decisions, the Committee shall not make decisions based on an applicant’s race, ethnicity, national identity, gender, age, sexual orientation, or patient type. We also redact identifying information from all files presented to the Credentialing Committee.

The PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.224. In brief, the PSCS Compliance Department produces and maintains a comprehensive Compliance and Program Integrity Plan. We ensure compliance with the Privacy Rule and Security Rule through this Plan (and corresponding policies and procedures) by focusing on the following elements: 1) reiterating a clear commitment to comply with federal and state laws; 2) maintaining a robust corporate compliance structure; 3) delivering a strong compliance training and education program; 4) maintaining open lines of compliance communication, reporting, and non-retaliation; 5) performing corrective actions; 6) monitoring and auditing internal and external departments and entities; 7) complying with exclusion and background check requirements; 8) overseeing subcontractors; and 9) conducting investigations.

Within these strategies, we adhere to policies that address the following issues: Use and Disclosure of Protected Health Information (PHI), Privacy and Confidentiality, Breach of Security of Personal Information and Notification, Security and Awareness Training, Information Security Incident and Management, Transmission Security, Audit Controls, Business Associate Contracts and Other Arrangements, Facility Access, Device and Media Controls, Members’ Rights Regarding PHI, Access Control, and Evaluation.

We take the security of our members’ PHI seriously. PHI is only to be used or disclosed appropriately and in strict accordance with our written policies and procedures relating to such use and/or disclosure. We strive to make the process as transparent as possible to members by adopting rules relating to the following: 1) notifying members of our privacy practices; 2) accessing PHI; 3) honoring members’ requests to restrict the use and disclosure of their PHI; 4) honoring members’ requests for amendments to PHI; 5) honoring members’ requests for an accounting of disclosures of PHI; and 6) protecting oral, written, and electronic information across our organization.

We have effective and documented processes for addressing security incidents, including detecting, investigating, and correcting any such incidents. We report, track, and follow up on any incident that would violate the confidentiality, integrity, or availability of PHI in our care, custody, or control, and require our subcontractors to comply with applicable law related to confidentiality, privacy, and security. We take any alleged violation of security seriously, and all employees are required to report incidents immediately.
We continually scan and perform an annual risk analysis of our information systems and have implemented specific components to help detect and prevent potential security incidents, including, but not limited to, the installation and use of system-wide security software and routine monitoring of our information system. These systems and software packages identify, monitor, and mitigate, to the extent reasonably practical, the harmful effects of any known security risks, viruses, etc. In addition, we regularly have an outside vendor perform a risk assessment, which we use to further enhance our information systems and the security of those systems. This independent report is shared with the Audit & Compliance Committee of the Board of Directors.

Our IT Department, in conjunction with the Chief Information Officer (CIO), is responsible for routine evaluations of the information system and for upgrading firmware, hardware, and software as necessary. The CIO designs training programs, policies, and procedures to ensure system security and integrity.

All PSCS employees are required to report any known or suspected security incidents to their supervisor, an IT professional, or the CIO. Once a report has been made, the CIO and IT Department will investigate the report and respond to any security incident. The CIO is empowered to take any and all reasonable steps to end a security threat and prevent future threats from occurring. In the event that the IT Department or the CIO determine that a PSCS information system has been subjected to a security incident, the investigation into the incident identifies what vulnerabilities led to the incident and establishes the security controls that would have prevented the incident and/or mitigated its effects. We implement any controls identified in the report. In addition, we require our subcontractors to comply with applicable federal and state law.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.
PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.228, as described in more detail in our narrative in response to Attachment 7, Section 5. In brief, PSCS has adopted a Grievance and Appeals Systems Policy, which complies with the requirements set forth in 42 CFR § 438.228 and Oregon Administrative Rule. We adhere to the timeliness requirements set forth in these authorities, along with the CCO contract. PSCS submits this Policy annually to the OHA for review and approval. We most recently received approval of this Policy from the OHA in March 2019. In addition, we submit grievance and appeals reporting to the OHA quarterly or more frequently as requested. We also monitor our own performance on a monthly basis and regularly review and audit subcontractors that perform delegated grievance functions.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.
PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.230, as described in more detail in our narrative in response to Attachment 6. In brief, PSCS has adopted a comprehensive policy regarding Delegation Contracts and Subcontractor Monitoring. In the event that PSCS decides to enter into a contract that involves delegating duties required of the CCO (excluding any non-delegable duties), PSCS will adopt contract language that includes a specific description of the activities delegated to
the subcontractor, reporting and performance requirements for the subcontractor, audit and access rights, specific revocation and sanctions for poor performance, a description of how performance will be monitored on at least an annual basis, and provisions that allow for corrective action for poor subcontractor performance. PSCS retains ultimate responsibility for compliance.

We use many activities to monitor subcontractor performance, including in-person stakeholder or work group meetings, secret shopper calls, surveys, audits, chart reviews, webinars and provider sessions, education, desk reviews, review of member-facing materials and member outreach activities, analysis of grievance data, and planning sessions. We document the performance of monitoring activities using many activities, including annual auditing plans, calendar invites, site visit reports, corrective action plans, email exchanges, minutes and meeting sign-in pages, meeting agendas, and memoranda. We are committed to sharing the results of our oversight and monitoring activities with the OHA.

i. Medicaid Assurance #9 - 42 CFR § 438.236 Practice guidelines.

PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.236, as described in more detail in our narrative in response to Attachment 7, Sections 6 and 9. In brief, PSCS has adopted a variety of practice guidelines. A complete list is available in our Practice Guideline Policy. As noted in the Practice Guidelines Policy, we adopt guidelines created by one of the Health Evidence Review Commission (HERC) "trusted sources." HERC lists only those entities that meet their evidence-based standards.

PSCS prioritizes which guidelines to adopt by determining if the guidelines provide decision support for targeted improvement projects or chronic condition programs that address specific member needs, quality improvement projects, or documented deficiencies in clinical care patterns. We select improvement projects and chronic condition programs based on CCO member needs.

We welcome input on criteria from practitioners throughout the service area, as well as from physician members of health plan clinical committees. We consider their comments and recommendations in the development of clinical criteria. However, practice guidelines extend beyond local clinical practice and have broad national consensus. PSCS presents practice guidelines specifically adopted by the Clinical Quality Utilization Management (CQUM) Committee for provider input and dissemination. CQUM members represent their local practices and serve as conduits for input and dissemination. Should a CQUM Committee member disagree significantly with a national practice guideline, the Committee will evaluate their concerns, and, if necessary, PSCS staff will make contact with the authoring agency to obtain additional clarity and discussion. The Pharmacy Department has a Drug Utilization Review program as part of the Pharmacy and Therapeutics Committee, which is a program to evaluate and consult with experts for input. PSCS works with a dentist on the CQUM Committee to specifically address dental practice guidelines. For any dental guidelines beyond those specifically adopted by PSCS, PSCS has delegated decisions to contracted DCOs. They utilize leadership, oversight, and
decision-making forums (such as quality and policy committees) to discuss, determine, and update guidelines.

Since each practice guideline is created and maintained, each guideline has its own update schedule. For those guidelines adopted by PSCS, the Quality Department tracks when updates occur and presents this information to the CQUM Committee. We follow state and federal coverage guidelines for the majority of service requests. These are updated based on state and federal schedules. Our Government Operations Committee reviews and approves any guidelines that become policies and procedures after they have been vetted with providers and affected parties. For these documents that are related to clinical criteria, we present, review, and approve them on a regular basis through the CQUM Committee or the Pharmacy and Therapeutics Committee.

PSCS disseminates practice guidelines in a variety of ways, including via member and provider utilization management decisions (through NOABDs), the Medicaid provider website, and the PSCS provider manual. Customer Service staff make new member calls, and our public website provides new or prospective members with information about practice guidelines. While our website conveys information about OHP benefits, we communicate most guidelines to providers rather than members. We also include practice guidelines within NOABDs, since the CCO must include the information that contributed to the denial. NOABDs are sent to members and providers and are made available to providers who utilize our online provider portal. We also include this information in the member handbooks (available online) and make it available upon request. DCOs make practice guidelines available to members or potential members upon request. Members may also access practice guidelines from our provider resources website.

We provide practice guidelines to members with limited English proficiency or individuals with hearing or visual impairment by identifying their preferred language and format within the field in their eligibility file. This file indicates who needs information in languages other than English. PSCS uses the services of a contractor to produce translated materials, but PSCS also employs bilingual staff that review these materials, to assure the translation delivers information in a clear and culturally appropriate manner.

PSCS uses multiple strategies to ensure that decision-making is consistent with applicable practice guidelines. We demonstrate this commitment through contractual language, posting guidelines on the company website, and through monitoring and oversight. We also take steps including reviewing audit templates to evaluate decision-making, conducting nurse meetings for education and to review NOABDs, performing interrater reliability reviews, and monitoring delegated processes. Appeal decision makers are assigned by staff from the Appeals and Grievance Department. We make assignments to ensure that decision makers have not been involved in the initial decision in any capacity. We use a health IT system called Dynamo to select and route cases electronically for timely decision-making. We link original denials in this system for review and cross-referencing to ensure appeal decision makers are not part of the original decision. In addition, during the routine review of medical records that occurs during either utilization management or appeals and grievance review by the medical directors, we assess the
clinical care of members and any deviation from practice guidelines. If we find any deviation, our team follows up to provide education. In the case of flagrant or repeated deviation from practice guidelines or an adverse outcome, staff will follow up with appropriate remedial or corrective action.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.
PSCS complies with the Medicaid requirements set forth in 42 CFR § 438.236, as described in more detail in our narrative in response to Attachment 7, Sections 5, 12, Attachment 9, and Attachment 11, Section J. In brief, we collect, analyze, integrate, and report data in a variety of ways as indicated below:

PSCS receives and processes weekly Medicaid Approved Provider files from the OHA to ensure providers are approved to provide Medicaid covered services to members. This information is loaded into our Facets software for accurate claims processing. We monitor and screen providers to determine if there are any providers termed by the OHA that need to be updated for contracting status and claims payment.

PSCS maintains utilization and appeals and grievance data in our Dynamo software. This software is integrated into the Facets claims processing system to ensure prior-authorizations and referral information is flagged in both systems. Providers can submit prior-authorizations in our online web-portal, InTouch. The information submitted through the portal is also integrated into the Dynamo and Facets systems to ensure consistency. System data is populated by providers and internal staff, from the Claims, Health Services, and Grievance & Appeals departments. All collected data is available to the OHA and upon request to CMS.

PSCS utilizes the 834 files delivered daily from the OHA for all member enrollment and demographic data. We retain the original format, X12, to reduce the risk for data manipulation. The 834 file provides enrolled member information including but not limited to, demographics, rate cohort, language spoken and written, and responsible party information if other than self. The 834 is an industry standard X12 5010 HIPAA compliant document. We follow the X12 companion guide and the OHA specification sheet for Oregon requirements. All 834 files are copied in their entirety to the Enrollment Management System (EMS) staging area. The staging area stores all data sent via 834 and is available for access and reporting. The EMS system parses the raw 834 and makes it readable and useable. EMS will then load the data to the Facets claims system. Once a month, the OHA sends an audit file. The audit file is used as a true-up of membership based on all of the changes, terminations and new members/reinstated members PSCS received throughout the previous month. We run this file through the same process as the daily files to ensure all member data is accurate and reconciled within 48 hours of receiving the file. We report any variance to the OHA using the Enrollment Reconciliation process. All PSCS electronic files related to Encounter Data follow the industry standard X12 5010 compliant formats. We use 837, 835 and 999 files for all encounter claims transfers with the OHA.
PSCS receives electronic and paper claims from providers, facilities and members. Paper claims are imaged through our vendors, electronically imaged to the OnBase system, and then entered to Facets. Electronic claims are sent using 837 transaction sets and batched through a clearinghouse for entry to the Facets system. We have reports in place that our claims team uses to verify timeliness of processing and aging of claims. We use a combination of reporting from the Encounter Module system and OHA provided reporting to verify that all data is submitted accurately and completely. We also have reports that allow for monitoring of the age, volume and timeliness of pended encounters, internal encounters and rejected encounters. We review the encounters daily and work, correct, or update them as necessary.

Concurrently with each submission to the OHA, PSCS must attest to the accuracy of the file and provide the claim count and billed charges for the 837 submitted. This attestation requires a signature by the PSCS authorized signer (currently VP of Government Operations) and must be received by the OHA EDI staff within 24 hours of the submission. After the OHA has initiated response files (835/999), PSCS must respond if there is any variance in what the stated submission was and what the OHA actually received. This can happen if claims are rejected in the 999 file or if there was a system glitch that dropped individual records during the transmission. PSCS investigates that variance, and responds to the OHA within fourteen calendar days of the notification, stating why there was a variance and how it will be corrected. This attestation also requires signature from the PSCS authorized signer.

All claims submissions, including those for capitated providers, are verified against maintained provider data sets, and are not adjudicated without a positive match to a single provider record. When claims submissions differ from provider records, our Provider Operations team obtains verification of updated provider data, or rejects the claim. Additionally, claims (including capitated claims) are subject to prepayment clinical and coding edits, as well as post-payment audits, to ensure our network providers are coding and billing accurately and following applicable guidelines.

PSCS utilizes Electronic Medical Records (EMR)/Electronic Health Records (EHR), and Health Information Exchange (HIE) data through a number of mechanisms. We have prebuilt reporting capabilities through our partnership with the Regional Health Information Exchange and a robust data interface to collect HL7 messages and documents provided from EHRs. We also have direct access to a clinic EHRs, which provides our case management, utilization management, and quality improvement staff access to key clinical data. This method of HIE access and sharing is beneficial when interfaces with the regional HIE have yet to be established. In addition, we work with provider partners to provide a standard format to collect clinically relevant data from EHRs, when point-to-point HL7 interfaces have yet to be completed. This export of EHR data increases the speed and availability of clinical information to our clinical care teams. One component related to Quality Incentive Metric reporting includes the collection of electronic clinical quality data. We also work with many Patient Centered Primary Care Home partners to obtain monthly reporting of data related to the eCQM measures.
Instructions: For each representation, Application will check "yes," or "no,". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?
   - Yes
   - No
   Explanation: PacificSource Community Solutions (PSCS) will continue to have an Administrative Services Agreement (ASA) with PacificSource, an Affiliate. The PacificSource family of companies consolidates all employees at the holding company level. This allows the PacificSource family to maximize economies of scale by managing staff, benefit programs, etc. at the holding company level. The same people that handle the CCO contract today will continue to manage and administer it going forward.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?
   - Yes
   - No
   Explanation: Pursuant to the same ASA mentioned in Question #1, PSCS will continue to utilize systems, including information technology systems, that are owned by PacificSource and utilized by the entire PacificSource family. While certain third party licenses are in place, the systems are managed and operated by PacificSource staff.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?
   - Yes
   - No
   Explanation: Personnel who perform the functions are employed by the PacificSource holding company and work on PSCS business pursuant to the ASA. The functions are not outsourced to a non-PacificSource entity; however, PSCS utilizes individuals employed at the holding company level.
4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?
   ☒ Yes  ☐ No
   Explanation: Similarly to the last question, PSCS will utilize individuals employed at the holding company level; however, none of the functions are outsourced to a non-PacificSource entity.

5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?
   ☒ Yes  ☐ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform this work. In addition, PSCS has delegated some credentialing work to certain third-party entities; however, PSCS maintains oversight responsibility and audits these delegates on a regular basis.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?
   ☒ Yes  ☐ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform the majority of this work. Please refer to the Subcontractor and Delegated Entities Report in Attachment 6 for additional details.

7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?
   ☐ Yes  ☒ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform this work; however, none of the functions are outsourced to a non-PacificSource entity.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?
   ☒ Yes  ☐ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform this work; however, none of the functions are outsourced to a non-PacificSource entity.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?
   ☒ Yes  ☐ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform this work; however, none of the functions are outsourced to a non-PacificSource entity.
10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?
   ☒ Yes  ☐ No
   Explanation: PSCS will utilize individuals employed by the PacificSource holding company to perform a variety of work required by the CCO contract; however, other than as specified in this Attachment 15 or elsewhere in the Application, none of the functions are outsourced to a non-PacificSource entity.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?
   ☒ Yes  ☐ No
   Explanation: PSCS will subcontract with certain third-parties for discrete functions, to include without limitation non-emergent medical transportation, dental care services, and participating providers for Covered Services. PSCS will not subcontract any work that may not be subcontracted and, in all circumstances, PSCS remains responsible for performance under the CCO contract.

12. Other than VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?
   ☐ Yes  ☒ No
   Explanation: No, PSCS will not sub-capitate any portion of the Capitation Payments to a RAE or health plan.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?
   ☒ Yes  ☐ No
   Explanation: Yes, PSCS has two 2019 CCO contracts with the OHA. No, PSCS is not a risk-accepting entity or Affiliate of a 2019 CCO. No, PSCS does not have a management services agreement with a 2019 CCO. No, PSCS is not under common management with a 2019 CCO.
Attachment 16 - Member Transition Plan

Attachment 16, Section 2.a: Coordination between Transferring and Receiving CCOs. This section should describe the Applicant’s plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This include but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

PacificSource Community Solutions (PSCS) is committed to working collaboratively with other successful applicants to achieve a successful transition for members who change CCOs during the open enrollment period. We share the Oregon Health Authority’s (OHA) goals of minimal disruption, successful care coordination, and minimizing provider and member burden. We also have significant experience managing large group transitions. Below, we address the following key components of our coordination plan:

- **Working Relationships and Agreements.** Once the OHA releases intent to award notices in July 2019, PSCS proposes that we convene or participate in discussions with successful applicants in choice areas to build detailed road maps, agree on template data sharing agreements and provider notification language, and identify key work streams to ensure a successful transition. At the outset, we propose to create health services, operations, and IT work streams. Because we have strong working relationships with every applicant and already participate in OHA work groups with key leaders from each applicant, we are confident that we can convene or participate in productive discussions to establish these relationships. Before July 2019, PSCS will prepare template agreements and draft workstream charter documents to help guide this work.

- **Data Sharing and Validation.** We propose to create draft data sharing agreements and validation plans for review by other successful applicants. We believe that if we can standardize agreements and plans across regions, we can reduce administrative burden and delay. In general, PSCS will follow standard electronic file processes that include testing, validation, and production phases. We propose to create a menu of standard fields that will promote successful data sharing. We have experience importing and exporting large files with member information because we routinely engage in this work for our commercial members. We will build test export files and set up secure file transfer protocol (SFTP) folders to share exports using dummy files. Our intent is to front load this work.

- **Member Prior Authorization History.** Consistent with our plan to establish solid working relationships and prepare templates ahead of schedule to facilitate robust discussion and convergence, we propose to prepare sample de-identified system exports of member prior authorization history and other key fields for care coordination to share with the work group and evaluate whether all successful applicants can use similar formats. We expect that by doing work ahead of time to test our export formats, we can accelerate the work during open enrollment and prevent delays in file transmission.

- **Provider Matching and Assignment.** PSCS has already taken significant steps to reduce barriers for provider matching and assignment. We assign members to PCPs, but we use open access models in all other areas, which will help create a smooth transition. We intend to address provider matching in our test exports and plan to share member profiles to aid other applicants in matching. By convening an early work group, we hope to learn
more about other applicants’ assignment strategies to understand what steps we might need to take to facilitate a smooth transition.

- **Continuity of Care.** Consistent with our plans described above to convene and participate in work groups, we plan to share our transition of care policy with other successful applicants and determine if we have a shared understanding of our scope of work. Pursuant to OAR 410-141-3061, PSCS defines the transition of care period as the effective date of enrollment and continuing for 30 days for physical and oral health, 60 days for behavioral health, 90 days for members who are dually eligible for Medicaid and Medicare, or until the member’s new provider reviews the member’s treatment plan, whichever comes first.

At a minimum, PSCS intends to provide transition of care support to the following members who may suffer serious detriment to their physical and mental health or who are at risk of hospitalization or institutionalization if any breakdown in service or access to care were to occur: medically fragile children, breast and cervical cancer treatment program members, members receiving CareAssist assistance due to HIV/AIDS, members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation or chemotherapy services, members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months, Members participating in Oregon’s CMS approved 1915(k) and 1915(c) programs, any member who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization, and other prioritized populations.

We believe it is critical to determine if other applicants have similar expectations, or, if the OHA intends to modify these time periods or prioritized populations, to confirm that receiving or transferring CCOs have a shared understanding of the requirements. While we recognize that utilization of work groups is a time-intensive strategy, we are committed to this structure or a similar structure to work with other applicants to meet members’, providers’, and the OHA’s needs for a smooth transition.

- **Customer Support.** PSCS will commit to expanding our call center hours during open enrollment and offering extended hours to members and providers. We will encourage other successful applicants to do the same and will discuss how we can work together to offer warm handoffs between applicants during the open enrollment period. If the workgroup reaches consensus, we will document our shared regional understanding.

Attachment 16, Section 2.b(1): Transferring CCOs with Outgoing Members – Data Sharing. This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s).

PacificSource has extensive experience managing large changes in membership in the commercial large group market, and we plan to leverage that experience to support membership changes as a result of CCO 2.0. PSCS will develop extracts related to information about members, their treatment, and services for care coordination to support successful transition efforts. PSCS will use standard extract development processes to develop data extracts to provide
and share electronic health information regarding the member and their treatment and services. Data will be extracted from source systems such as the Dynamo care management system and will be integrated with other information from the data warehouse, including the Member Insight 360-view report to give the receiving CCO information for the transition. Data elements will be determined based on need, but could include elements from prior authorizations and care management events. Some specific examples of data elements include OHA member number, member name, date of birth, rate category, prior authorization events, prior authorization service codes, prior authorization dates, prior authorization determinations, active care management program events, inpatient events, historic transportation utilization, booked transportation rides or modes, and active referrals. Other supplemental information to support the transition of care management services from our Member Insight report includes the number of emergency department visits in the last 3, 6, 12 months, the number of inpatient admissions in the last 3, 6, 12, months, as well as chronic condition information such as diabetes, asthma, coronary artery disease, severe or persistent mental illness, substance abuse, and others. We will also be prepared to share Primary Care Provider (PCP) visits and QIM/HEDIS gaps in care. All of these fields will be formatted in a standard file format. As discussed above, we propose to generate sample de-identified extracts to share with regional work groups and the OHA to facilitate discussion and shared consensus.

PSCS intends to set up a secure file sharing mechanism with other successful applicants or use a mechanism provided by the OHA, as available. PSCS has developed a standard file sharing process for this type of file via SFTP and would follow typical electronic file processes that include testing and validation processes before moving into production environments. Because PSCS performs this work in house, we are able to staff this work using experts that work across lines of business. We also plan to expand our staffing during the open enrollment period to facilitate this information sharing. We intend to leverage existing resources including experts from our IT department, our Dynamo software developer, the business intelligence department, and team members that are trained in data testing and validation. In addition, we have already begun programming new reports that we will use to manage these processes. We use an annual project management process to execute on IT and business intelligence projects, and we will use that project management structure to facilitate successful transitions.

For those receiving applicants that request additional member information beyond the extracts PSCS prepares, we will provide all claims, referral, authorization, and pharmacy information, including physical, dental, behavioral health services, and transportation, within 21 days of the request for information. This will occur either after a verbal or written/secure email request from the receiving CCO. We will transmit all data requested to the receiving CCO in a secure manner and in compliance with the written arrangement with the receiving CCO.

Attachment 16, Section 2.b(2): Transferring CCOs with Outgoing Members – Provider Matching. This section should describe the methods for identifying Members’ primary care and Behavioral Health home Providers and any specialty Providers, and transmitting that information to the Receiving CCO(s).

In accordance with OAR 410-141-3061, PSCS will provide the receiving CCO the members’ primary care, dental health, behavioral health home, and specialty providers extracted from the members’ records that are captured in our claims and care management systems. These fields
will include provider name, provider address, NPI, group name, TIN, etc. As discussed above, it is our intent to standardize this reporting and to use a work group process to reach consensus. PSCS will also set up SFTP's with other CCOs or use a mechanism provided by the OHA as available to securely transmit this data consistent with data sharing agreements.

Attachment 16, Section 2.b(3): Transferring CCOs with Outgoing Members – Continuity of Care. This section should describe plans to support Member continuity of care, including but not limited to Prior Authorizations, prescription medications, medical Case Management Services, and Transportation. This section should include all Members regardless of health status with specific details to address those Members at risk as described in Section (1).

PSCS will work with receiving CCOs to transmit the extracts described above. For those receiving CCOs that request additional member information, we will provide claims files and system notes and transmit such information securely and in compliance with our written data sharing agreements. We can transmit this information either after a verbal or written/secure email request from the receiving CCO. Upon request, our Member Support Specialist (MSS) Team will work with the receiving CCO to assist with coordination and will organize a nurse-to-nurse call from a PSCS Care Manager to the receiving CCO care manager, as appropriate.

For members with known complex care needs, including those groups who are prioritized by the OHA, or who are actively being case managed by the PSCS care management team, we will develop reporting to identify members who are terming from PSCS and flag their need for ongoing care coordination. Once we identify that a member is transferring to another CCO, a PSCS Care Manager will reach out to the receiving CCO to alert them to the member’s clinical needs and arrange delivery of an expanded data set, as noted above. We will also convene interdisciplinary care team meetings with additional PSCS staff who have experience working with the member, treating clinicians, Aging and People with Disabilities, and the educational system, as needed.

Attachment 16, Section 2.c: Member/Provider Outreach for Transition Activities. This section should describe plans to work directly with outgoing Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the Member.

PSCS will use the following strategies to work directly with members and providers to perform warm handoff activities for high-need members and other specific member groups, as well as provide additional support during the transition to the receiving CCO to ensure a seamless transition:

- **Expanded Call Center Hours and Training.** PSCS has experience managing expanded member and provider customer service call center hours during the Annual Enrollment Period for Medicare. We will adopt similar strategies to offer evening and weekend call center support to assist members and providers during times that are convenient for them. In order to provide customer service access during the open enrollment period, PSCS will have customer service call hours from 8 AM-8 PM, seven days a week for the period of
10/1/2019-1/31/2020. We will post these hours on our website and share them in member materials. At the end of this open enrollment period, we will evaluate our call customer service call hours to determine if times other than 8 am-5pm M-F are needed. PSCS will monitor call data on an ongoing basis, and we will revise staffing and call center hours as needed. We will continue to offer walk-in support for members and providers as well. PSCS will provide special training to all Medicaid customer service representatives to ensure that they can properly assist members who are transitioning. This training will include education on how to have prescriptions and care approved for medical, dental, and behavioral services.

- **Expanded Customer Service and Case Management Staffing.** PSCS uses established staffing ratios for anticipated membership changes. We will build a staffing plan during summer 2019 and staff to those ratios to support members and providers. This expanded staffing is key to our ability to conduct the outreach described below.

- **Expanded Claims Examiner Staffing.** We anticipate that we will expand our team of claims examiners to work reports during the transition of care period and through mid-2020. We believe this department will be critical in monitoring the success of the transition period and will enable outbound outreach.

- **In-Person Transition of Care Meetings.** PSCS intends to offer and coordinate in-person transition of care meetings for members and providers. We currently use this structure for interdisciplinary care team meetings and believe it is effective to ensure comprehensive support for members.

- **In-Person Member Meetings.** PSCS currently offers support for both scheduled and walk-in in-person member education sessions. Our Customer Service representatives meet with members and their families throughout the year, and we intend to continue to offer this support during open enrollment. We know that for many of our members, particularly those with limited English proficiency, face-to-face meetings are highly effective.

- **Outbound Outreach.** As discussed above, PSCS will develop reporting to identify members who are terming from PSCS and need care coordination. The PSCS Care Management Team will use these reports to contact the receiving CCO, the member, and the member’s providers for any member that is being actively case managed to determine how we can assist with the transition. PSCS will organize a nurse-to-nurse call from a PSCS Care Manager to the receiving CCO in order to monitor the transition of care, if needed. We will prioritize outreach for Intensive Care Coordination (ICC) members.

- **Provider Reporting.** PSCS will create reports for providers that list the members who are terming from a PSCS CCO. If information is available to PSCS as to where the member is transitioning, we will include this information in reports that we share with providers to help support their work with the receiving CCO.

- **Monitoring Reports.** As discussed below, we are building a series of reports to evaluate the transition of care process and to generate lists for outreach and support. We intend to utilize these reports to identify any members or providers who need additional outreach. We will use our Provider Service Representatives and Customer Service Department to act on these reports.

Attachment 16, Section 2.d(1): Receiving CCOs with Incoming Members – Data Sharing. This section should describe the data reception plan for incoming Members, including but
not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

PSCS has significant experience in managing data feeds and incoming membership, and that experience forms the basis of our data reception plan. PSCS can receive and process standard and flat file extracts related to members, their treatment, and services for care coordination to support successful transition efforts. As part of this plan, PSCS will set-up a secure file sharing mechanism with other CCOs or use a mechanism provided by the OHA as available. PSCS will follow standard processes to download and store electronic data files, as appropriate, including testing and validating the data files. These processes include: downloading files from the SFTP site or other secure file transfer mechanism as defined by OHA, staging the files into the data warehouse, testing the files to confirm that appropriate members and other information was sent, where appropriate, uploading data from the files into the care management platform, claims platform and other systems, and making data from the file available via report for use by care management teams and others as part of the transition.

Attachment 16, Section 2.d(2): Receiving CCOs with Incoming Members – Provider Matching.
This section should describe the methods for identifying Members’ primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot be enrolled with the Provider from the Transferring CCO.

CCOs do not currently receive any PCP information from the OHA as members are enrolled, so we welcome the opportunity to enhance our provider matching methodology based on information provided by transferring CCOs. Our current practice is to automatically assign a member to a PCP within their area using an algorithm that evaluates past claims from a provider, member and provider language, and geographical location. PSCS is currently working on a strategic initiative (which will be complete before 2020) to enhance our assignment methodology. Within five days of receiving enrollment information, we send members an ID card indicating their assigned PCP and inform them that they can call us if this is not their current PCP. If a member contacts PSCS for any reason, we verify that we have the correct PCP on file. PSCS also conducts new member welcome calls to all new members and answers any questions they may have about their benefits or how to use the plan. During this outreach, we also confirm that we have the correct PCP information in our system. Of course, any data we receive from the transferring CCO will supplement our existing practices. PSCS will also produce reporting to compare PCP assignments to PCP information we receive from transferring CCOs and perform back-end quality assurance and auditing to resolve any matching errors.

PSCS has taken steps to eliminate barriers for members to seek care. We use an open access model for behavioral health services and do not require that members navigate any gate keeping to seek care. As a result, we will match incoming members and behavioral health providers (including behavioral health homes) for care coordination purposes, but not for purposes of assignment. We support member choice of behavioral health providers. Similarly, we will match incoming members and specialty providers for care coordination purposes, but not for purposes of assignment. Members may seek outpatient services from any behavioral health provider in our network. If a transferring member is seeing a primary care, behavioral health, oral health, or any other specialty provider that is not within our network, we will work with the member to identify any transition needs and ensure that the member has a seamless transition of care. Members have
the right to continue to see their providers during the transition period, and we will ensure these providers are reimbursed at a rate no less than fee-for-service reimbursement. PSCS offers commercial and Medicare coverage in many regions in Oregon and our systems are set up to recognize most providers that could submit a claim. We will ensure these claims do not deny during the transition period.

Attachment 16, Section 2.d(3): Receiving CCOs with Incoming Members – Continuity of Care. This section should describe plans to support Member continuity of care, including but not limited to honoring Prior Authorizations, prescription medications, and Treatment Plans from the Transferring CCO, medical Case Management Services, and Transportation. This section should address the approach for all Members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan should address how the Receiving CCO will ensure access to all medically necessary services for Members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization. During the transition period, PSCS will allow eligible members to continue to access their previous providers, including out-of-network providers, and will honor existing authorizations. Such access will conclude after the transition period or after the minimum or authorized prescribed course of treatment has been completed or the reviewing provider concludes the treatment is no longer medically necessary. Specialty care treatment plans will be reviewed by a qualified provider. PSCS will follow the following transition periods: 30 days for physical and oral health, 60 days for behavioral health, 90 days for members who are dually eligible, or until the member’s new provider reviews the treatment plan, whichever comes first.

PSCS will cover the entire course of treatment with a member’s previous provider for prenatal and postpartum care, transplant services through the first-year post-transplant, radiation or chemotherapy services for the current course of treatment, and prescriptions with a defined minimum course of treatment that exceeds the continuity of care period pursuant to applicable regulations.

For members transitioning into a PSCS CCO, we will take the following actions to support continuity of care for members:

- **Prompt Processing.** Members enrolling into a PSCS CCO will be entered into our systems within 12 hours of receipt of the 834 files from the OHA. At that point, members may immediately contact PSCS to schedule transportation and get assistance for services taking place on or after their effective transition date. All member materials will be distributed to members within 10 calendar days of receipt of the 834 file. PSCS will assign members to PCPs and will assign family members to the same PCP or clinic whenever possible.

- **Health Risk Screening.** PSCS will send a health risk screening assessment to every new member at the time of enrollment. One question asks the member whether they need assistance with arranging their medical care. For members who answer yes to this question, we will follow up and refer the member to a clinician, who will then contact the member. We will offer assistance with care coordination, including physical, behavioral, dental, and transportation services. In conjunction with this outreach, we will review all prior authorization and referral history and any documented care plans on file with the transferring CCO. We will also request chart notes from clinical providers and an up-to-
- New Member Welcome Calls. The PSCS Customer Service Department calls all new PSCS CCO members regardless of risk and need. We feel strongly that this early connection with our members promotes an understanding of benefits, supports care coordination, promotes member satisfaction, and reduces inappropriate utilization. During these calls, our staff welcomes members to the plan and answers any questions they may have about their benefits or how to use the plan and confirm that PSCS has the member’s correct provider information in our system. If members request additional assistance, our staff makes a warm hand off to the Care Management Team.

- Prioritized Populations. We will identify prioritized population members by rate groups and using extracts provided by transferring CCOs, consistent with the list of at-risk members set forth above. For those identified members, we will review information obtained from the data transfer process outlined above. In addition, for members who are actively being managed by the transferring CCO, we will request any documented care plans, as well as chart notes from clinical providers to support care coordination.

- Additional Members. For members not otherwise identified as set forth above, we will ensure that claims for new members that would ordinarily deny for no prior authorization will pend and be reviewed by our utilization management team to determine if the member was previously enrolled in a transferring CCO. For those members, the same process as above will be followed, including requesting prior authorization information from the transferring CCO. No claim will deny for no prior authorization without confirming what services were approved during the previous enrollment with the transferring CCO.

- Prescriptions. As discussed above, all prescriptions that are not managed for coverage by the OHA (certain behavioral health prescriptions) will follow our transition of care policy, which provides for a 30-day supply of medication without prior authorization or step therapy for newly identified members. For any medications managed by PSCS for the treatment of a behavioral health condition, an override will be allowed for the first 60 days of enrollment, or for 90 days if the member is dually eligible with Medicare. We will also contact providers and members directly to ensure that we support treatment plans. After any transition refill is provided, our Pharmacy Team will reach out to the provider and member to determine what additional steps are needed to ensure that the member does not experience any interruption in their care. In addition, PSCS will develop reports to identify all active prescriptions. We will use these reports to identify any active prescriptions that are not currently on our formulary and take follow-up action as needed.

- Contracting. PSCS will run reports to list providers currently serving members under transition of care provisions (either through claims or through extracts from transferring CCOs). We will analyze those reports for any gaps, and the Provider Network Department will contact the providers and offer contracts to ensure members have continued access beyond the transition of care period if a need is identified. Our Provider Network Department will set up any provider not currently in our network so that the provider is reimbursed consistent with OAR 410-120-1295 at no less that Medicaid fee-for-service rates.

- Transportation. PSCS has experience onboarding non-emergent medical transportation (NEMT) as a CCO benefit, and we plan to leverage this experience to make
improvements during the transition period. We plan to work with our NEMT partners to open call center operations early to allow for early booking of rides and transfer of booked rides. We are also working with our NEMT partners to utilize common transportation transition of care data import formats that can be used across regions. As applicable, PSCS will request transportation utilization information as well as mobility needs assessments to ensure PSCS is arranging for and continuing to provide the most appropriate modes of transportation for members.

Attachment 16, Section 2.d(4): Receiving CCOs with Incoming Members – Member/Provider Outreach for Transition Activities. This section should describe plans to work directly with incoming Members and their Providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping Members and Providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the Member.

PSCS will use the following strategies to work directly with members and providers to perform warm handoff activities for high-need members and other specific member groups, as well as provide additional support to ensure a seamless transition into the PSCS:

- **Expanded Call Center Hours and Training.** PSCS has experience managing expanded member and provider customer service call center hours during the Annual Enrollment Period for Medicare. We will adopt similar strategies to offer evening and weekend customer service call center support to assist members and providers during times that are convenient for them. In order to provide customer service access during the open enrollment period, PSCS will have customer service call center hours from 8 AM-8 PM, seven days a week for the period of 10/1/2019-1/31/2020. We will post these hours on our website and share them in member materials. At the end of this open enrollment period, we will evaluate our customer service call center hours to determine if times other than 8 am- 5pm M-F are needed. PSCS will monitor call data on an ongoing basis, and we will revise staffing and call center hours as needed. We will continue to offer walk-in support for members and providers as well. PSCS will provide special training to all Medicaid customer service representatives to ensure that they can properly assist members who are transitioning. This training will include education on how to have prescriptions and care approved for medical, dental, and behavioral services.

- **Expanded Customer Service and Case Management Staffing.** PSCS uses established staffing ratios for anticipated membership changes. We will build a staffing plan during summer 2019 and staff to those ratios to support members and providers. This expanded staffing is key to our ability to conduct the outreach described below.

- **Expanded Claims Examiner Staffing.** We anticipate that we will expand our team of claims examiners to work reports during the transition of care period and through mid-2020. We believe this department will be critical in monitoring the success of the transition period and will enable outbound outreach.

- **In-Person Transition of Care Meetings.** PSCS intends to offer and coordinate in-person transition of care meetings for members and providers. We currently use this structure for interdisciplinary care team meetings and believe it is effective to ensure comprehensive support for members.
- **In-Person Member Meetings and Community Education Sessions.** PSCS currently offers support for both scheduled and walk-in in-person member education sessions. Our Customer Service representatives meet with members and their families throughout the year, and we intend to continue to offer this support during open enrollment. We know that for many of our members, particularly those with limited English proficiency, face-to-face meetings are highly effective. We also have experience offering community education sessions where members and their families can meet with PSCS representatives (including customer service representatives and nurses) to answer their questions. We will offer to host or collaborate in hosting community education sessions to support the transition process.

- **Outbound Outreach.** When the 834 files are received from the OHA, PSCS will load the members into our Facets system. During this process, we will create a report to identify members transitioning from another CCO and/or those who qualify as ICC. We will prioritize outbound outreach to these members so that we contact them as quickly as possible to identify any immediate needs and to ensure that we can assign or connect them to their current providers for physical, behavioral, and dental services. Our Customer Service Department will contact these members and use a script that has been designed specifically for this population and approved by the OHA. The script will be drafted in a manner that will collect information necessary to ensure that the transitional needs of the member can be identified and resolved. Any member who needs immediate assistance will be transferred to the Care Management Team for further assistance.

- **Monitoring Reports.** As discussed below, we are building a series of reports to evaluate the transition of care process and to generate lists for outreach and support. We intend to utilize these reports to identify any members or providers who need additional outreach. We will use our Provider Service Representatives and Customer Service Department to act on these reports.

- **Health Risk Screening.** PSCS sends a health risk screening assessment to every new member at the time of enrollment. One question asks the member whether they need assistance with arranging their medical care. For members who answer yes to this question, we will follow up and refer the member to a clinician, who will then contact the member. We will offer assistance with care coordination, including physical, behavioral, dental, and transportation services. In conjunction with this outreach, we will review all prior authorization and referral history and any documented care plans on file with the transferring CCO. We will also request chart notes from clinical providers and an up-to-date claims feed, if needed.

- **New Member Welcome Calls.** The PSCS Customer Service Department calls all new PSCS CCO members regardless of risk and need. We feel strongly that this early connection with our members promotes an understanding of benefits, supports care coordination, promotes member satisfaction, and reduces inappropriate utilization. During these calls, our staff welcome members to the plan and answer any questions they may have about their benefits or how to use the plan and confirm that PSCS has the member’s correct provider information in our system. If members request additional assistance, our staff makes a warm hand off to the Care Management Team.