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:
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

(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: 6/14/2022
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):

[Redacted]
# 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 Marion and Polk Counties, we will partner with the Willamette Health Council (Health Council) to serve members through shared commitments to transparency in governance and financial operations, collective impact, and community reinvestment. PSCS will formalize these commitments through a Joint Management Agreement with the Health Council, which in turn will operate 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 in our current service areas. We are able to maintain sustainable cost growth through careful financial oversight and health services processes.

The unique Health Council structure will enable community leaders across the 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, as well as transform health care to address social determinants of health and health equity. We will build on our experience in current service areas to substantially improve the availability of integrated and specialty behavioral health services through technical assistance, aligned payment models, contract incentives, and removing barriers.

We look forward to partnering with the Oregon Health Authority to promote health system transformation in Marion County and Polk County as we work with Oregon’s health care providers and Medicaid members in CCO 2.0.

Sincerely,

Kenneth P. Provencher    Lindsey Hopper  
President and CEO, PacificSource   VP, Medicaid Programs, PacificSource
### Reference – Current Client

**Organization Name:** Marion County  
**Type of Organization:** Large Group Commercial  
**Organization Primary Contact:** Justine Flora  
**Organization Address:** 555 Court Street NE #4130, Salem, OR 97301  
**Phone Number:** 503.584.7786  
**E-Mail Address:** JFlora@co.marion.or.us

<table>
<thead>
<tr>
<th>Project performed by the CCO for the Client within the last 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource Health Plans (PSHP), an affiliate of Applicant PacificSource Community Solutions, provides large group commercial health care coverage for employees of Marion County.</td>
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<tr>
<th>How the Project relates to Work under the RFA Sample Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Insurance Benefits:</strong> PSHP provides Marion County with access to high-quality health care services, including medical, specialty care, behavioral health, and oral health care. PSHP offers a comprehensive network to Marion County employees and their dependents to give them choices to meet their unique health care needs. PSHP partners with Marion County to design and administer a health insurance program that improves employee health, wellness, and productivity. We work with Marion County on designing and deploying a wellness program to improve the health of the County’s workforce, to address specific areas of higher risk, and to engage employees in their health and health care services.</td>
</tr>
</tbody>
</table>

| Claims Payment: PSHP pays provider claims in a timely manner and monitors the health plan’s performance on a suite of operational claims metrics to ensure that the County’s employees and dependents receive high-quality services. PSHP provides Marion County with high-level claim utilization metrics, disease relativity measures, and other information to assist the County in its wellness efforts, employee offerings, and budgeting. |

| Accessibility: PSHP offers an online interface, In-Touch, to allow members real-time access to health benefit information, including explanations of benefits, pre-authorizations, health assessments, provider directory, healthy living education, and wellness programming. |

| Customer Service: PSHP offers customer service to ensure Marion County’s needs are met. The health plan answers all calls within 30 seconds without phone trees. Nurse case managers are available to assist with serious medical situations and guide members through the complex world of health care. |
Reference – Current Client

Organization Name: Oregon State University

Type of Organization: Large Group Commercial

Organization Primary Contact: Marcie Thompson, MBA

Organization Address: 108 SW Memorial Place, 328 Plageman Bldg., Corvallis, OR 97333

Phone Number: 541.737.4619

E-Mail Address: marcie.thompson@oregonstate.edu

<table>
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<td><strong>Health Insurance Benefits</strong>: PSHP provides Oregon State University with access to high-quality health care services, including medical, specialty care, behavioral health, and oral health care. PSHP offers a comprehensive network to the University’s employees and their dependents to give them choices to meet their unique health care needs. PSHP partners with the University to design and administer a health insurance program that improve employee health, wellness, and productivity. We work with the University on designing and deploying a wellness program to improve the health of the University’s workforce, to address specific areas of higher risk, and to engage employees in their health and health care services.</td>
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| Claims Payment: | PSHP pays provider claims in a timely manner and monitors the health plan’s performance on a suite of operational claims metrics to ensure that Oregon State University’s employees and their dependents receive high-quality services. PSHP provides the University with high-level claim utilization metrics, disease relativity measures, and other information to assist the University in its wellness efforts, employee offerings, and budgeting. |

| Accessibility: | PSHP offers an online interface, In-Touch, to allow members real-time access to health benefit information, including explanations of benefits, pre-authorizations, health assessments, provider directory, healthy living education, and wellness programming. |

| Customer Service: | PSHP offers customer service to ensure the University’s needs are met. The health plan answers all calls within 30 seconds without phone trees. Nurse case managers are available to assist with serious medical situations and guide members through the complex world of health care. |
**Reference – Former Client**

**Organization Name:** Oregon Community Credit Union  
**Type of Organization:** Credit Union  
**Organization Primary Contact:** Tammy Donahue, Sr. Human Resource Generalist  
**Organization Address:** 2880 Chad Drive, Eugene, OR 97408  
**Phone Number:** 541.681.6314  
**E-Mail Address:** TDonahue@MyOCCU.org

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<td><strong>Claims Payment:</strong> PSHP paid provider claims in a timely manner and monitored the health plan’s performance on a suite of operational metrics to ensure that Oregon Community Credit Union’s employees and dependents received high-quality services. PSHP provided Oregon Community Credit Union with high-level claim utilization metrics, disease relativity measures, and other information to assist Oregon Community Credit Union in its wellness efforts, employee offerings, and budgeting.</td>
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<td><strong>Customer Service:</strong> PSHP offered customer service to ensure Oregon Community Credit Union’s needs were met. The health plan answered all calls within 30 seconds without phone trees. Nurse case managers were available to assist with serious medical situations and guide members through the complex world of health care.</td>
</tr>
</tbody>
</table>
Reference – Former Client

**Organization Name:** Pape’ Group

**Type of Organization:** Equipment/Supply Chain

**Organization Primary Contact:** Lee Ballard, Director of Human Resources

**Organization Address:** P.O. Box 407 Eugene, Oregon 97440

**Phone Number:** 541.334.3453

**E-Mail Address:** lballard@pape.com

<table>
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| **Claims Payment:** PSHP paid provider claims in a timely manner and monitored the health plan’s performance on a suite of operational metrics to ensure that Pape’ Group’s employees and dependents received high-quality services. PSHP provided Pape’ Group with high-level claim utilization metrics, disease relativity measures, and other information to assist Pape’ Group in its wellness efforts, employee offerings, and budgeting. |

| **Accessibility:** PSHP offered an online interface, In-Touch, to allow members real-time access to health benefit information, including explanations of benefits, pre-authorizations, health assessments, provider directory, healthy living education, and wellness programming. |

| **Customer Service:** PSHP offered customer service to ensure Pape’ Group’s needs were met. The health plan answered all calls within 30 seconds without phone trees. Nurse case managers were available to assist with serious medical situations and guide members through the complex world of health care. |
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 [ ] NO [x]

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 [x] NO [ ]
   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 [x] NO [ ]
   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 ☑

   Is Applicant experiencing financial distress or having difficulty securing financing?
   YES ☐ NO ☑

   Does Applicant have sufficient cash flow to fund day-to-day operations throughout the proposed Contract period?
   YES ☑ 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 ☑

   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 ☑ 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 ☑ 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: [Redacted] (Authorized to Bind Applicant)  Title: President & CEO  Date: 04/15/2019
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
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
ARTICLES OF INCORPORATION

Corporation Division
www.filinginoregon.com

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 PROVENCER
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>1000</td>
<td>1000</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
Exhibit A

AGREEMENT AND PLAN 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 (ii) 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.

Agreement and Plan of Merger - 3
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  Springfield, OR
1995–Present

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  Springfield, OR
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  Eugene, OR
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  Portland, ME
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.

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
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
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.
1999–2012

President
Responsible for all healthcare developments for this venture capital firm

University of Utah Department of Orthopaedics
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>
<tr>
<td>Attachments</td>
<td>Contact Name</td>
<td>Telephone Number</td>
<td>Email Address</td>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<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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<tr>
<td>Attachments</td>
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<tr>
<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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample Contract</th>
<th>Contact Name</th>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</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>
</tr>
<tr>
<td>Exhibit A - Definitions</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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Exhibit B – Statement of Work: Covered/Non-Covered Services</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>
</tr>
<tr>
<td>Exhibit B – Statement of Work: Patient Rights and Responsibilities, Engagement and Choice</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>
</tr>
<tr>
<td>Exhibit B – Statement of Work: Providers and Delivery System</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>
</tr>
<tr>
<td>Exhibit B – Statement of Work: Operations</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>
</tr>
<tr>
<td>Exhibit B – Statement of Work: Quality, Transformation,</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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<tr>
<td>Sample Contract</td>
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<tr>
<td>Performance, Outcomes, and Accountability</td>
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<td>541-706-5181</td>
<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<tr>
<td>Exhibit C - Consideration</td>
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<td>541-706-5181</td>
<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
</tr>
<tr>
<td>Exhibit D – Standard Terms and Conditions</td>
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<td>541-706-5181</td>
<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
</tr>
<tr>
<td>Exhibit E – Required Federal Terms and Conditions</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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<tr>
<td>Exhibit F – Insurance Requirements</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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<tr>
<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><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<tr>
<td>Exhibit H – Value Based Payment</td>
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<td><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
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<tr>
<td>Exhibit I – Grievance and Appeal System</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>
</tr>
<tr>
<td>Exhibit J – Health Information Technology</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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<tr>
<td>Exhibit L – Solvency Plan and Financial Reporting and Cost</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 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><a href="mailto:jessica.sayers@pacificsource.com">jessica.sayers@pacificsource.com</a></td>
</tr>
<tr>
<td>Operations and Administration</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>
</tr>
<tr>
<td>Service Delivery</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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<tr>
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<tr>
<td>Financial Management</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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<tr>
<td>Systems Management</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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<tr>
<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

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.

**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**
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: 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:

<table>
<thead>
<tr>
<th>PacificSource Community Health Plans (PCHP)</th>
<th>PCHP is the sole member of PacificSource Community Solutions. PCHP offers Medicare Advantage products.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource Health Plans (PSHP)</td>
<td>PSHP is the sole member of PCHP and is an Oregon non-profit corporation that offers commercial products.</td>
</tr>
<tr>
<td>PacificSource</td>
<td>PacificSource is the sole member of PSHP and is an Oregon non-profit corporation that serves as a holding company.</td>
</tr>
<tr>
<td>Pacific Health Associates</td>
<td>Pacific Health Associates has a 50% member interest in PacificSource.</td>
</tr>
<tr>
<td>Legacy Health</td>
<td>Legacy Health has a 50% member interest in PacificSource.</td>
</tr>
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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.
Yes. Despite early and ongoing outreach attempts, Salem Health has not responded to our requests to engage in contracting and governance discussions. We presume this is because Salem Health is a founding member of a competing applicant to serve Marion and Polk counties. PSCS will continue to reach out to Salem Health and request a meeting to discuss how best to meet the needs of the community.

Attachment 6, Section A.1.c: What is the address for the Applicant’s primary office and administration located within the proposed Service Area?
PSCS believes strongly that local engagement and presence are key to successful community governance and health care transformation. While PacificSource intends to make best use of its multiple office locations throughout Oregon to serve CCO members (particularly through available space for expansion in Bend and Springfield) and will add additional office locations based on service area designations and corresponding enrollment, PacificSource’s primary address within the proposed service area is: Executive Administration, 342 Fairview Street, Silverton, Oregon 97381.

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.
Marion County and Polk County. PSCS has met with County representatives multiple times. County representatives have participated in community governance and in developing this Application. Each County has agreed to participate with PSCS.
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.

<table>
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<tr>
<th>Plan</th>
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<td>Essentials 2 (HMO)</td>
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<td>Essentials Rx 6 (HMO)</td>
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<td>Explorer Rx 7 (PPO)</td>
<td>Coos and Curry</td>
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<td>Explorer 8 (PPO)</td>
<td>Coos, Curry, and Lane</td>
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<td>Essentials Choice Rx 14</td>
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<td>(HMO-POS)</td>
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<td>MyCare Rx 40 (HMO)</td>
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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.

During 2018 and 2019, PSCS helped convene a local governing board, the Willamette 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 will be upheld through a Joint Management Agreement, which will delineate the role and function of PSCS as the CCO and its governing structure. The community governance model imposes a limit on PSCS’s 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.

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 Willamette 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 draft 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.

<table>
<thead>
<tr>
<th>Key Committees</th>
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<tbody>
<tr>
<td><strong>Health Council Committees</strong> - Community Advisory Council (CAC)</td>
<td>Described in Attachment 6, Section F.1.c: CAC</td>
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<tr>
<td><strong>Health Council Committees</strong> - Clinical Advisory Panel (CAP)</td>
<td><strong>Composition:</strong> PSCS clinical staff, community providers, public health directors, etc.</td>
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<tr>
<td><strong>Health Council Committees</strong> - Finance Committee</td>
<td><strong>Composition:</strong> CFOs and executives from health care and community stakeholder organizations, PSCS staff, Health Council staff</td>
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<tr>
<td>Leadership Committees</td>
<td>Medicaid Leadership Team / Composition: PSCS staff</td>
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<td>-----------------------</td>
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<tr>
<td>Reporting Relationship: Medicaid Administration and Executive Management Group</td>
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<tr>
<td>Responsibilities: Monitor performance and provide strategic and operational direction.</td>
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<tr>
<td>Oversight Responsibility: Oversee CCO functions to monitor performance and compliance.</td>
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<tr>
<td>Monitoring Activities: CCO performance, member engagement, Quality Incentive Measures, access to care, compliance, etc.</td>
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<thead>
<tr>
<th>Leadership Committees</th>
<th>Executive Management Group / Composition: PSCS staff</th>
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</thead>
<tbody>
<tr>
<td>Reporting Relationship: Chief Executive Officer / Responsibilities: Provide strategic direction for the company, oversee major and critical initiatives, and monitor company performance. / Oversight Responsibility: Oversee functions to monitor performance and compliance. / Monitoring Activities: Financials, quality metrics, corporate operational metrics, annual work plans, etc.</td>
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</tbody>
</table>

| Leadership Committees | Corporate Compliance / Composition: PSCS staff / Reporting Relationship: PSCS Board of Directors / Responsibilities: Monitor performance of work plan, program policies, FWA, and compliance plan. / Oversight Responsibility: Oversee compliance and FWA plan and activities. / Monitoring Activities: CAPs, external audits, internal audits and monitoring. |


| Quality Committees | Credentialing / Composition: PSCS staff / Reporting Relationship: Chief Medical Officer / Responsibilities: Review and decision of credentialing applications, adherence with credentialing standards using NCQA requirements, and monitoring of delegated credentialing oversight. / Oversight Responsibility: Annual audits of delegated activities and provider compliance. / Monitoring Activities: Conducts annual audits of delegated credentialing entities, monitoring of provider rosters, and compliance with credentialing standards. |

| 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: Oversee 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:** Oversees 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. The CAC has been established in the bylaws of the Willamette Health Council, which have been approved by the Willamette Health Council as the governing body for the proposed CCO. Efforts are underway to recruit CAC members and will continue throughout 2019. The CAC composition will meet or exceed the OHA’s requirements for consumer representation. The workgroup that met for many months (starting in October 2018) to form the governance in support of this application has strong support and commitments from key community stakeholders and consumer organizations.

**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 work plans, CHA/CHP, and CCO services and programs. 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. PSCS, in partnership with its Health Council, will regularly provide education, analytics support, and performance reports to the CAC so they can then make informed recommendations on such topics.

**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

| Group Code | Group Name | NAI Company Code | ID Number | FEDERAL R SSD | CK | 7 | Names of Securities Exchange or Publicity Traded (U.S. or International) | 8 | Names of Parent, Subsidiaries or Affiliates | 9 | Domiciliary Location | 10 | Relationship to Reporting Entity | 11 | Directly Controlled by (Name of Entity / Person) | 12 | Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other) | 13 | If Control is Ownership, Ultimate Controlling Entity(ies) Provide Percentage | 14 | Is an SCA Filing Required? (Y/N) |
|------------|------------|------------------|-----------|--------------|----|---|------------------------------------------------|----|------------------------------------|----|---------------------------|----|---------------------------------|----|------------------------------------------------|----|---------------------------------|----|------------------------|
| 4704       | PacificSource | 00000   | 81-0652554 |              |    |   | PacificHealthAssociates                         |    | OR                                  |    | UIP                               |    | PacificHealthAssociates and LegacyHealth | N          | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | PacificSource | 00000   | 23-7425300  |              |    |    | LegacyHealth                                     |    | OR                                  |    | UIP                               |    | PacificHealthAssociates and LegacyHealth | N          | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | PacificSource | 00000   | 46-3939564  |              |    |    | PacificSource                                    |    | OR                                  |    | UIP                               |    | PacificHealthAssociates and LegacyHealth | N          | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | PacificSource | 00000   | 46-3939564  |              |    |    | PacificSource                                    |    | OR                                  |    | UIP                               |    | PacificHealthAssociates and LegacyHealth | N          | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | PacificSource | 00000   | 30-0140934  |              |    |    | PacificSource Administrators, Inc.               |    | OR                                  |    | NIA                               |    | PacificSourceHealthPlans Ownership | 100.0     | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | PacificSource | 00000   | 82-0493800  |              |    |    | PrimaryHealthInc.                                |    | DE                                  |    | NIA                               |    | PacificSourceHealthPlans Ownership | 100.0     | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   | 82-0462956  |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | PrimaryHealthInc. Ownership            | 60.0       | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Charles P. Schneider, M.D. Ownership  | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Darrell J. Ludders, M.D. Ownership     | 0.5        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Frank J. Fazioz, M.D. Ownership        | 4.9        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | George A. Wade, M.D. Ownership         | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Graham Wetherley, M.D. Ownership       | 1.4        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Graham Wetherley, M.D. Ownership       | 0.1        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Gregory J. Kent, M.D. Ownership        | 0.5        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | James Johnston, M.D. Ownership         | 0.5        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Jeffrey G. Hessing, M.D. Ownership     | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | John Hine, M.D. Ownership             | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Jon R. Kattenhorn, M.D. Ownership      | 4.9        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Kirk Lewis, M.D. Ownership             | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Mark C. Claxton, M.D. Ownership        | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Michael J. Addo, M.D. Ownership       | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Michael J. Coughlin, M.D. Ownership    | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Nagar Narasimhan, M.D. Ownership       | 0.5        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Robert E. Lindsay, M.D. Ownership      | 0.8        | PacificHealthAssociates and LegacyHealth | N          |
| 4704       | IPN, Inc.    | 00000   |              |              |    |    | IPN, Inc.                                       |    | ID                                  |    | NIA                               |    | Robert H. Friedman, M.D. Ownership     | 0.8        | PacificHealthAssociates and LegacyHealth | N          |

**Note:**
- The table provides details on the ownership structure of various entities, including the percentage of ownership and the individuals involved.
- The entities listed include PacificSource, Legacy Health, PacificSource Administrators, IPN, Inc., and others.
- The table also indicates the types of control and the entities involved, such as Board of Directors, Ownership, and Ultimate Controlling Entity.
- Some entries are marked with a 'U' for Underwriter or 'I' for Insurer.
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<th>Group Code</th>
<th>Group Name</th>
<th>NAC Company Code</th>
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### SCHEDULE Y

**PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES**

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<td>Income/(Disbursements) Incurred Under Reinsurance Agreements</td>
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**Schedule Y Part 2 Explanation:**

** PacificSource performs certain administrative services and grants the right to use certain equipment, furniture, and leased office space to PacificSource CommunitySolutions. All employees in the PacificSource family of companies are employed by PacificSource and work for the various entities via an Administrative ServicesAgreement. 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 utilize a unique, locally oriented governance structure that meets OHA requirements. In our experience, this model is effective in engaging community stakeholders. 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 Willamette Health Council:

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Colm Willis</td>
<td>Marion County Commissioner</td>
</tr>
<tr>
<td>Craig Pope</td>
<td>Polk County Commissioner</td>
</tr>
<tr>
<td>Lindsey Hopper</td>
<td>VP, PacificSource</td>
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<tr>
<td>Sarah Brewer</td>
<td>Legacy Health</td>
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<tr>
<td>Robert Steele, MD</td>
<td>Willamette Family Medicine</td>
</tr>
<tr>
<td>Justin Hopkins</td>
<td>Mid-Valley Behavioral Care Network</td>
</tr>
<tr>
<td>Sandy Bumpus</td>
<td>Oregon Family Support Network</td>
</tr>
<tr>
<td>Carlos Olivares</td>
<td>Yakima Valley Farmworkers Clinic</td>
</tr>
<tr>
<td>Elizabeth Spinning</td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td>Pending</td>
<td>OHP Consumer</td>
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<td>Pending</td>
<td>Dental Care Organization (Mark Shalvarjian, CEO of Capitol Dental, participated in many meetings throughout fall and spring)</td>
</tr>
<tr>
<td>Pending</td>
<td>Community at Large</td>
</tr>
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</tr>
<tr>
<td>Pending</td>
<td>Member, Community Advisory Council</td>
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</table>

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.

In forming this governance structure, we are committed to standing up a strong CAC, which will operate as a standing committee of the Health Council. The CAC will meet at least monthly and meetings will be open to the public. The Chair of the CAC will also be a member of the Health Council. The Health Council’s bylaws outline the Selection Committee composition, duties, and intention to appoint CAC members consistent with OHA requirements. CAC members will meet OHA requirements and the Health Council bylaws. PSCS will employ a collaborative strategy with County representatives, providers, and other community partners that would leverage regional demographic data sources, to illustrate OHP member composition as it pertains to race/ethnicity, sex, language, disability, age and geographic location. The goal of this strategy is to ensure the CAC engages members from all backgrounds, to ensure the CAC is representative.
of the population in the service area and to ensure we are engaging members who may be experiencing health care inequities or health disparities. The Health Council will request CAC members to voluntarily submit information about REAL-D, age, rurality of residence, and county of residence during recruitment and on the CAC application. The CAC Selection Committee will assess race/ethnicity, age, gender identity, sexual orientation, disability, and geographic location criterion to ensure adequate representations of the diversity of the community. The CAC Selection Committee will refer to the CAC Assessment Matrix to ensure an adequate and diverse representation of our community. CAC members should also possess a collaborative working style, and provide expertise and insight in the areas of social services, public safety, and community resources.

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. As described in our response to Attachment 10, 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 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. The Health Council reviewed the CAP charter and is developing a recruitment plan to expand CAP membership across all care domains, including long-term care, safety net providers, integrated care settings, behavioral health, and oral health. We plan to capitalize on the workgroups that have formed to support this application and governance model to aid in recruitment. The Health Council endorsed a recruitment plan during its April meeting and will deploy that plan in May.

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.
Work is underway to establish an MOU. We received a letter from the Type B AAA office that they will sign an MOU with us once the OHA issues an intent-to-award notice. APD indicated that the office will co-sign once the OHA issues intent-to-award notices. We believe we have laid a solid foundation for this work and have met with staff in person on three occasions.

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.
PSCS met with staff in March and April in March to discuss care coordination efforts and discuss terms of the proposed MOU. We have since had multiple email exchanges and will continue to communicate. Please see our response, above, for information about the status of the document.

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.

<table>
<thead>
<tr>
<th>LMHA/CMHP</th>
<th>Current Status</th>
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<tbody>
<tr>
<td>Marion County (LMHA and CMHP)</td>
<td>Marion County has executed an MOU to be a participating provider. Marion County has indicated that it intends to sign the system coordination MOU before Readiness Review.</td>
</tr>
<tr>
<td>Polk County (LMHA and CMHP)</td>
<td>Polk County has executed an MOU to be a participating provider. Polk County has indicated that it intends to sign the system coordination MOU before Readiness Review.</td>
</tr>
</tbody>
</table>

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).
We have been meeting with both Marion and Polk County representatives regularly over the past six months. On March 14, 2019, we met with representatives of both Polk and Marion Counties in a joint meeting to review the MOU requirements outlined by the OHA. Both counties expressed their intention to work closely with us as partners and providers in a PSCS CCO. Since that time, we have met several times and exchanged emails to discuss the details of the
MOU. Each County has entered into an MOU with PacificSource to participate in our provider network. Each County has indicated it will sign the system coordination MOU before Readiness Review. We will continue to meet regularly and shape our shared plans.

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 the Community Engagement Plan tables.

- **DHS Child Welfare and Self Sufficiency field offices in the Service Area.** We will work closely with DHS to coordinate care for children in foster care to develop workflows designed to expedite screenings. We will prioritize community initiatives that support collaboration to improve health outcomes for our shared population. We will meet regularly with representatives to identify strengths and areas of improvement. We will invite DHS to be an active participant in the community governance model to elevate the voice of our most vulnerable population.

- **Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area.** We have established relationships with the OYA in our current CCO service areas to coordinate care and transitions for youth who are engaged with OYA. We also work closely with Juvenile Departments in our current service areas. We will leverage this experience as we reach out to engage Juvenile Departments and OYA in Marion and Polk counties. We will invite these partners to participate in the community governance model and meet regularly with them to coordinate care and transitions for youth.

- **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 have met regularly with representatives of Marion and Polk Counties. We are impressed by the high degree of collaboration between law enforcement and LMHAs in the region. Law enforcement and Marion County crisis teams jointly respond to emergency situations. The counties have also worked closely with the court system to establish both Drug Courts and Mental Health Courts. PSCS will support these efforts and work collaboratively to serve OHP members in the region.

- **School districts, education service districts that may be involved with students having special needs, and higher education in the service area.** We will conduct outreach to school districts and educational institutions to establish a relationship built on the foundation of shared responsibility for positive outcomes for children, youth and families in the region. We will support school districts in coordinating referrals to healthcare services, and we will participate in collaborative projects to strengthen the workforce pipeline.

- **Developmental disabilities programs.** We have conducted outreach to Northwest Senior and Disabled Services to discuss care coordination for our shared population. We will continue to expand this relationship by meeting regularly for care coordination and to develop relationships with other service providers in the region.

- **Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives.** We will seek to establish relationships with these organizations by consistently showing up and participating in events,
and we will work to institute shared agreements to coordinate health care services. We will continue to engage in relationship building activities and invite participation in the community governance model while continuing to meet regularly to address care coordination for our shared populations.

- **Housing organizations.** PSCS has a strong history of working very closely with housing organizations across the state, including initiating collaborative strategies to address housing insecurity. We will leverage this experience as we develop relationships with housing organizations in Marion/Polk counties. We will engage housing organizations in the community governance model and meet with them regularly to address housing as a social determinant of health.

- **Community-based Family and Peer support organizations.** We toured a number of these organizations to establish relationships built on the foundation of shared responsibility for the health and well-being of OHP members. We will engage these organizations in the community governance model and continue to meet regularly to address care coordination for our shared populations.

- **Other social and support services important to communities served.** We will meet regularly with representatives of social and support organizations to establish a relationship built on the foundation of shared responsibility for the health and well-being of OHP members. We will engage organizations that provide social and support services in the community governance model and meet regularly to address care coordination for our shared populations.

**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. For example, we are currently piloting a member survey to collect information about member satisfaction and engagement with health care. This data will inform our Quality Improvement activities, and the pilot project will inform future efforts to collect member feedback.

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 health care language 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 improvement activities. 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 currently 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 about health and wellness.
PSCS uses our in-house marketing and communication staff with experience in developing mixed media 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:

- 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 April 1, 2019, our contracted network includes primary care capacity for over 81,000 members, with all of the clinics in this network at Tier 4 or 5 PCPCH status. Over 60% of this member capacity is in clinics that are certified as PCPCH Tier 5. Of the total primary care capacity, over 80% is in clinics reporting integrated Behavioral Health services and one-third of the capacity is in clinics with integrated dental care services. Two of the clinical systems, with a combined capacity for over 16,000 CCO members, include integrated pharmacies to serve their patients.

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.
PSCS met with local staff in early 2019, discerned shared plans and needs, and created MOUs that describe our shared intent. We discussed our plans to hold care team meetings at least quarterly and include PCPCH providers for members identified as needing this level of coordination and planning. We plan to use the processes detailed in the MOU to coordinate outreach to PCPCH clinics at additional 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 extended contracting offers to every such clinic in the service area and received commitments from nearly all of them to participate with us, and we expect to continue to execute agreements throughout the summer and fall. We are pleased that so many providers see us as a trusted partner. Many of these providers are serving on the recently formed Health Council and on corresponding work groups, and representatives have participated in forming and authorizing the application. We plan to work cooperatively with these clinics to understand needs and design a system with the community that encourages use of these key providers. Given the strong network and governance participation, we expect little difficulty in executing on additional plans.

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.

We do not anticipate using a medical home model other than PCPCH. We are not aware of any interest from our provider network in pursuing this and strongly prefer that we remain aligned with the Oregon PCPCH medical home model. We have aligned our strategies around the evidence-based foundation of the PCPCH medical home model.

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 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. In 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 begin evaluation and 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.** 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.

- **Data Points.** PSCS will continue to gather various data points 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 analysis 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, as required by applicable regulations or the 2020 CCO contract. When the OHA releases performance 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 the Quest Analytics suite to identify deficiencies and gaps, 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, like Access to Care) 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, thoroughly investigate it, and provide resolution to the member or representative. We use a tracking system to categorize types of grievances, 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 brokerages. We use this 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 related to access complaints to evaluate need and execution of interventions across all service domains. We are also creating a subcontractor communication schedule to evaluate trends from monthly monitoring and establishing actionable next steps to meet baselines and targets for access to care improvements, consistent with our current practice with NEMT brokerages.

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 to meet member needs. 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 target our improvement efforts and close any gaps. We envision that this approach will allow us to set targets for grievances about travel times or distance to obtain services, the number of in-network providers available, and the number of overturned appeals to 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 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, PSCS management meets 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 appropriate 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. By combining our resources, we can help structure and implement prevention and self-management programs and services.

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 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 training and 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, and 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 provider groups through our current 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 culturally and linguistically 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 community mental health programs and connecting our member with high-quality individualized community-based services, we are able to effectively transition members with SPMI 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. One example of our work is our support of the Bridges to Health (B2H) Pathways Hub in the Columbia Gorge and the transformative Accountable Health Communities project in Central Oregon. 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 needed 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 referenced above 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 who is able to meet that need. Once members are matched to PCPs, those providers will conduct culturally and linguistically appropriate health screenings as part of their primary care practice. In addition, as part of our initial onboarding process, we conduct screening assessments in each member’s preferred language. In addition to screenings and welcome calls, 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. We are also
working to improve our feedback loop across the organization to connect with PCPs at every turn.

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 dually-eligible members. We plan to expand on these strategies with Type B AAA partners and have established relationships to carry out this coordinated work.

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 their 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 semiannual 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 work in partnership with DCOs and provider partners to review referral pathways, eliminate barriers to referrals, and promote integrated care. This is particularly important as FQHCs in the region look to expand their integrated oral health services. 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. Two clinic systems and a specialty practice are participating in this program, which provides technical assistance pertaining to 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 care coordination among all types of providers and care 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 going forward.

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 assessment. 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. Beginning as soon as 2021, PSCS plans to transform the current dental payment model to a tiered payment system tied to both
utilization and performance measures, including those intended to drive improvements in care coordination and integration.

- **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 interprofessional 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 specified primary care providers. We also plan to use Transformation and Quality Strategy efforts to test the best way to align information dissemination 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 tools that we provide for the purpose of care coordination and to clarify coordination and collaboration expectations. For example, we are currently conducting an audit with DCOs that reviews how analytics were used to support the care for a specific 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. Together, these strategies decrease the need for urgent and emergent dental care. We describe each strategy in turn. 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. Also, we send a welcome letter and ID card that have information about the member’s DCO, enabling the member to initiate care. 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 higher risk populations such as diabetic and/or pregnant members.

- **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.** As discussed above, we plan to support new access models for members to easily and efficiently receive care (through co-location, integration, and teledentistry). 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 our network PCP clinics have access to PreManage, and all 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 specifically flags members receiving DHS Medicaid-funded LTC services, our CM Team works to coordinate care delivery and address SDOH-HE. We also leverage existing work stream meetings on a monthly, quarterly, and as needed basis with regional APD offices and provider partners to eliminate
duplicate services and identify members in greater need of support. We focus on care 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 for our members, coordinate appropriate service delivery with key community partners, and collaborate with the assigned PCP.

**Attachment 7, Section 6.c(2)(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. This unique model reduces overall cost and improves health outcomes.

**Attachment 7, Section 6.c(2)(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): 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 care management services. In addition, our teams identify any cross system resources such as Non-Emergent Medical Transportation (NEMT), Skilled Nursing Facility, Durable Medical Equipment, or any health related service requests 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): 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 having 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 dental 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. 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 or not 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 convert 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 are met. 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.

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 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. We submit cases to regulatory agencies as required. 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 recurrences. 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, auditing schedules, 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 (PIPs) 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 launch 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. Because of our experience with community governance in our existing CCOs, we feel confident that we can create CCOs that will capitalize on the tremendous community goodwill and desire for innovation we’ve experienced in meeting with providers and community representatives over the course of the past nine months.

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 healthcare.

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 plan to share these reports in this proposed CCO as well. 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 continue to 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 conduct 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 via 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.

<table>
<thead>
<tr>
<th>Proposed Service Area</th>
<th>Maximum Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marion County and Polk County</td>
<td>81,910</td>
</tr>
</tbody>
</table>

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;

No, we do not propose to cover less than a full County in any County.

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.
Please see the attached **DSN Provider Report Template** in Excel.

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 and engaged in exploratory meeting with regional stakeholders beginning in June and with publicly funded providers starting in October. We began with a series of one on one meetings with providers, community partners, and publicly funded agencies in the region. Through the course of this relationship building, providers and partners conducted site visits with existing PSCS staff and providers to get a better sense of the CCO model. A group of leaders from organizations in Marion and Polk counties, including representatives from the LMHAs and LPHAs, traveled to Central Oregon and interviewed stakeholders. Since January 2019, PSCS has convened a series of community workgroups and developed an integrated and coordinated application to serve as a CCO in Marion and Polk counties. We have also toured local provider and service sites and gathered input and perspectives of staff and members. We have conducted targeted outreach to AAA providers in the region to get a deeper understanding of the needs of members with disabilities and dual eligible members. Since January 2019, we have convened work streams and meetings involving publicly funded entities on the following dates:

- Governance workgroup: 2/15, 2/20, 3/6, 3/20, 4/3, 4/16
- Behavioral health work group (including County representatives)
  - March 13 (tours) and March 27
  - April 10 (tours)
- Type B AAA meetings: 3/19, 3/27, 4/4, 4/10
- Counties: 3/14, 3/27
- Value Based Payment meetings: March 8-18

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. Marion County and Polk County have each signed an MOU to participate in the PSCS CCO. As of April 12, we continue to meet to discuss the LMHA, LPHA, and CMHP coordination MOUs. Our next governance meeting is April 16.

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.

We will continue to meet on a regular basis with Marion County and Polk County to finalize agreements and execute outstanding documents before Readiness Review. We also have a
standing meeting schedule for the Health Council. We do not expect any challenges going forward. These agreements are feasible. We would be pleased to update the OHA or SPC during Readiness Review or sooner, if requested.

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 sources of data.
- 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 Coordinated Care Organization 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.

PSCS puts members first. Our business practices centralize around our core values to do the right thing for our members, for the community, and for our organization. The Pharmacy Department, comprised of pharmacists, certified technicians, and regulatory administrative staff, operates under our core values as it serves all members. 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 applicable 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 supporting documentation, and check decision 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 Pas.

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 usable by Providers and Members.

In accordance with Section 508 of the Rehabilitation Act and Section 255 of the Communications Act, 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. To further ensure access to services when contracting with facilities for participation, PSCS does not discriminate, in terms of participation, against any hospital or facility who is acting within the scope of its license or certification under State law.

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.

Preauthorization and referral requirements are developed and communicated to providers and facilities in the area. 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 access to members for these services is timely. PSCS partners with facilities and providers in the service area to identify opportunities for improvement to timeliness, amount, duration, and scope for all membership. Contractual provisions have been made detailing
investments in these improvement opportunities, including, for example, the funding of a pediatric hospitalist program and partnership for the development of embedded behavioral health in an inpatient setting.

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

The hospital systems in Marion and Polk Counties do not offer the following services, but they are contracted and available in the tri-County metro region: adult and pediatric intensive care, pediatric inpatient psychiatry, neonatal intensive care, services requiring a burn unit, and transplants. PSCS nurse 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 (e.g. sedan, secure, stretcher transport), 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 established access to care work 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 Ambulance, 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 robust suite of analytics to track inappropriate use of ambulance, emergency rooms, and urgent care/walk-in clinics, including, but not limited to:

- Utilization monitoring through our Member Insight Provider Insight (MiPi) 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 Member Profiles part of the MiPi 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 for members to use as an urgent care instead of the emergency room.

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. We document care outcomes and severity of harm to member. 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 determined to be an Adverse Event, our Claims Department reduces or recoups claims 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 claims 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 to streamline manual work.

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” and associated procedures. 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 and 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. We discuss each in turn.

- **Maximize the primary care system.** 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 support 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. As discussed in our THW Integration and Utilization Plan, our THW Liaison will help support expanding this work going forward.

- **Explore specialty value-based payments.** 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.

- **Expand use of hospital capitation to other facilities across the state.** 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, rural hospitals, we have been successful in adding metrics to some of these 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, ensuring they watch for warning signs and symptoms and that they have a plan in place if they cannot get into their PCP. In the event a member cannot get into his or her PCP in a timely fashion, the case manager helps find the nearest urgent care clinic and makes sure they have 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 to coordinate to reduce member and provider abrasion.

- 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 level 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>Annual Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$0.50</td>
<td>5%</td>
</tr>
<tr>
<td>2</td>
<td>$1.00</td>
<td>10%</td>
</tr>
<tr>
<td>3</td>
<td>$2.50</td>
<td>15%</td>
</tr>
<tr>
<td>4</td>
<td>$5.00</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>$15.00</td>
<td>25%</td>
</tr>
</tbody>
</table>

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 level 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.
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 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 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.

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.

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.
<table>
<thead>
<tr>
<th>Role</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>How would you describe the current state of the value-based payment system in your organization?</td>
<td>Described in detail here.</td>
</tr>
<tr>
<td>CFO</td>
<td>What challenges are you currently facing in implementing value-based payment models?</td>
<td>Challenges listed here.</td>
</tr>
<tr>
<td>CMO</td>
<td>How do you plan to measure the success of value-based payment strategies?</td>
<td>Success metrics outlined here.</td>
</tr>
<tr>
<td>CTO</td>
<td>What technology solutions are being integrated to support value-based payment initiatives?</td>
<td>Technologies described in detail here.</td>
</tr>
<tr>
<td>HRM</td>
<td>How are employees being trained to support value-based payment initiatives?</td>
<td>Training programs detailed here.</td>
</tr>
<tr>
<td>ADM</td>
<td>How are patient outcomes being tracked and analyzed in the context of value-based payment models?</td>
<td>Analysis methods and tools described here.</td>
</tr>
<tr>
<td>TFM</td>
<td>What financial strategies are being employed to manage the financial impact of value-based payment models?</td>
<td>Financial strategies outlined here.</td>
</tr>
<tr>
<td>LMM</td>
<td>How are incentives being structured to encourage participation in value-based payment initiatives?</td>
<td>Incentive structures described here.</td>
</tr>
</tbody>
</table>

Note: Questions and responses are placeholders and should be replaced with actual content.
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>CCO</th>
<th>Service Type</th>
<th>LAN Category</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Pay for Performance</td>
</tr>
<tr>
<td>CCO B</td>
<td>Specialty Care</td>
<td>Shared Savings</td>
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<tr>
<td>CCO C</td>
<td>Hospital Care</td>
<td>Shared Risk</td>
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<td>CCO D</td>
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<td>CCO E</td>
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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. 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 has collected preliminary information using data from federal sources and initial information from contracted and participating providers. We will use this information to help establish a baseline. PSCS will capitalize on the work done in Central Oregon and the Columbia Gorge during CCO 1.0, as well as work across multiple lines of business, to support providers in this region.
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.

<table>
<thead>
<tr>
<th>Goal: Increase rate of EHR adoption among contracted physical health providers</th>
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<tbody>
<tr>
<td><strong>Strategy 1 (EHR Physical Health)</strong></td>
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<tr>
<td>Identify gaps in EHR adoption by physical health providers and scope needs to address gaps</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
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<tr>
<td><strong>By 12/31/19</strong></td>
</tr>
<tr>
<td>Determine data collection format</td>
</tr>
<tr>
<td>Collect data on EHR status across range of physical health providers</td>
</tr>
<tr>
<td>Calculate baseline across service area</td>
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<tr>
<td>By 12/31/20</td>
</tr>
<tr>
<td>Establish threshold above which non-EHR clinics receive adoption support</td>
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<tr>
<td>Complete scoping analysis of resources needed to address gaps in EHR adoption</td>
</tr>
<tr>
<td>During 2021-2024</td>
</tr>
<tr>
<td>Complete annual update to baseline assessment, including all OHA-specified data elements for reporting</td>
</tr>
<tr>
<td><strong>Activities:</strong></td>
</tr>
<tr>
<td>This strategy includes activities related to Assessment and Governance. For details, see attached HIT Roadmap.</td>
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<table>
<thead>
<tr>
<th>Goal: Increase rate of EHR adoption among contracted physical health providers</th>
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<tbody>
<tr>
<td><strong>Strategy 2 (EHR Physical Health)</strong></td>
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<tr>
<td>Encourage and support EHR adoption by physical health providers</td>
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<tr>
<td><strong>Milestones and Activities</strong></td>
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<tr>
<td><strong>By 6/31/20</strong></td>
</tr>
<tr>
<td>Complete inventory of resources available for educational, financial, and technical support</td>
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<tr>
<td>By 8/31/20</td>
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<tr>
<td>Complete assessment of adequacy of available resources and respond as needed</td>
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<tr>
<td>By 12/31/20</td>
</tr>
<tr>
<td>Complete deployment of at least one resourcing strategy listed above with 5 non-adopting providers</td>
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<tr>
<td>Set numeric targets for future change in adoption rates</td>
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<tr>
<td>During 2021-2024</td>
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<tr>
<td>Complete annual update of resources available and needs</td>
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<tr>
<td>Update and achieve numeric targets</td>
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<tr>
<td><strong>Activities:</strong></td>
</tr>
<tr>
<td>This strategy includes activities related to Assessment, Education, Peer Learning, and Technical Assistance. For details, see attached HIT Roadmap.</td>
</tr>
</tbody>
</table>

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. PSCS will capitalize on the work done in Central Oregon and the Columbia Gorge during CCO 1.0, as well as work across multiple lines of business, to support providers in this region.

**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

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

#### Strategy 3 (EHR Behavioral Health)

<table>
<thead>
<tr>
<th>Milestones and Activities</th>
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<tbody>
<tr>
<td><strong>By 12/31/19</strong></td>
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<td><strong>By 12/31/20</strong></td>
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<tr>
<td><strong>During 2021-2024</strong></td>
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<tr>
<td><strong>Activities:</strong></td>
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#### Goal: Increase rate of EHR adoption among contracted Behavioral Health providers

#### Strategy 4 (EHR Behavioral Health)

<table>
<thead>
<tr>
<th>Milestones and Activities</th>
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</thead>
<tbody>
<tr>
<td><strong>By 6/31/20</strong></td>
</tr>
</tbody>
</table>
Identify 2-4 EHR solutions appropriate to meet needs of Behavioral 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.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. PSCS will capitalize on the work done in Central Oregon and the Columbia Gorge during CCO 1.0, as well as work across multiple lines of business, to support providers in this region.

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.

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### 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.

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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.

<table>
<thead>
<tr>
<th>Potential Barriers and Mitigation Plans – Physical Health and Across All Care Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barrier: RHIO catalog not available or missing necessary data fields</td>
</tr>
<tr>
<td>Mitigation: Work with RHIO and OHA to align data elements to be collected and reported Maximize use of other data sources such as CHPL</td>
</tr>
<tr>
<td>Barrier: Clinics unwilling or without time to respond</td>
</tr>
<tr>
<td>Mitigation: Consolidate inquiry with other CCO interactions such as provider contract negotiation or provider service representative site visits Align with other vendors or CCOs who need the same data from providers to make a single inquiry</td>
</tr>
<tr>
<td>Barrier: Community partners involved in decision making may have conflicts of interest</td>
</tr>
<tr>
<td>Mitigation: 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>Barrier: Clinic readiness to adopt may be impaired by technological, industry, functional, financial, and legal barriers</td>
</tr>
<tr>
<td>Mitigation: Use educational materials, technical assistance, on-site coaching and peer learning to mitigate functional barriers Identify acceptable EHR options across a range of pricing Connect providers with large systems willing to add others to their EMR Use financial incentives initially then contract metrics or requirements to overcome financial barriers</td>
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</table>

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 expansive 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:

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<thead>
<tr>
<th>Potential Barriers and Mitigation Plans – Additional Items Specific to Behavioral Health</th>
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<tbody>
<tr>
<td><strong>Barrier:</strong> Financial incentives for adoption were never available for most Behavioral Health provider types</td>
</tr>
<tr>
<td><strong>Mitigation:</strong> Prioritize cost-effective EHR solutions</td>
</tr>
<tr>
<td>Support the creation of financial incentives specific to EHR adoption, for example through federal/state programs like the HIE Onboarding Program</td>
</tr>
<tr>
<td><strong>Barrier:</strong> Behavioral Health services typically need a very limited range of functionality, making comprehensive systems most costly than the benefit they provide</td>
</tr>
<tr>
<td><strong>Mitigation:</strong> Work with providers and experts to determine right-size software solutions</td>
</tr>
<tr>
<td><strong>Barrier:</strong> Behavioral Health providers are less organizationally aligned than other sectors, with no common structures like a DCO or Independent Practice Association</td>
</tr>
<tr>
<td><strong>Mitigation:</strong> 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</td>
</tr>
</tbody>
</table>
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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<tbody>
<tr>
<td><strong>Barrier:</strong></td>
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<tr>
<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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</table>

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

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**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. PSCS will capitalize on the work done in Central Oregon and the Columbia Gorge during CCO 1.0, as well as work across multiple lines of business, to support providers in this region.

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.

**Goal: Providers in all sectors improve their ability to provide coordinated care through use of HIE.**

**Strategy 7 (HIE Care Coordination)**

Partner with providers and other stakeholders to establish governance, technological, and operational structures to enable care coordination across the community

**Milestones and Activities**
By 12/31/19 Complete assessment of current Health Information Exchange (HIE) use for care coordination by provider type: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings

By 12/31/20 Establish community governance structure to evaluate, choose, fund, and steer implementation of HIE infrastructure

By 12/31/21 Adopt community plan for implementing, funding, and operationalizing HIE
Establish targets for participating organizations as annual milestones

During 2021-2024 Target number of health care and social service providers are using HIE for care coordination
Establish annual targets for connected providers and scope of use

Activities: This strategy includes activities related to Assessment, Governance, 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>Goal: 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>
<tr>
<td>Increase the number of providers receiving hospital event notification (HEN) and support them to make use of the information</td>
</tr>
</tbody>
</table>

**Milestones and Activities**

<table>
<thead>
<tr>
<th><strong>By 12/31/19</strong></th>
<th>Define process for establishing baseline by provider type: physical health primary care, physical health specialty, oral health, Behavioral Health, and integrated settings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduce non-adopting providers to basic HEN functionality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>By 12/31/20</strong></th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During 2021-2024</strong></td>
<td>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</td>
</tr>
</tbody>
</table>

**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.

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>
</tr>
</thead>
<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>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td>By 12/31/19 Execute a data sharing agreement with Collective Medical</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>By 12/31/21 Evaluate the ability to provide alerts and notifications directly to provider organizations</td>
</tr>
<tr>
<td>By 12/31/21 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</td>
</tr>
<tr>
<td><strong>During 2022-2024</strong> Anually assess opportunities to interface and exchange data with platforms, both Regional Health Information Organizations and other HIE platforms</td>
</tr>
<tr>
<td><strong>Activities:</strong> This strategy includes activities related to Governance and Infrastructure. For details, see attached HIT Roadmap.</td>
</tr>
</tbody>
</table>

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—includes 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.

<table>
<thead>
<tr>
<th>Goal: HIT supports Value Based Payment (VBP) arrangements through scale and spread of performance measurement in VBP strategies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 10 (HIT VBP and Metrics)</strong></td>
</tr>
<tr>
<td>Leverage HIE to provide and validate clinical data for performance measures in VBP arrangements</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td><strong>By 12/31/19</strong> 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</td>
</tr>
<tr>
<td><strong>By 12/31/20</strong> 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><strong>By 12/31/22</strong> 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>
</tr>
<tr>
<td><strong>During 2023-2024</strong> 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</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.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

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 12/31/19</td>
<td>Complete a thorough evaluation of existing PCP assignment and attribution processes to identify where improvements need to be made.</td>
</tr>
<tr>
<td>By 12/31/19</td>
<td>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</td>
</tr>
<tr>
<td>By 12/31/20</td>
<td>Improve from 2019 baseline of existing PCP assignment and attribution Produce monthly specialist performance reporting</td>
</tr>
<tr>
<td>During 2021-2024</td>
<td>Improve from baseline of existing PCP assignment and attribution processes, year over year, and distribute monthly specialist performance reporting based on accurate specialist attribution</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 12/31/19</td>
<td>Integrate Milliman MedInsight software in PSCS IT environment</td>
</tr>
<tr>
<td>By 12/31/20</td>
<td>Develop Phase 1 reports for use in 2021 VBP contracts Deliver reports to providers on a monthly basis</td>
</tr>
<tr>
<td>During 2021-2024</td>
<td>Develop later phase reports for use in 2022-25 VBP contracts, including member level detail</td>
</tr>
</tbody>
</table>

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

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**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 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**

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 12/31/19</td>
<td>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</td>
</tr>
<tr>
<td>By 12/31/20</td>
<td>Continue to align measures in our VBP arrangements with the OHA Aligned Measures Menu</td>
</tr>
<tr>
<td>During 2021-2024</td>
<td>Continue development to align measures in our value based arrangements with the OHA Aligned Measures Menu as measures are added or changed</td>
</tr>
</tbody>
</table>

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

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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. PSCS will capitalize on the work done in Central Oregon and the Columbia Gorge during CCO 1.0, as well as work across multiple lines of business, to support providers in this region.

**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:**

1. 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 of 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.

<table>
<thead>
<tr>
<th>Goal: Providers have information to improve care for individuals and populations and control costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 14 (HIT VBP General)</strong></td>
</tr>
<tr>
<td>Implement information sharing processes with providers that identify members who will most benefit from outreach, intervention, or care management support</td>
</tr>
<tr>
<td><strong>Milestones and Activities</strong></td>
</tr>
<tr>
<td><strong>By 12/31/19</strong> Implement reporting of additional information to provider partners that supports population health management and quality of care</td>
</tr>
</tbody>
</table>
By 12/31/20 | Add new information based on new reporting capacity based on growth in scope of available information
---|---
**During 2021-2024** | Annually implement new tools and algorithms
**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.

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

#### Strategy 15 (HIT for Population Health)

Improve risk stratification reporting to include enrollment in care management and other support programs and data from clinical and other non-claims sources

<table>
<thead>
<tr>
<th>Milestones and Activities</th>
</tr>
</thead>
</table>
| **By 12/31/19** Complete the second version of the care program identification algorithm to integrate non-claims-based data sources  
Complete the Patient-Activation Measure (PAM) project and integrate relevant data  
Integrate that information into reporting for provider partners |
| **By 12/31/20** Develop revised version of reports completed in 2019 |
| **During 2021-2024** On an annual basis, update reporting with data from provider insight and care program identification |

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

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.

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.

<table>
<thead>
<tr>
<th>Strategy 16 (HIT for Population Health)</th>
</tr>
</thead>
<tbody>
<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>
</tr>
</tbody>
</table>

Milestones and Activities

| By 12/31/19 | Complete assessment of SDOH-HE information currently available and of viability for inclusion in data warehouse |
| By 12/31/20 | Integrate SDOH-HE data in information used internally and reported to providers |
| By 12/31/21 | Complete two cycles of design and expansion of clinical data warehouse with additional clinical and SDOH-HE data |
| During 2022-2024 | On an annual basis, identify opportunities to expand our storage capabilities for SDOH-HE data reported by providers and members |

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

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>Domain</th>
<th>Source</th>
<th>Updated</th>
<th>Collection Method</th>
<th>Quality Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims and Encounter Data (physical, BH, NEMT)</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>Pharmacy Claims</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</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>Data Source</th>
<th>Data Type/Source Details</th>
<th>Frequency</th>
<th>Processing Method</th>
<th>Monitoring Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Encounters</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>Hospital Events</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>Member-Reported Health Status</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>Immunization Status</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>Laboratory Test Results</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>Consumer Information</td>
<td>Axiom 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>Clinical Data for eCQM and Hospital Measures</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>Clinical Data for Hybrid Measures</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>
<tr>
<td>Advanced analytics processes</td>
<td>SAS, R integration into Tableau, R integration into Microsoft SQL Server Management Studio, Alteryx Designer</td>
</tr>
<tr>
<td>Analytic languages</td>
<td>SAS, SQL, C#.NET, Python</td>
</tr>
</tbody>
</table>

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.
(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 above 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</td>
</tr>
<tr>
<td>Member</td>
<td>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 updates 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.

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:

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

**Staffing and Infrastructure**

| **Barrier:** | Expense and strain placed on providers and CCOs by increasing needs for reporting and responding to information |

**Mitigation:** Increase automation to support real-time communication with providers, continue to partner with RHIOs and other HIEs to share information bi-directionally, create consistent points of contact within PSCS for providers that are independent of business line.

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**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>Date</th>
<th>Action</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022-01-01</td>
<td>Implement EHR system</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>2022-03-15</td>
<td>Provide training sessions</td>
<td>Completed</td>
<td></td>
</tr>
<tr>
<td>2022-06-30</td>
<td>Encourage cohort participation</td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>2022-09-15</td>
<td>Achieve 50% adoption rate</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>2023-01-01</td>
<td>Monitor adoption rate and performance</td>
<td>Completed</td>
<td></td>
</tr>
</tbody>
</table>

*Note: This table represents a draft roadmap for increasing EHR adoption among contracted physical health providers. The status and notes columns are placeholders for actual progress and updates.*
### Attachment 9, Section B.1.a

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluate current adoption rates.</td>
<td>Train providers on EHR usage.</td>
</tr>
<tr>
<td>2. Develop a comprehensive EHR adoption plan.</td>
<td>Implement a tiered support system for providers.</td>
</tr>
<tr>
<td>3. Offer financial incentives for early adopters.</td>
<td>Provide ongoing training and support.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify gaps in current EHR implementation.</td>
<td>Develop a tailored EHR implementation plan.</td>
</tr>
<tr>
<td>2. Collaborate with Behavioral Health providers.</td>
<td>Provide specialized training resources.</td>
</tr>
<tr>
<td>3. Monitor adoption progress and adjust strategies as needed.</td>
<td>Establish regular follow-up mechanisms.</td>
</tr>
</tbody>
</table>
### Attachment 9, Section B.1.b

**Goal: Increase rate of EHR adoption among contracted Behavioral 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>1. Identify current EHR usage among providers.</td>
<td>2. Conduct provider surveys to assess readiness.</td>
<td>3. Develop customized implementation training programs.</td>
<td>4. Allocate financial resources for EHR adoption.</td>
<td>5. Monitor progress and adjust strategies as needed.</td>
</tr>
</tbody>
</table>
Attachment 9, Section B.1.c

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

<table>
<thead>
<tr>
<th>Objectives and Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
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**
Attachment 9, Section D.2.a

Goal: HIT supports Value Based Payment (VBP) arrangements through scale and spread of performance measurement in VBP strategies.
## 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.
Attachment 9, Section D.2.b

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

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.
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.

<table>
<thead>
<tr>
<th>Table 1: HIT Capabilities</th>
<th>Table 2: VBP Support</th>
<th>Table 3: Population Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requirement A</td>
<td>Requirement B</td>
<td>Requirement C</td>
</tr>
<tr>
<td>Requirement D</td>
<td>Requirement E</td>
<td>Requirement F</td>
</tr>
<tr>
<td>Requirement G</td>
<td>Requirement H</td>
<td>Requirement I</td>
</tr>
<tr>
<td>Requirement J</td>
<td>Requirement K</td>
<td>Requirement L</td>
</tr>
<tr>
<td>Requirement M</td>
<td>Requirement N</td>
<td>Requirement O</td>
</tr>
<tr>
<td>Requirement P</td>
<td>Requirement Q</td>
<td>Requirement R</td>
</tr>
<tr>
<td>Requirement S</td>
<td>Requirement T</td>
<td>Requirement U</td>
</tr>
</tbody>
</table>
Social Determinants of Health and Health Equity (SDOH-HE) Spending Policy

<table>
<thead>
<tr>
<th>State(s):</th>
<th>LOB(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Idaho</td>
<td>□ Commercial</td>
</tr>
<tr>
<td>□ Montana</td>
<td>□ Medicare</td>
</tr>
<tr>
<td>✖ Oregon</td>
<td>✖ Medicaid</td>
</tr>
<tr>
<td>□ Washington</td>
<td>□ PSA</td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
</tr>
</tbody>
</table>

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.
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

**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]

**Effective:** 4/21/2014  
**Next review:** 4/29/2020

**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

<table>
<thead>
<tr>
<th>State(s):</th>
<th>LOB(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>Commercial</td>
</tr>
<tr>
<td>Montana</td>
<td>Medicare</td>
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<tr>
<td>Oregon</td>
<td>Medicaid</td>
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<tr>
<td>Washington</td>
<td>PSA</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

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 receive integrated person centered care and services designed to provide choice independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

To have consistent and stable relationship with a care team that is responsible for comprehensive care management;

To receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member’s care team to provide cultural and linguistic assistance appropriate to the member’s need to access appropriate services and participate in processes affecting the member’s care and services;

To obtain covered preventive services;

To have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;

To receive a referral to specialty practitioners for medically appropriate covered coordinated care services in the manner provided in the CCO's referral policy;

PSCS will ensure that each member has access to Covered Services which at least equals access available to other persons served by the CCO.

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 42 CFR 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.
Residential Services Rights

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 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
RFA OHA-4690-19-PacificSource Community Solutions-Marion Polk
staff have continual access to company policies through the intranet on the PS Web. In addition, staff are informed of policy creation or updates through email and/or team meetings.

**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 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**

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<thead>
<tr>
<th>Policy Number: [Policy Number]</th>
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<tbody>
<tr>
<td>Effective: 2/1/2017</td>
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<tr>
<td>Next review: 4/1/2020</td>
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</table>

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

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 and providers 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.
Appendix

Policy Number: [Policy Number]

Effective: 3/15/2019  Next review: 3/15/2020

Policy type: Government  [Authors]

Depts:

Applicable regulation(s): CCO Contract Exhibit B, OAR 410-141-3320

External entities affected: N/A

Approved by:
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>
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<tbody>
<tr>
<td>All applicants must complete this full table. Applicants may add rows as needed.</td>
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</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),

**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, 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>Regional Health Equity Coalitions (if present in the service area), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add additional rows as needed.</th>
</tr>
</thead>
</table>

**OHP consumers (list in first column below)**

<table>
<thead>
<tr>
<th>OHP Consumers</th>
<th>CAC member consumer representatives</th>
<th>The community governance model utilizes the Community Advisory Council (CAC) as a forum for OHP Consumer Representatives to have a voice in decision-making for the CCO.</th>
</tr>
</thead>
</table>

**Develop**

- We worked in partnership with the newly formed Willamette Health Council (WHC), the proposed CCO’s governing body, to establish the CAC to represent OHP member needs. The WHC is finalizing a CAC charter that outlines roles and responsibilities of the CAC. We will continue further development efforts throughout spring and summer 2019.

**Maintain**

- The CAC will meet monthly and provide recommendations to the WHC and PSCS regarding funding decisions related to Social Determinants of Health and Community Benefit Initiatives. The CAC will be responsible for the development and implementation of a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHP) that will guide the direction of the CCO and investments of shared savings.

**Strengthen**

- PSCS will negotiate a Joint Management Agreement with WHC that will include a provision for ongoing support to
| Community-based Organizations | Marion and Polk Food Share | Marion and Polk Food Share addresses food insecurity, a Social Determinant of Health. Marion and Polk Food Share has been identified as a key community partner by many of our provider partners in the region. | Develop
We visited and toured many of the Federally Qualified Health Centers, Patient Centered Primary Care Home (PCPCH) clinics and community partner organizations in the region. One thing that stood out is the partnership that Marion and Polk Food Share developed and their work in the community. An example is the food drop sites in clinics they organized in Area Agency on Aging offices and other sites where people in need of food are likely to frequent. We will reach out to Marion and Polk Food Share to gain a deeper understanding of their program.

Maintain
We will invite Marion and Polk Food Share to participate at our CAC meetings and engage them as partners in our processes to develop a regional CHA and CHP.

Strengthen
We will seek opportunities to support the work of Marion and Polk Food Share to address food insecurity in the region. |

| Community-based Organizations | Northwest Human Services Transitional Living Program and drop-in | Northwest Human Services provides comprehensive medical, dental, and mental health services in the region. They also provide a wide array of programs and services related to SDOH-HE, including outreach and services for people who are homeless, | Develop
We have conducted multiple face to face meetings and phone calls with Northwest Human Services and they have participated in workgroups to inform this application. Northwest Human Services has agreed to participate in our provider network.

Maintain
We look forward to contracting and working with Northwest Human Services as a provider in our network and a community partner in efforts to address SDOH-HE to improve outcomes for OHP members in the region. We |
transitional living, case management, peer support, crisis support, and intervention. We met several times with Northwest Human Services in advance of this application and plan to work closely with them as a service provider in the region.

will support their efforts to serve a high risk population through a value based payment framework.

Strengthen

We will invite Northwest Human Services to be a participant in the Clinical Advisory Panel (CAP) and engage them as community partners in efforts to transform health care in the region.

| Community-based Organizations | Farm Worker Housing Development Corporation (FHDC) | The FHDC partners with health care providers in the region to assist OHP members and other patients experiencing housing insecurity. We will work to expand activities that address SDOH in the region. | Develop
FHDC has established a partnership with Willamette Family Medicine, a member of the WHC. PSCS will leverage this connection to establish a relationship and partner on efforts to improve the SDOH for members in the region.

Maintain
PSCS will reach out to FHDC and collaborate on strategies to address housing insecurity in the region.

Strengthen
PSCS will invite FHDC to be an active participant at the CAC to provide subject matter expertise in the arena of housing insecurity. |

| Community-based Organizations | Oregon Family Support Network (OFSN) | The OFSN of Marion County provides support for families with children that experience behavioral, emotional, or mental health challenges to help them succeed at school and in life. They offer peer support and | Develop
OFSN has contributed to the development of this application. They serve on the WHC.

Maintain:
PSCS will seek opportunities to engage OFSN in developing and/or updating Wraparound infrastructure in the region. We will also work with OFSN to development individual treatment plans for CCO members.

Strengthen: |
utilize a wraparound approach. We will partner with OFSN to address health disparities and support children and families with severe and persistent mental illness. PSCS will invite OFSN to be an active participant at the CAC and/or CAP to provide subject matter expertise in the area of Wraparound and supports for families experiencing behavioral, emotional or mental health challenges.

<table>
<thead>
<tr>
<th>Providers, physical health, including culturally specific providers as available (list in first column below)</th>
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<tr>
<td><strong>Providers, Physical Health</strong></td>
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<td><strong>Providers, Physical Health</strong></td>
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of healthy lifestyles, researching disease and injury prevention, preventing and responding to infections disease and efforts to limit health disparities. PSCS will work closely with the Polk County Public Health Department to transform health care in the region.

<table>
<thead>
<tr>
<th>Providers, Physical Health</th>
<th>Legacy Medical Group-Silverton</th>
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<tr>
<td></td>
<td>Legacy Medical Group is a PCPCH delivering services in the region and has been a key stakeholder engaged in establishing the community governance model in the region.</td>
</tr>
</tbody>
</table>

application. Polk County has signed agreed to participate in our provider network.

**Maintain**

Polk County serves on the WHC. We will engage them as active participants in decision-making through the community governance model. Polk County has agreed to participate in our provider network.

**Strengthen**

We will invite the Polk County Public Health Department to be an active participant at the CAP and CAC. We will work with them as a key stakeholder in efforts to develop and implement a collaborative CHA and CHP in the region.

<table>
<thead>
<tr>
<th>Providers, Physical Health</th>
<th>Kaiser Permanente</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kaiser Permanente is a medical provider delivering services in the</td>
</tr>
<tr>
<td></td>
<td>Develop</td>
</tr>
<tr>
<td></td>
<td>We engaged Kaiser Permanente in face-to-face and telephone meetings over the past eight months. They</td>
</tr>
<tr>
<td>Providers, Physical Health</td>
<td>Northwest Human Services Inc.</td>
</tr>
<tr>
<td>Providers, Physical Health</td>
<td>Yakima Valley Farmworkers Clinic</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Providers, Physical Health</td>
<td>Salem Women’s Clinic</td>
</tr>
</tbody>
</table>
Providers, Physical Health

<table>
<thead>
<tr>
<th>Legacy Medical Group-Women’s Health</th>
<th>Legacy Medical Group—Women’s Health specializes in obstetrics and gynecological services and has agreed to serve PSCS CCO members.</th>
</tr>
</thead>
</table>

**Develop**

PacificSource and Legacy have a long-term relationship for all government and commercial lines of business, and work together on a variety of population health initiatives in all markets. We engaged Legacy Medical Group—Women’s Health in face-to-face and telephone meetings over the past six months. They participated in several workgroups and information gathering processes to inform this application. Legacy Medical Group-Women’s Health serves on the WHC. They were instrumental in developing the community governance infrastructure in the region. Legacy has agreed to participate in our provider network.

**Maintain**

We will continue to partner Legacy Medical Group—Women’s Health as a member of the WHC to further the development of our community governance structure. We will meet with Legacy Medical Group—Women’s Health to develop a process to develop and implement a provider services contract. This process will include site visits and extensive dialog.

**Strengthen**

We will invite Legacy Medical Group—Women’s Health to participate in our provider network.

- We will set up a series of meetings to engage Salem Women’s Clinic in a process to develop and implement a provider services contract. This process will include site visits and extensive dialog.
- We will invite Salem Women’s Clinic to be an active participant at the CAP and engage them as partners in efforts to transform health care in the region.
<table>
<thead>
<tr>
<th>Providers, Physical Health</th>
<th>Childhood Health Associates of Salem</th>
<th>Childhood Health Associates of Salem (CHAOS) is a Tier 5 “5 STAR” PCPCH that has agreed to serve PSCS CCO members.</th>
<th>To be an active participant at the CAP and engage them as partners in efforts to transform health care in the region.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Develop</td>
<td>We have an established relationship with CHAOS and contract with them to provide services in our commercial line of business. We met with them to discuss expanding our relationship. A Central Oregon clinic hosted CHAOS for a site visit in Central Oregon, and PSCS also participated in a site visit at CHAOS. CHAOS has agreed to participate in our provider network.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain</td>
<td>We will collaborate with CHAOS on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen</td>
<td>We will invite CHAOS to be an active participant at the CAP and engage them as partners in efforts to transform health care in the region.</td>
<td></td>
</tr>
<tr>
<td>Providers, Physical Health</td>
<td>Silver Creek Family Medicine</td>
<td>Silver Creek Family Medicine is a primary care practice that has agreed to serve PSCS CCO members.</td>
<td>Develop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>We have an established relationship with Silver Creek Family Medicine as a contracted service provider for our commercial line of business. We met with them to discuss expanding our relationship. Silver Creek Family Medicine has agreed to participate in our provider network.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain</td>
<td>We will collaborate with Silver Creek Family Medicine on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of</td>
<td></td>
</tr>
</tbody>
</table>
| Providers, Physical Health | Hope Orthopedics | OHP members and the community at large.  
**Strengthen**  
We will engage Silver Creek Family Medicine in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, Transformation Quality Strategy (TQS), and other community projects. PSCS will invite Silver Creek Family Medicine to be an active participant at the CAP and engage them as partners to transform health care in the region.  

| Hope Orthopedics provides orthopedic care services in the region and has agreed to serve PSCS CCO members. | Develop | We have an established relationship with Hope Orthopedics as a contracted service provider for our commercial and Medicare lines of business. We had multiple discussions with them to work toward expanding our relationship. Hope Orthopedics has agreed to participate in our provider network.  
**Maintain**  
We will collaborate with Hope Orthopedics on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.  
**Strengthen**  
We will engage Hope Orthopedics in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Hope Orthopedics to be an active participant at the CAP and engage them as partners in efforts to transform health care in the region. |
| Providers, Physical Health | Woodburn Pediatric Clinic | Woodburn Pediatric Clinic is a Tier 4 PCPCH clinic that has agreed to serve PSCS CCO members. | Develop
We have an established relationship with Woodburn Pediatric Clinic as a contracted service provider for our commercial line of business. We met with them to discuss expanding our relationship. Woodburn Pediatric Clinic has agreed to participate in our provider network.  
Maintain
We will collaborate with Woodburn Pediatric Clinic on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.  
Strengthen
We will engage Woodburn Pediatric Clinic in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Woodburn Pediatric Clinic to be an active participant at the CAP and engage them as partners to transform health care in the region. |
|---------------------------|---------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Providers, Physical Health | Willamette Surgery Center | Willamette Surgery Center offers outpatient surgery services and has agreed to serve PSCS CCO members. | Develop
We met with Willamette Surgery Center to discuss expanding our relationship. Willamette Surgery Center has agreed to participate in our provider network.  
Maintain
We will collaborate with Willamette Surgery Center on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP consumer members and the community at large.  
Strengthen |
We will engage Willamette Surgery Center in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Willamette Surgery Center to be an active participant at the CAP and engage them as partners to transform health care in the region.

<table>
<thead>
<tr>
<th>Providers, Physical Health</th>
<th>Oregon Medical Centers, LLC</th>
<th>Oregon Medical Centers, LLC offers pain management services and has agreed to serve PSCS CCO members.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We have an established relationship with Oregon Medical Centers, LLC as a contracted service provider for our commercial and Medicare Advantage lines of business. We met with them to discuss expanding our relationship. Oregon Medical Centers, LLC has agreed to participate in our provider network.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain We will collaborate with Oregon Medical Centers, LLC on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Strengthen We will engage Oregon Medical Centers, LLC in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Oregon Medical Centers, LLC to be an active participant at the CAP and engage them as partners to transform health care in the region.</td>
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</tbody>
</table>

**Providers, behavioral health, including culturally specific providers as available (list in first column below)**

<table>
<thead>
<tr>
<th>Providers, Behavioral Health</th>
<th>Connections 365</th>
<th>Connections 365 provides therapeutic foster care, mentoring and mental</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We engaged Connections 365 in several workgroups to inform this application and reached out to engage them in</td>
<td></td>
</tr>
</tbody>
</table>
| Providers, Behavioral Health | Mid-Valley Behavioral Care Network | Mid-Valley Behavioral Care Network (BCN) is an intergovernmental organization that manages the mental health and alcohol & drug benefits for OHP members in Marion and Polk counties. Mid-Valley Behavioral Care Network has been instrumental in coordinating workgroups to bring partners together to inform this application. | Maintain  
We will continue to collaborate with Mid-Valley Behavioral Care Network to ensure continuity of services throughout the CCO transition process.  
Strengthen  
We will continue to meet with Mid-Valley Behavioral Care Network and provider partners to further our understanding of the strengths and opportunities in the Behavioral Health system in the region. | Maintain  
We will collaborate with Connections 365 on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.  
Strengthen  
We will conduct site visits and engage Connections 365 in efforts to coordinate care for their high risk population including outreach by our Member Support Specialist team | Maintain  
We will continue to collaborate with Mid-Valley Behavioral Care Network to ensure continuity of services throughout the CCO transition process.  
Strengthen  
We will continue to meet with Mid-Valley Behavioral Care Network and provider partners to further our understanding of the strengths and opportunities in the Behavioral Health system in the region. | Maintain  
We will continue to collaborate with Mid-Valley Behavioral Care Network to ensure continuity of services throughout the CCO transition process.  
Strengthen  
We will continue to meet with Mid-Valley Behavioral Care Network and provider partners to further our understanding of the strengths and opportunities in the Behavioral Health system in the region. | Maintain  
We will continue to collaborate with Mid-Valley Behavioral Care Network to ensure continuity of services throughout the CCO transition process.  
Strengthen  
We will continue to meet with Mid-Valley Behavioral Care Network and provider partners to further our understanding of the strengths and opportunities in the Behavioral Health system in the region. |
|---|---|---|---|---|---|---|---|
| Providers, Behavioral Health | Options Counseling | Options Counseling provides counseling and | Develop  
We engaged Mid-Valley Behavioral Care Network in face-to-face and telephone meetings over the past six months. They participated in several workgroups and information gathering processes to inform this application. The Director of Mid Valley Behavioral Care Network is a member of the WHC. | Develop  
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| Providers, Behavioral Health | Options Counseling | Options Counseling provides counseling and | Develop  
We engaged Mid-Valley Behavioral Care Network in face-to-face and telephone meetings over the past six months. They participated in several workgroups and information gathering processes to inform this application. The Director of Mid Valley Behavioral Care Network is a member of the WHC. | Develop  
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We engaged Mid-Valley Behavioral Care Network in face-to-face and telephone meetings over the past six months. They participated in several workgroups and information gathering processes to inform this application. The Director of Mid Valley Behavioral Care Network is a member of the WHC. |
<table>
<thead>
<tr>
<th>Providers, Behavioral Health</th>
<th>Valley Mental Health</th>
<th>Valley Mental Health is an outpatient mental health clinic that provides individual, group and family therapy, medication management, case management, and skills training. Valley Mental Health is a key stakeholder in the development of our application and has agreed to participate in our provider network.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Options Counseling for our commercial and Medicare Advantage lines of business. Options Counseling participated in workgroups to inform this application throughout February, March and April 2019. Options Counseling has agreed to participate in our provider network.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong>&lt;br&gt;<strong>Strengthen</strong>&lt;br&gt;We will collaborate with Options Counseling on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.&lt;br&gt;We will work closely with Options Counseling to make consistent quality improvements by offering technical assistance, value based payment methods, and collaborating on system-wide improvements. We will invite Options Counseling to be an active participant at the CAP and engage them as partners to transform health care in the region.</td>
</tr>
</tbody>
</table>
| Providers, Behavioral Health | Marion County Behavioral Health | Marion County Behavioral Health offers high-quality behavioral health services, crisis services and community supports and has agreed to serve PSCS CCO members. | We will collaborate with Valley Mental Health to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large. Strengthen
We will work closely with Valley Mental Health to make consistent quality improvements by offering technical assistance, value based payment methods, and collaborating on system-wide improvements. We will invite Valley Mental Health to be an active participant at the CAP and engage them as partners to transform health care in the region. |

Develop
We engaged in face-to-face, phone meetings and workgroups with Marion County Behavioral Health, beginning in the fall of 2018. Marion County serves on the WHC. Marion County has agreed to participate in our provider network. Maintain
We will continue to partner with Marion County Behavioral Health to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Marion County Behavioral Health’s efforts to provide high quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed. Strengthen
We will engage Marion County Behavioral Health in community processes and clinical quality improvements led by PSCS and the Health Council, such as the |
<table>
<thead>
<tr>
<th>Providers, Behavioral Health</th>
<th>Polk County Behavioral Health</th>
<th>Polk County Behavioral Health offers high-quality behavioral health services, crisis services and community supports and has agreed to serve PSCS CCO members.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Develop \nWe engaged in face-to-face, phone meetings and workgroups with Polk County Behavioral Health, beginning in the fall of 2018. Polk County serves on the WHC. Polk County has agreed to participate in our provider network. \nMaintain \nWe will continue to partner with Polk County Behavioral Health to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Polk County Behavioral Health’s efforts to provide high quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed. \nStrengthen \nWe will engage Polk County Behavioral Health in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Polk County Behavioral Health to be an active participant at the CAP and engage them as partners to transform health care in the region.</td>
</tr>
<tr>
<td>Providers, Behavioral Health</td>
<td>West Salem Mental Health Clinic – Northwest Human Services</td>
<td>West Salem Mental Health Clinic of Northwest Human Services offers a full range of mental health services for patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop \nWe conducted multiple face-to-face meetings and phone calls with Northwest Human Services and they participated in workgroups to inform this application. Northwest Human Services has agreed to participate in our provider network.</td>
</tr>
<tr>
<td>Providers, Behavioral Health</td>
<td>Catholic Community Services</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
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<td></td>
</tr>
<tr>
<td>Non-profit organization serving people with intellectual and developmental disabilities and children, youth, and families facing adversity. Catholic Community Services has agreed to serve PSCS CCO members.</td>
<td>Develop</td>
<td></td>
</tr>
</tbody>
</table>

- **Maintain**: We will support Northwest Human Services to continue providing high quality mental health services at their West Salem Mental Health Clinic by contracting for services, monitoring the contract and providing technical assistance as needed.

- **Strengthen**: We will engage Northwest Human Services in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Northwest Human Services to be an active participant at the CAP and engage them as partners to transform health care in the region.

<table>
<thead>
<tr>
<th>Providers, Behavioral Health</th>
<th>Catholic Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-profit organization serving people with intellectual and developmental disabilities and children, youth, and families facing adversity. Catholic Community Services has agreed to serve PSCS CCO members.</td>
<td>Develop</td>
</tr>
</tbody>
</table>

- **Develop**: We reached out to Catholic Community Services and engaged them in meetings and workgroups to inform this application and develop a foundational relationship.

- **Maintain**: We will collaborate with Catholic Community Services on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.

- **Strengthen**: We will engage Catholic Community Services in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. We will invite Catholic Community Services to be an active participant at the CAP and engage them as partners to transform health care in the region.
Providers, Behavioral Health | Center for Addiction and Counseling | The Center for Addiction and Counseling Services provides substance abuse and mental health services and has agreed to serve PSCS CCO members.

Develop
The Center for Addiction and Counseling Services has agreed to participate in our provider network.

Maintain
We will collaborate with the Center for Addiction and Counseling on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.

Strengthen
We will engage the Center for Addiction and Counseling in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects.

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Providers, Behavioral Health | Creekside Counseling | Creekside Counseling provides intensive outpatient substance use disorder services and has agreed to serve PSCS CCO members.

Develop
Creekside Counseling has agreed to participate in our provider network.

Maintain
We will collaborate with Creekside Counseling on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP consumer members and the community at large.

Strengthen
We will engage Creekside Counseling in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects.
| Providers, Behavioral Health | New Perspectives Center for Counseling and Therapy | This provider group offers individual counseling and group therapy services and has agreed to serve PSCS CCO members. | Develop  
We have an existing contractual relationship with New Perspectives Center for Counseling and Therapy for our commercial and Medicare lines of business. We have reached out to New Perspectives Center for Counseling and Therapy to engage in dialog about expanding our relationship to provide services for OHP members in the region. New Perspectives Center for Counseling and Therapy has agreed to participate in our provider network.  
Maintain  
We will collaborate with New Perspectives Center for Counseling and Therapy on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the community at large.  
Strengthen  
We will engage New Perspectives Center for Counseling and Therapy in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. |
|---|---|---|---|
| Providers, Behavioral Health | Bridgeway | Bridgeway provides intensive residential and outpatient services for Substance Use Disorder and problem gambling and has agreed to serve PSCS CCO members. | Develop  
PacificSource and Bridgeway have had an established contractual relationship for our commercial lines of business for over a year. PSCS engaged in multiple face to face meetings with Bridgeway and engaged them in workgroups to inform this application. Bridgeway has agreed to participate in our provider network.  
Maintain  
We will collaborate with Bridgeway on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging |
them in the community governance model in order to improve the health and well-being of OHP members and the community at large.

**Strengthen**
We will engage Bridgeway in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. PSCS will invite Bridgeway to be an active participant at the CAP and engage them as partners to transform health care in the region.

<table>
<thead>
<tr>
<th>Providers, oral health, including culturally specific providers as available (list in first column below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers, Oral Health</td>
</tr>
</tbody>
</table>
| | | Develop
PSCS has an existing contractual relationship with Advantage Dental Services and a history of collaborating to improve service delivery in our existing CCO regions. PSCS and Advantage Dental Services engaged in multiple face-to-face and phone meetings and they participated in workgroups to inform this application. Advantage Dental Services has agreed to participate in our provider network. |
| | | Maintain
We will expand our existing relationship with Advantage Dental Services to ensure OHP members in Marion and Polk counties have access to dental services in the region by contracting for services, monitoring contracts, offering technical assistance. We will also engage Advantage Dental Services in activities to coordinate care and integrate care across the full care continuum. |
| | | Strengthen
We will engage Advantage Dental Services in community processes and clinical quality improvements led by PSCS and the Health Council, such as the CHA/CHP, TQS, and other community projects. PSCS will invite Advantage Dental to be an active participant at the CAP and engage
Providers, Oral Health

<table>
<thead>
<tr>
<th>Capitol Dental</th>
<th>Capitol Dental is a Dental Care Organization and has agreed to serve PSCS CCO members.</th>
<th>them as partners to transform health care in the region.</th>
</tr>
</thead>
</table>

Develop
PSCS has an existing contractual relationship with Capitol Dental and a history of collaborating to improve service delivery in our existing CCO regions. They were a key stakeholder in the formation of this application, participating in multiple meetings and workgroups over the past six months.

Maintain
We will expand our existing relationship with Capitol Dental to ensure OHP members in Marion and Polk counties have access to dental services in the region by contracting for services, monitoring contracts, offering technical assistance. We will collaborate with Capitol Dental to coordinate services and work toward dental integration across the full continuum of care in the region.

Strengthen
We will invite Capitol Dental to be an active participant at the CAP and engage them as partners to transform health care in the region.

Providers, Long Term Services and Supports, Including Culturally Specific Providers as Available (List in First Column Below)

| District Northwest Senior and Disability Services-Marion and Polk Counties | District Northwest Senior and Disability Services-Marion and Polk Counties works with individuals needing long term services and support and/or other resourcing needs. We will partner with Northwest Senior | Develop
We reached out to Northwest Senior and Disability Services and participated in face-to-face meetings and site visits at Northwest Senior and Disability Services. Northwest Senior and Disability Services shared a letter with us indicating their intent to sign an MOU after the OHA issues intent-to-award notices so that we can work together to coordinate care for senior and disabled members. |
| Providers, Traditional Health Workers | Marion County Public Health/Mental Health | Marion County Public Health and Mental Health employs several types of traditional health workers (THWs) and has agreed to serve PSCS CCO members. | Develop
We engaged in face-to-face, phone meetings and workgroups with Marion County, beginning in fall of 2018. Marion County serves on the WHC. Marion County has agreed to participate in our provider network.  
Maintain
We will continue to partner with Marion County to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Marion County’s provide high-quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.  
Strengthen
We will invite Marion County to be an active participant at the CAP and engage them as partners to transform health care in the region. We will evaluate opportunities to support THWs in the region by organizing a Community of Practice learning collaborative. |

and Disability Services-Marion and Polk Counties to coordinate care for OHP members in the region. |

Maintain
We will participate in regular meetings designed to coordinate care and care transitions for OHP members and dual-eligible members. We will partner with Northwest Senior and Disability Services to identify strengths and areas of opportunities to improve services that support our shared population including SDOH-HE.  
Strengthen
We will invite Northwest Senior and Disability Services to be an active participant at our CAC and CAP to contribute to the CHA/CHP and TQS as well as sharing clinical best practices and collaborating on system-wide quality improvement initiatives.
<table>
<thead>
<tr>
<th>Providers, Traditional Health Workers</th>
<th>Polk County Public Health/Mental Health</th>
<th>Polk County Public Health/Mental Health employs several types of traditional health workers and has agreed to serve PSCS CCO members.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We engaged in face-to-face, phone meetings and workgroups with Polk County, beginning in fall of 2018. Polk County serves on the WHC. Polk County has agreed to participate in our provider network.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong> We will continue to partner with Polk County to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Polk County’s efforts to provide high quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Strengthen</strong> We will invite Polk County to be an active participant at the CAP and engage them as partners to transform health care in the region. We will evaluate opportunities to support THWs in the region by organizing a Community of Practice learning collaborative.</td>
<td>---------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers, Traditional Health Workers</th>
<th>Yakima Valley Farmworkers Clinic</th>
<th>Yakima Valley Farmworkers Clinic is an FQHC in the region and provides a wide variety of services, including traditional health workers and has agreed to serve PSCS CCO members.</th>
<th>Develop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>We met with Yakima Valley Farmworkers Clinic in face-to-face, phone and workgroup meetings over the past six months. They participated in several workgroups to inform this application. Yakima Valley Farmworkers Clinic serves on the WHC. They were instrumental in developing the community governance infrastructure in the region. Yakima Valley Farmworkers Clinic has also agreed to participate in our provider network.</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong> We will continue to partner with Yakima Valley Farmworkers Clinic as a member of the WHC to further the development of our community governance structure. We will also engage Yakima Valley Farmworkers Clinic</td>
<td>---------</td>
</tr>
</tbody>
</table>
Providers, Traditional Health Workers | Northwest Human Services Inc. | Northwest Human Services is an FQHC and provides comprehensive medical, dental and mental health services in the region. They also provide a wide array of programs and services related to SDOH-HE including outreach and services for people who are homeless, transitional living, case management, peer support and crisis support and intervention. Several of these positions are filled with certified THWs. We had several meetings with Northwest Human Services Inc. and plan to work closely with them as a service provider in the region. | Develop
PSCS conducted multiple face-to-face meetings and phone calls with Northwest Human Services and they participated in workgroups to inform this application. Northwest Human Services has agreed to participate in our provider network. Maintain
We will work with Northwest Human Services to implement a contract for services. Northwest Human Services contributed to the development of a value based payment framework for the region. We will use this framework to build a contract that will support Northwest Human Services’ efforts to serve a high risk population. We look forward to working with Northwest Human Services as a provider in our network and a community partner in efforts to address SDOH-HE to improve outcomes for OHP members in the region. Strengthen
We will invite Northwest Human Services to be a participant in the CAP and engage them as community partners to transform health care in the region. We will evaluate opportunities to support THWs in the region by organizing a Community of Practice learning collaborative.
| Providers, health care interpreters (list in first column below) | Oregon Certified Interpreters Network | Translation for various spoken languages | Develop  
We have agreements with health care interpreters in other regions. We will reach out to Oregon Certified Interpreters Network with the intention of developing a service agreement as needed/appropriate.  
Maintain  
We will collaborate with Oregon Certified Interpreters Network on their current efforts to provide clinical care by contracting for services, meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP consumer  
Strengthen  
We will engage Oregon Certified Interpreters Network in community processes and clinical quality improvements led by PSCS and the Health Council. Such as the CHA/CHP, TQS, and other community projects. PSCS will encourage this agency to be an active participant at the CAP and the CAC.  

| Providers, Health Care Interpreters | IRCO: International Language Bank | IRCO’s International Language Bank provides on-site interpretation services as well as Health Care Interpreter Training. PSCS has a history of contracting with IRCO to enhance service delivery. | Develop  
PSCS has an existing contractual relationship with IRCO to provide Health Care Interpreter training in our existing CCO regions. We will work with IRCO to ensure that OHP members in Marion and Polk counties have access to services that are delivered in a linguistically and culturally appropriate manner.  
Maintain:  
We will evaluate the need for translation services and training in the region and contract for services as needed.  
Strengthen:  
We will implement a long-range plan to implement CLAS standards throughout the region.  


| **Providers, Health Care Interpreters** | **Certified Languages** | **Certified Languages offers translation services for multiple languages including American Sign Language and is already a contracted provider with PSCS.** | **Develop**
We have a current contractual relationship with Certified Languages and will work to extend our contract to include services to providers in Marion and Polk counties.  
**Maintain**
We will evaluate service delivery in Marion and Polk counties and ensure that members are able to access services that are linguistically and culturally appropriate.  
**Strengthen**
We will monitor this contract to ensure adequate service delivery and offer technical assistance as needed. |
|---|---|---|---|
| **Providers, Health Care Interpreters** | **Passport to Languages** | **Passport to Languages offers translation services for multiple languages including American Sign Language and is already a contracted provider with PSCS.** | **Develop**
We have a current contractual relationship with Passport to Languages and will work to extend our contract to include services to providers in Marion and Polk counties.  
**Maintain**
We will evaluate service delivery in Marion and Polk counties and ensure that members are able to access services that are linguistically and culturally appropriate.  
**Strengthen**
We will monitor this contract to ensure adequate service delivery and offer technical assistance as needed. |
| **Early learning hubs (list in first column below)** | **Marion & Polk Early Learning Hub Inc.** | **Marion & Polk Early Learning Hub Inc. is an active partner that offers a voice for young children and families and their education readiness. We will engage Marion & Polk Early Learning Hub Inc. as an active community partner.** | **Develop**
We currently attend Marion & Polk Early Learning Hub Inc. meetings in other regions and will attend and participate at this forum regularly.  
**Maintain**
We will collaborate with Marion & Polk Early Learning Hub Inc. on their current community efforts by meeting regularly, partnering on projects, and engaging them in the community governance model in order to improve the health and well-being of OHP members and the **Early learning hubs (list in first column below)** |
community at large.

**Strengthen**
PSCS will invite Marion & Polk Early Learning Hub Inc. to be an active participant at the CAC. We will engage Marion & Polk Early Learning Hub Inc. in community processes and quality improvements related to kindergarten readiness. We will include Marion & Polk Early Learning Hub Inc. in planning, development and implementation of the CHA/CHP.

<table>
<thead>
<tr>
<th>Local public health authorities (list in first column below)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Health Authorities</strong></td>
<td><strong>Marion County Health Department</strong></td>
<td><strong>Marion County Health Department is the Local Public Health Authority and a provider and community partner.</strong></td>
</tr>
<tr>
<td><strong>Develop</strong></td>
<td>We engaged in face-to-face, phone meetings and workgroups with Marion County Health Department, beginning in fall of 2018. Marion County Health Department serves on the WHC. Marion County has agreed to participate in our provider network.</td>
<td></td>
</tr>
<tr>
<td><strong>Maintain</strong></td>
<td>We will continue to partner with Marion County Health Department to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Marion County Health Department’s efforts to provide high quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.</td>
<td></td>
</tr>
<tr>
<td><strong>Strengthen</strong></td>
<td>We will invite Marion County Health Department to be an active participant at the CAP and engage them as partners to transform health care in the region. We will engage Marion County Health Department in the planning, development and implementation of a regional CHA/CHP.</td>
<td></td>
</tr>
</tbody>
</table>
| Local Health Authorities | Polk County Public Health Department | Polk County Public Health Department is the Local Public Health Authority and a provider and community partner. | Develop  
We engaged in face-to-face, phone meetings and workgroups with Polk County Public Health Department, beginning in fall of 2018. Polk County serves on the WHC. Polk County Public Health Department has agreed to participate in our provider network.  
Maintain  
We will continue to partner with Polk County Public Health Department to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region.  
Strengthen  
We will invite Polk County Public Health Department to be an active participant at the CAP and engage them as partners to transform health care in the region. We will engage Polk County Health Department in the planning, development and implementation of a regional CHA/CHP. |

**Local mental health authorities (list in the first column below)**

| Local Mental Health Authorities | Polk County | Polk County is the local mental health authority and a provider and community partner. | Develop  
We engaged in face-to-face, phone meetings and workgroups with Polk County, beginning in fall of 2018. Polk County serves on the WHC. Polk County has agreed to participate in our provider network.  
Maintain  
We will continue to partner with Polk County to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support |
| Local Mental Health Authorities | Marion County | Marion County is the Local Mental Health Authority and a provider and community partner. | Develop  
We engaged in face-to-face, phone meetings and workgroups with Marion County, beginning in fall of 2018. Marion County serves on the WHC. Marion County has agreed to participate in our provider network.  
Maintain  
We will continue to partner with Marion County to further develop our Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Marion County’s efforts to provide high quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.  
Strengthen  
We will invite Marion County to be an active participant at the CAP to be an active participant at the CAP and engage them as partners to transform health care in the region. We will engage Marion County in the planning, development and implementation of a regional CHA/CHP. |
|---|---|---|---|
| Other local government (list in the first column below) | Other Local Government Commissioners | Marion County Commissioners are elected officials who | Develop  
We reached out to Marion County Commissioners in multiple face-to-face meetings to share information and |
<table>
<thead>
<tr>
<th>Other Local Government</th>
<th>Polk County Commissioners</th>
<th>Polk County Commissioners are elected officials who oversee public health and mental health services in their respective county. They are key stakeholders in health care transformation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>gain a deeper understanding of the strengths and opportunities that exist in the county related to health and wellness. Polk County serves on the WHC. Polk County has agreed to participate in our provider network.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong> We will continue to partner with Polk County to further develop the Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Polk County’s efforts to provide high-quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Strengthen</strong> We will invite Polk County to be an active participant at the CAP and engage them as partners to transform health care in the region. We will engage Polk County in the planning, development and implementation of a regional CHA/CHP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Develop</strong> We reached out to Polk County Commissioners in multiple face-to-face meetings to share information and gain a deeper understanding of the strengths and opportunities that exist in the county related to health and wellness. Polk County serves on the WHC. Polk County has agreed to participate in our provider network.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Maintain</strong> We will continue to partner with Polk County to further develop the Health Council governance structure and collaborate on shared activities to transform health care and address SDOH-HE in the region. We will support Polk County’s efforts to provide high-quality clinical care by contracting for services, monitoring the contract and providing technical assistance as needed.</td>
</tr>
</tbody>
</table>
We will invite Polk County to be an active participant at the CAP and engage them as partners to transform health care in the region. We will engage Polk County in the planning, development and implementation of a regional CHA/CHP.

<table>
<thead>
<tr>
<th>Tribes, if present in the service area (list in first column below)</th>
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</thead>
<tbody>
<tr>
<td>Tribes</td>
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<td></td>
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<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Health Equity Coalitions, if present in the service area (list in first column below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no Regional Health Equity Coalitions present in the service area</td>
</tr>
<tr>
<td>Health Services in an Educational Setting (list in first column below)</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Maintain</td>
</tr>
<tr>
<td>Strengthen</td>
</tr>
</tbody>
</table>
### Table 2: Major activities and deliverables for which the CCO will engage the community

<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>Shared decision-making, Collaborate.</td>
</tr>
<tr>
<td>CHP</td>
<td>Shared decision-making, Collaborate.</td>
</tr>
<tr>
<td>SDOH spending priorities</td>
<td>Shared decision-making, Collaborate.</td>
</tr>
<tr>
<td>Health Related Services spending priorities</td>
<td>Shared decision-making, Collaborate.</td>
</tr>
<tr>
<td>TQS</td>
<td>Involve, Consult.</td>
</tr>
<tr>
<td>Member engagement strategies</td>
<td>Collaborate.</td>
</tr>
<tr>
<td>Policy development</td>
<td>Involve, Consult.</td>
</tr>
<tr>
<td>Setting priorities for health care transformation</td>
<td>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

<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>Part 2. 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>Part 3. 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>Part 4. 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>Part 5. 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>Part 6. 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 by which the applicant will complete key tasks.***</td>
</tr>
<tr>
<td>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. List the health priorities from existing plans.</td>
</tr>
</tbody>
</table>

Local public health authorities (list in this column below)

<table>
<thead>
<tr>
<th>Polk County Public Health</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

Based on the data in their 2017 CHA, Polk County Public Health’s current CHP has endorsed and implemented an evidence based program called 5-2-1-0. The aim of the program is to create healthy lifestyle changes by eating five fruits and vegetables per day,
limiting to two hours or less of non-educational or non-work screen time per day, engaging in one hour of physical activity per day and consuming zero sugar-sweetened beverages per day.

<table>
<thead>
<tr>
<th>Marion County Health Department</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-profit hospitals (list in this column below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salem Hospital</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Santiam Hospital</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Based on the data in their 2019 CHA, Marion County Health Department’s updated 2019 CHP is focused on the following priorities:

- Decreasing the number of adults that are obese
- Increasing the number of women who receive early prenatal care
- Reducing the number of adults that smoke cigarettes
- Improving the mental health of the community

Salem Hospital is also an active partner in Marion County’s updated 2019 CHP and is committed to working on the following community priorities:

- Decreasing the number of adults that are obese. This will include addressing SDOH, as stated in Salem Hospital’s Community Benefit Implementation Plans for 2018-2020.
- Reducing the number of adults that smoke cigarettes
- Improving the mental health of the community. This will include addressing SDOH, as stated in Salem Hospital’s Community Benefit Implementation Plans for 2018-2020.

Santiam Hospital is an active partner in Marion County’s updated 2019 CHP and is committed.
<table>
<thead>
<tr>
<th>Legacy Health Medical Center-Silverton</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>
|                                      | Legacy Health Medical Center-Silverton is an active partner in Marion County’s updated 2019 CHP and is committed to working on the following community priorities:  
  - Decreasing the number of adults that are obese  
  - Improving the mental health of the community |

Legacy Health Medical Center-Silverton’s 2017 Community Health Needs Assessment and Community Health Improvement Plan identifies SDOH as one of their three prioritized focus areas which specifically includes:  
  - Access to healthy food  
  - Improving health literacy  
  - Affordable housing  
  - Meaningful employment |

Current coordinated care organizations, as of 2019 (list in this column below)  

<table>
<thead>
<tr>
<th>Willamette Valley Community Health</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>
| Willamette Valley Community Health is listed as a partner in Marion County’s updated 2019 CHP and committed to working on the following community priorities:  
  - Decreasing the number of adults that are obese  
  - Increasing the number of women who receive early prenatal care |
- Reducing the number of adults that smoke cigarettes
- Improving the mental health of the community

<table>
<thead>
<tr>
<th>Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Confederated Tribes of Grand Ronde</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The Confederated Tribes of Grand Ronde is an active partner in Marion County’s updated 2019 CHP and is committed to working on the following community priorities:

- Decreasing childhood obesity

* 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 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs Applicants may add rows as needed.

<table>
<thead>
<tr>
<th>All applicants must complete Part 1.</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 complete Parts 2a and 4a.</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. <strong>Part 3.</strong> Applicants with an existing CHA and CHP will describe gaps in existing relationships with identified organizations. <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>
</tr>
<tr>
<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 or more CHAs or CHPs; b) The organization was not explicitly involved in</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 participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**</td>
</tr>
<tr>
<td></td>
<td>CHA</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Confederated Tribes of Grand Ronde</td>
<td>N/A</td>
</tr>
<tr>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>PSCS will form a relationship with the Confederated Tribes of Grand Ronde by engaging in existing community forums and in the community governance committees no later than August 1, 2019. Representatives from the Confederated Tribes of Grand Ronde actively collaborated in the 2019 CHA. PSCS will secure participation from the tribe prior to the development of the next CHP no later than December 31, 2019.</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>There are no RHECs in the service area.</td>
<td>N/A</td>
</tr>
<tr>
<td>Local government, including counties</td>
<td></td>
</tr>
<tr>
<td>Marion County Health and Human Services</td>
<td>N/A</td>
</tr>
<tr>
<td>The organization was explicitly involved in developing one or more CHAs or CHPs.</td>
<td>PSCS established a relationship with Marion County Health and Human Services by engaging in existing community forums and in the forming of community governance committees. Marion County Health and Human Services actively collaborated in the 2019 CHA. PSCS will secure participation from Marion County Health and Human Services prior to the development of the next CHP no later than December 31, 2019.</td>
</tr>
<tr>
<td>Organization</td>
<td>Safe Routes to School</td>
</tr>
<tr>
<td>---------------------------------------</td>
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</tr>
<tr>
<td>PSCS established a relationship with</td>
<td></td>
</tr>
<tr>
<td>Polk County Health Department by</td>
<td></td>
</tr>
<tr>
<td>engaging in existing community</td>
<td></td>
</tr>
<tr>
<td>forums and in the forming of community</td>
<td></td>
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<tr>
<td>governance committees. Polk</td>
<td></td>
</tr>
<tr>
<td>County Health Department actively</td>
<td></td>
</tr>
<tr>
<td>collaborated in the 2019 CHA. PSCS</td>
<td></td>
</tr>
<tr>
<td>will secure participation from Polk</td>
<td></td>
</tr>
<tr>
<td>County Health Department prior to</td>
<td></td>
</tr>
<tr>
<td>the development of the next CHP no</td>
<td></td>
</tr>
<tr>
<td>later than December 31, 2019.</td>
<td></td>
</tr>
</tbody>
</table>

Organizations that address the four key domains of social determinants of health* (list in this column below).

<table>
<thead>
<tr>
<th>Organization</th>
<th>Safe Routes to School</th>
<th>Cherriots Regional</th>
<th>Polk County Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSCS will establish a relationship</td>
<td></td>
<td></td>
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<tr>
<td>with Cherriots Regional by</td>
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<td></td>
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</tr>
<tr>
<td>engaging in existing community</td>
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<td></td>
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<tr>
<td>forums and in the forming of</td>
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<td></td>
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<tr>
<td>community governance committees. We</td>
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<tr>
<td>will leverage this</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Relationship to Solidify Community Governance Structure</td>
<td>Relationship to Cherriots Regional</td>
<td>Relationship to PSCS</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Marion Polk Food Share</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Marion &amp; Polk Early Learning Hub Inc.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The organization was explicitly involved in developing one or more CHAs or CHPs.
<table>
<thead>
<tr>
<th>Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marion County Public and Behavioral Health</td>
</tr>
<tr>
<td>Polk County Public and Behavioral Health</td>
</tr>
<tr>
<td>Culturally specific organizations and organizations that work with underserved or at-risk populations (list in this column below).</td>
</tr>
<tr>
<td>Micronesian Islander Community</td>
</tr>
</tbody>
</table>
CHAs or CHPs.  

existing community forums and in the forming of community governance committees. The Micronesian Islander Community actively collaborated in the 2019 CHA. PSCS will secure participation from the Micronesian Islander Community prior to the development of the next CHP no later than December 31, 2019.

*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.

**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 of health priorities

All applicants must complete this full table to describe how the applicant will identify social determinants of health (“SDOH-HE”) priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.

<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>Obesity and SDOH</td>
<td>Salem Hospital’s 2018-2020 Community Benefit Implementation Plans</td>
<td>Health outcome goal: Decreasing the number of adults that are obese and addressing accompanying SDOH factors.</td>
</tr>
<tr>
<td>Mental health and SDOH</td>
<td>Salem Hospital’s 2018-2020 Community Benefit Implementation Plans</td>
<td>Health outcome goal: Improving the mental health of the community and addressing accompanying SDOH factors.</td>
</tr>
<tr>
<td>Access to healthy food</td>
<td>Legacy Health Medical Center-Silvertton’s 2017 Community Health Needs Assessment and Community Health Improvement Plan</td>
<td>Priority population: Support food banks and programs that provide food to individuals with food insecurities to increase the number of meals served.</td>
</tr>
<tr>
<td>Improving health literacy</td>
<td>Legacy Health Medical Center-Silvertton’s 2017 Community Health Needs Assessment and Community Health Improvement Plan</td>
<td>Other: Improve health literacy by increasing the number of community organizations and individuals reached through a regional health literacy conference.</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>Legacy Health Medical Center-Silvertton’s 2017 Community Health Needs Assessment and Community Health Improvement Plan</td>
<td>Priority population: Provide workforce training and college scholarships to support and increase the number of ethnically diverse youth entering health careers.</td>
</tr>
<tr>
<td>Meaningful employment</td>
<td>Legacy Health Medical Center-Silvertton’s 2017 Community Health Needs Assessment and Community Health Improvement Plan</td>
<td>Priority population: Provide financial support for labor resources to education and community-based programs focused on healthy lifestyle, educational attainment and career readiness to improve graduation rates.</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**
SDOH-HE spending priorities will align 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. 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**
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**
The Willamette Health Council, CAC, other governance committees, and community partners will collaborate to develop a regional CHA with data, input, and information from a wide variety of health and community-based organizations, stakeholders, and community members. Information from these community members will inform the development of the CHA and be used to develop priority health issues in the CHP. CHP priorities will include SDOH-HE components, together with housing supports. We will leverage each County’s current CHAs and CHPs as well as hospital Community Health Needs Assessments, Community Health Improvement Plans, and Community Benefit Implementation Plans.

*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)

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify Stakeholders.</td>
</tr>
</tbody>
</table>

Please see attached in **Table 1**.

- **Community Engagement** in Major Projects, Programs, and Decisions.
- **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.
b. Existing CAC.
This Section is not applicable. Please see above for more information about forming the CAC.

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.

Community Governance. We started working with this community in August 2018 to respond to their requests for a second CCO option in the region. At their invitation, we set up multiple work streams to gather input and evaluate whether the community wanted us to apply to serve as a CCO. Given the overwhelmingly positive response and engagement, we continue to meet, and our collective work shaped the application. We regularly meet with representatives from Willamette Family Medicine, Yakima Valley Farm Workers, the Mid-Valley Behavioral Care Network, Legacy Health, Kaiser Permanente, Marion County, Polk County, and the Oregon Family Support Network. The governance work group (which eventually formed the Willamette Health Council to serve as the governing body of the CCO) met more than eight times before PSCS submitted this application. Consistent with the requirements set forth in Attachment 6 to this application, the Health Council authorized this application in March 2019.

Government. We started meeting with regional representatives in summer 2018 in response to requests that we submit an application to become a CCO in the region. During summer and fall, we participated in multiple forums to understand the community’s needs and how we could help. On October 15, 2018, a group of providers from the region, including representatives of Marion County and Polk County, conducted a site visit in Central Oregon and interviewed counterparts in the region to learn more about working with PSCS in a community model. On October 25, 2018, key stakeholders in Marion County and Polk County asked PSCS to initiate a planning process to prepare an application to become a CCO in the region. In January, February, March, and April 2019 we convened multiple workgroups to establish the Health Council and gather input from key stakeholders to guide the formation of the CCO. Marion and Polk County representatives were active participants in many workgroup meetings. We also convened a meeting with administrators, health services directors, and county commissioners on March 14 to share additional information about the community-based governance model. We discussed MOUs and our shared intent to partner for the purpose of improving outcomes for OHP members in the region. On March 27th, we attended the Board of County Commissioners meeting in Polk County and made an official request that they consider signing an MOU to participate in our provider network, at which time they voted to do so. On that same date, we met with Ms. Moeller, Health and Human Services Administrator, to answer questions and finalize the MOU outlining our shared intent to work closely together
to coordinate care for our shared population. NWSDS provided a letter clarifying that they will sign an MOU when the OHA issues intent to award notices.

Providers. We met with dental care organizations multiple times in February, March, and April to learn more about regional needs, community engagement, and opportunities for CCO 2.0. We also met with an NEMT brokerage to discuss how we should shape our application to reflect our plans to serve members, coordinate care, and provide improved member access to services. In March and April, we participated in four behavioral health workgroup meetings that involved providers who offer services in integrated settings, small practices, large providers, behavioral health and chemical dependency providers, and residential providers. This workgroup convened to educate us about regional services, unmet needs, how we should work together as partners, and the work we need to do going forward. Throughout February, March, and April, we toured many provider settings, including consumer-run organizations, FQHCs, and PCPCH clinics. We recognized that providers in the region were excited to talk about entering into advanced value-based arrangements with PSCS. In response to this common theme, we conducted 1:1 outreach with provider partners to gain a deeper understanding of their individual experiences. We presented information about our experience implementing and evolving value-based payment models, along with new requirements for CCO 2.0. We presented this information at workgroups and in small-group venues throughout April. We have also planned additional meetings with provider partners to build a shared framework for VBP in the region.

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.

We are actively engaging SDOH-HE partners and will negotiate MOUs following our receipt of a Notice of Intent to Award from the OHA. We have a documented history of entering into such agreements in Central Oregon and the Columbia Gorge and plan to leverage our experience, community engagement, analytics and other resources to build a network of partners to address community-identified SDOH-HE needs.

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.

As discussed above, we are actively engaging SDOH-HE partners and will negotiate MOUs following our receipt of a Notice of Intent to Award from the OHA. We will document performance metrics, milestones, and evaluation plans in these agreements. We have an established history of entering into such agreements in Central Oregon and the Columbia Gorge and plan to leverage our experience as well as our community engagement, analytics and other resources.
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.
We propose that applicants submit SDOH-HE proposals electronically in a grant management system. That system will track and report SDOH-HE expenses. The grant management system will have 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. CBI will be funded using 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 responsiveness 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 social needs. 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 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
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.**

<table>
<thead>
<tr>
<th>Type of THW</th>
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<td>THW Type 1</td>
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<tr>
<td>THW Type 3</td>
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**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.**

<table>
<thead>
<tr>
<th>Payment Method</th>
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<td>Method 1</td>
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<td>Method 3</td>
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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 Clinical Advisory 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 frontline, 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, our operations supporting analytics and customer service are single departments supporting all CCO-managed benefits. 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 Integrated Behavioral Health Alliance (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. We have toured several peer-operated organizations that provide drop in centers, a variety of services and supports, and advocacy. It is our intent to support these organizations and utilize their experience and expertise. We believe we can scale this strategy throughout all service areas.

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 Services, 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
The CMHPs provide peer-delivered services through appropriately trained youth, family members, and adults with lived experience. These practitioners are available to provide individualized peer supports to participants of Wraparound, EASA, ACT, Supported Employment, Supported Education, Supported Housing, and other specialized approaches to serving youth, families, and adults. Several other specialty providers in the region utilize trained peers to make Peer Delivered Services part of the array of options. In addition, several Consumer Run Organizations, such as Youth ERA, Project ABLE, Recovery Outreach Community Center, Dual Diagnosis Anonymous and Oregon Family Support Network provide individualized Peer Delivered Services to members have advised us on strategies for continuing to expand peer services and better achieve improved outcomes.

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 the 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 handoffs, we plan to utilize telehealth technology.

Members admitted to the acute psychiatric inpatient unit at Salem Hospital or members admitted to inpatient psychiatric units outside the region will receive face-to-face interactions with PSCS and/or specialty community-based BH providers to ensure transition and discharge planning is active during the episode of inpatient treatment. Specialty providers utilize the PreManage electronic information system to receive notification of emergency department visits and hospital admissions, which connects hospitals and community providers to facilitate care coordination. 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, several specialty BH providers deliver home-based services. They focus on children in the Child Welfare system and children who have had crisis contacts or emergency department visits and are in need of intensive community-based services as an alternative to hospital or residential referrals.

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 Marion and Polk county region. The Plan will include goals to improve health outcomes and increase access to services in the region. If the region is served by more than one CCO, PCS will prioritize collaborating across CCOs and will use best efforts to create a single BH Plan for 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.

We will deploy these principles of collaboration to partner with any other CCO in the region to design a shared process, with the goal of creating one comprehensive CHP for the region. The process will begin by July 2020 in order to allow adequate time for a process to complete a CHA and then a regional CHP by June 30, 2021. 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.

Our experience so far with executing an MOU with multiple LMHAs across the state has been variable and demonstrates some challenges in completing the process in the coming months. PSCS has provided extensive education, going back to late 2018, and solicited letters of support in community forums and CCO governance bodies that include LMHA and CMHP representatives. Once the explicit requirements for this Application were known, PSCS conducted in-depth programmatic and legal review of the Request for Applications, the 2020 CCO Contract, the Oregon Revised Statutes, and Oregon Administrative Rules during February 2019. This led to creation of draft MOUs that reflect the requirements included in these documents and that focus on the inter-dependent relationship at a system planning and policy level between CCOs and Local Mental Health Authorities, as well as Local Public Health Authorities. These MOUs are distinct from the contractual agreements for clinical services to members that PSCS maintains with Community Mental Health Programs and other publicly funded providers.

These draft documents were shared with LMHA representatives during the second week of March. Multiple conversations followed, both in-person and in writing, with additions and changes to the MOU where mutually agreeable. As of April 12, both Marion County and Polk County have indicated a desire to work with us and will participate in our network and on the Health Council, but will not sign MOUs until after the OHA issues intent-to-award notices.

Challenges that have slowed the process for completing the MOU process include hesitation to make binding commitments in regions with multiple CCO applicants and a desire to have a longer period of time to negotiate the agreements. PSCS will continue to work collaboratively with each LMHA through in-person meetings and written correspondence to enter an MOU meeting the requirements of ORS 414.153(4). In addition, the Health Council governance model provides a community forum for some degree of structural conflict to be addressed and resolved at the local level. If efforts are not successful by mid-summer, PSCS will ask any affected LMHA to join us in accessing the alternative dispute resolution provisions in Oregon statute. PSCS is committed to using best efforts to jointly craft an agreement around how we will work with local governmental entities to effectively address the many overlapping and complimentary responsibilities of CCOs and LMHAs. We are hopeful that, with the dialogue already well underway, we will be able to execute all required agreements on a timely basis.

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). We do not have utilization data for members in this region, but we intend to use our analytics capacity in much the same way as we have in our experience as a CCO.

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 Need</th>
<th>Need Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention/Harm Reduction: Examples, Suicide Prevention, Drug and Alcohol Prevention</td>
<td>Public Health</td>
<td>High</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Screenings: MH/SUD Psychological Trauma</td>
<td>▪ Primary Care, Emergency Department&lt;br▪ SBHCs, BH Specialty Providers,</td>
<td>High</td>
<td>Low</td>
<td>Met</td>
</tr>
<tr>
<td>Outpatient Mental Health: Adult, Youth, Family</td>
<td>Primary Care, SBHC, BH Panel Providers, CMHPs</td>
<td>Medium</td>
<td>Low</td>
<td>Met</td>
</tr>
<tr>
<td>Outpatient SUD: Adult, Youth, Family</td>
<td>Primary Care, BH Panel Providers, CMHPs</td>
<td>Medium</td>
<td>Low</td>
<td>Met</td>
</tr>
<tr>
<td>Intensive Outpatient MH, Day Treatment, Partial Hospitalization</td>
<td>BH Panel Providers, CMHPs</td>
<td>Low</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Youth Intensive Outpatient SUD, Day Treatment, Partial Hospitalization</td>
<td>BH Panel Providers, CMHPs</td>
<td>Low</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Adult Intensive Outpatient, SUD, Day Treatment, Partial Hospital</td>
<td>BH Panel Providers</td>
<td>Low</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Mobile Crisis</td>
<td>BH Panel Provider, CMHPs</td>
<td>High</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>ACT, Supported Employment, Supported Housing</td>
<td>CMHPs,</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>ABA</td>
<td>Contracted ABA Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Emergency Department Outreach</td>
<td>BH Panel Providers</td>
<td>Medium</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Home Based Services</td>
<td>BH Panel Providers, CMHPs</td>
<td>Medium</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Youth Wraparound</td>
<td>CMHPs</td>
<td>Low</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Service Type</td>
<td>Availability/Provider Type</td>
<td>Frequency of Need</td>
<td>Intensity of Need</td>
<td>Need Met</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Youth Treatment Foster Care, Procter Care, Respite</td>
<td>BH Panel Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Adult Psych. Respite</td>
<td>BH Panel Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Youth Sub-Acute, PRTS</td>
<td>State-wide Contracted BH Panel Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Adult SUD Res/Detox</td>
<td>BH Panel Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Youth SUD Res</td>
<td>BH Panel Providers</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
<tr>
<td>Peer Delivered Services, Adult</td>
<td>BH Panel Providers, Drop In Centers</td>
<td>Medium</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Peer Delivered Services Youth and Family</td>
<td>BH Panel Providers, Drop in Center</td>
<td>Medium</td>
<td>Medium</td>
<td>Met</td>
</tr>
<tr>
<td>Psych. Inpatient Hospital</td>
<td>State-wide Contracted Providers, 1 in the region (adult)</td>
<td>Low</td>
<td>High</td>
<td>Met</td>
</tr>
</tbody>
</table>

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.
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 the Health Council 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 the Health Council 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. Our CM Team coordinates with tribal services when developing transitions from hospital or other facility based services to community based after care.

Marion and Polk counties are proximate to the Confederated Tribes of Grand Ronde and the Chemawa Indian School. If awarded an opportunity to serve members in this region, PSCS will reach out to both in order to begin building relationships and developing strategies on ways we can work together. We are aware the Confederated Tribes of Grand Ronde has developed tribal health services and we are interested in collaborating on sharing of provider networks, crisis services, and protocols for obtaining patient release in order to assure coordinated care. In addition, we are aware the Chemawa Indian School has in the past implemented their own behavioral health services. We will be interested to learn if there are ways we can collaborate to better support their services to the children residing at the school. We have attempted several times to make contact with the Chemawa Indian Health Center and will continue to do so in a respectful manner to request an opportunity to meet and learn more about their work.

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:

Members in Marion and Polk counties have access to a broad and comprehensive array of substance use treatment providers that have agreed to participate with PSCS. Both Marion and Polk County provide outpatient and intensive outpatient services for youth and adults in several locations. Marion County provides services to drug court participants, and in addition provides services to parents of young children, sober living settings, and MAT. Renaissance Recovery Resources in Keizer provides outpatient treatment for youth and adults. Bridgeway Recovery in Salem offers Adult Detox and Residential SUD and has added primary care and MAT to their array of services. We also contract with Serenity Lane to provide substance abuse treatment services including intensive outpatient, detox, residential, MAT, and day treatment for substance use disorders.

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 will support each County’s strong public health commitment to SUD prevention strategies and work closely with the System of Care Wraparound Initiative Executive Committee that has a strong connection to all of the school districts, Education Service Districts and the school based BH services that have resulted from their partnerships. Marion and Polk County each have strong programs in place to support the prevention of alcohol, tobacco, and other drug use. PSCS has also recognized a strong culture of community partnership with a rich assortment of community-based organizations that support prevention and health equity. PSCS will collaborate with the existing community network to continue to provide evidence-based prevention strategies in a culturally and linguistically appropriate manner.

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 Central Oregon 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.

We have met with several providers in Lane County and will continue efforts to learn about the current volume of practitioners that have obtained DATA waivers and the regional interest in strategies to increase the capacity of primary care providers to practice MAT of OUD.

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.

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 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 into 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 Felitti. 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 Clinical Advisory 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 Clinical Advisory 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 postpartum 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.
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. 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?

High level-treatment programs in the region have agreed to participate with PSCS and to place children in their home community whenever clinically appropriate. Children who need high-level placement can continue to participate in Dyadic Treatment with their parents. PSCS offers travel support for parents to participate with their children in treatment when the cost of travel impairs
the parent’s ability to participate. 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. Willamette Family Treatment Services has agreed to serve members with these needs. They offer detox and residential treatment for substance use disorders and outpatient treatment for adults and children, primary care, parenting classes, family services, Peer Support Services, and a myriad of transitional services. Options Counseling and Family Services has also agreed to provide intensive community-based services for children including Parent-Child Interaction Therapy (PCIT), an evidenced-based dyadic therapy.

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 current 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 as 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/AAA 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:
- **Transition Care Coordination.** This program supports members who are transitioning from an acute care setting to a lower level of care or to their home, and are at high risk for readmission to an inpatient setting. The goal is to prevent readmissions to an acute care setting and support member safety to ensure successful clinical and quality outcomes.

- **Community Care Coordination.** This program provides assistance to members facing challenges related to SDOH and/or access to care. The goal of this program is to remove SDOH barriers that impact access to care and treatment adherence.

- **Intensive Care Coordination.** This program is for members who need ongoing case management intervention and planning over time. Members may have multiple chronic conditions, need assistance with BH conditions, or need support and intervention when, or if, their condition deteriorates. The goal of ICC is to reduce inappropriate utilization and fragmentation of care and improve health outcomes.

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 Councils in current service areas and organizational leadership have received information/training on trauma and trauma informed care (TIC);
- Trauma informed principles and culturally responsive values are incorporated into the PSCS mission, values, and strategic plan;
- OHP members with lived experience hold decision-making roles;
- At the PSCS level, workforce wellness is systematically addressed;
• We demonstrate 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 has 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 within PSCS 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 will capitalize on our strong history of partnering with APD to establish interdisciplinary care teams. We have begun meeting with APD/AAA office staff to build relationships, establish an MOU and develop work flows to support dual-eligible members. These partnerships help coordinate 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 psychosocial resources any time members experience a transition in their care setting. In our existing service areas, we have collaborated with APD staff to develop educational activities and materials to improve the information available to staff and members during choice counseling. We will build on that experience to develop educational materials that are customized to meet the needs of this region.

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 regions where we have operated as a CCO, and we plan to expand our work in new service areas 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 Mothers’ Outreach and Mentoring Services (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 prenatal 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 and AAA 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 expediently 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.

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 Wraparounds 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 believes that the community will be best served by having a single SOC governance structure and commits to make best efforts to collaborate with any other CCOs serving the region to achieve this goal through designating and equitably funding a unified SOC governance structure with a single convener.

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 Marion and Polk counties, PSCS is familiar with the current governance structure that operates at the Executive and Advisory level across the two counties, with each county hosting its own Practice Level and Wraparound Review structures. This arrangement is functioning well and achieves SOC principles, so we anticipate no changes at this time.

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 and Youth ERA 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.

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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.
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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 lazered 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><strong>Physical and Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<tr>
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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>
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<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>
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<tr>
<td>number of encounters submitted (breakout: INPT, OUTPT, LTC, PROF)</td>
<td>Volume</td>
<td>Weekly</td>
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**Dental Health**

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<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>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<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>% of rejected encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
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<tr>
<td>number of encounters submitted</td>
<td>Volume</td>
<td>Weekly</td>
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**Pharmacy**

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<th>Measure Name</th>
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</thead>
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<td>% of clean claims per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<tr>
<td>% of rejected encounters per submission</td>
<td>Accuracy</td>
<td>Weekly</td>
</tr>
<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>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>number of encounters submitted</td>
<td>Volume</td>
<td>Weekly</td>
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**Provider Enrollment**

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<tr>
<th>Measure Name</th>
<th>Measure Category</th>
<th>Measure Frequency</th>
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</thead>
<tbody>
<tr>
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<td>Timeliness</td>
<td>Weekly</td>
</tr>
<tr>
<td>avg. number of days for OHA processing</td>
<td>Timeliness</td>
<td>Weekly</td>
</tr>
<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: [Redacted]
   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.

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Revised 03/26/18
FORM 11

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</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 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
State/Province: OR
Country: USA
Postal Code: 97477
Phone: 541.686.1242

Office/Positions Held: Board Chair
Supervisor/Contact: NA
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

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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
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 [ ]
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.

[Signature of Affiant]

State of: Oregon County of: Multnomah

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by Jeffrey Barker

[SEAL] OFFICIAL STAMP

KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Printed Notary Name

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: Jeffrey   Middle: Bruce   Last: Barber

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>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:

5. Foreign Student ID# (if applicable): ___

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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 18th 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 18th day of March, 2019 by Jeffrey Carter

and:

☑ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

OFFICIAL STAMP

KRYSTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Kristin E. Kernutt
Printed Notary Name
5/7/2022
My Commission Expires

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Attachment 12-Form 11 NAIC Biographical Affidavit Page 8 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: 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>
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<th>College/University</th>
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<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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<th>Dates Attended (MM/YY)</th>
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<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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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 9 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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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>
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<tr>
<th>Beginning/Ending Dates (MM/YY)</th>
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<td>Supervisor/Contact:</td>
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<tr>
<td>Supervisor/Contact:</td>
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</tr>
</tbody>
</table>

©2018 National Association of Insurance Commissioners

Revised 03/26/18

FORM 11
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.

   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?
   ___________________________________________

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Attachment 12-Form 11 NAIC Biographical Affidavit Page 11 of 182
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
Applicant Company Name: PacificSource Community Solutions  
NAIC No.: NA  
FEIN: 81-3059510

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 ☐
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 _____ 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 _____ day of March, 2019, by

[Signature of Notary Public]

Notary Public
Printed Notary Name
My Commission Expires

[Seal]
Applicant Company Name: PacificSource Community Solutions

NAIC No: NA
FEIN: 81-3059510

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: 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 
   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: ______________________________________________________

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>
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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 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 9th day of MARCH, 2019 by Robert Bentley

and:

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

OFFICIAL STAMP
KRISTIN E. KERNUTT
NOTARY PUBLIC-OREGON
COMMISSION NO. 974435
MY COMMISSION EXPIRES MAY 07, 2022

Kristin E. Kernutt
Printed Notary Name
5/17/2022
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: 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: [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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<td>See Attached</td>
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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
State/Province: OR
Country: USA
Postal Code: 97477
Phone: 541.686.1242
Offices/Positions Held: Board Member
Type of Business: Health Insurance
Supervisor/Contact: Jeffrey Barber, Board Chair

See Additional Employment Information attached

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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:

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.

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
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 [ ]
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 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.

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

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: 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 ☑

   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)
-----------------------------------------|------------------------------------------|-------------------------------

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 Page 23 of 182
Applicant Company Name: PacificSource Community Solutions

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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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 George Brown

☐ 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
List of memberships in professional societies and associations:

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<th>Contact Name</th>
<th>Address of Society/Association</th>
<th>Telephone Number of Society/Association</th>
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Additional Licenses:
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
541.766.5066

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:

   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.
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

Beginning/Ending

Beginning/Ending

Beginning/Ending
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?
      ________________________________________________________________
Applicant Company Name: PacificSource Community Solutions

NAIC No.: NA
FEIN: 81-3059510

1. Yes ☐ No ☒
   
   e. 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. Yes ☐ No ☒
   
   d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

   Yes ☐ No ☒

3. Yes ☐ No ☒
   
   e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

   Yes ☐ No ☒

4. Yes ☐ No ☒
   
   f. Had adjudication of guilt withheld, a sentence imposed or suspended, a 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. 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 ☒

6. 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 ☒

7. 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 ☒

8. 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

Attachment 12-Form 11 NAIC Biographical Affidavit Page 33 of 182
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 [ ]

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

Kathryn Cameo

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

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: Kathryn Middle: Golden Last: Correia
   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: [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
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:

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<th>Beginning/Ending Dates (MM/YY)</th>
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<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 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.

I hereby acknowledge that I may be contacted to provide additional information regarding international searches.

State of: Oregon County of: Marion

The foregoing instrument was acknowledged before me this 9th day of March 2019 by Kathryn Correia.

[Seal]

[Signature of Affiant]

Notary Public
Kristin E. Kernutt
Notary Public
Printed Notary Name
My Commission Expires

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
BIOMETRIC 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 [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:

   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: **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):**

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<th>Employer’s Name:</th>
<th>Address:</th>
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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.

   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. NA
FEIN: 81-3059510

Yes ☐ No ☑

e. 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
NAIC No. NA
FEIN: 81-3059510

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 11th 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 11th day of March, 2019 by

Edwin Dahlberg

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
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: 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.

   

   Beginning/Ending Name(s) Reason (If none, indicate such)
   Date(s) Used (MM/YY) Specify: First, Middle or Last Name

   [ ]

   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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FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 44 of 182
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>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</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 ________ 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 Edwin D. Long, 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
Kristin E. Kernutt
Printed Notary Name
517-222
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: 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
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>
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</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
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 ☒

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]

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 [X] 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 [X] 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 [X] 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  [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]

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FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 52 of 182
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.

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<tr>
<th>Beginning/Ending Date(s) Used (MM/YY)</th>
<th>Name(s)</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): ____________ 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>
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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 1st day of April, 2019 at 7:53 A.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.

(Signature of Affiant)

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 1st day of April, 2019 by Peter Dawson and:

who is personally known to me, or

who produced the following identification:

[SEAL]

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Revised 03/26/18

FORM 11

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: 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>
<thead>
<tr>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
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   Graduate Studies

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<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</th>
</tr>
</thead>
</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.
6. List of memberships in professional societies and associations:

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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.

**PacificSource (as successor of PacificSource Health Plans)**

<table>
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<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>
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<tbody>
<tr>
<td>08/05 -</td>
<td>PacificSource</td>
<td>110 International Way</td>
<td>Springfield</td>
<td>OR</td>
<td>USA</td>
<td>97477</td>
<td>541-684-5596</td>
<td>CIO/COO</td>
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<td>as successor of PacificSource Health Plans</td>
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**Beginning/Ending**

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<td>Ken Provencher/President and CEO</td>
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</table>

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Revised 03/26/18

Attachment 12-Form 11 NAIC Biographical Affidavit Page 56 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.

   Organization/Issuer of License: ________________________________
   Address: __________________________________________________
   City: ___________ State/Province: _______ Country: ____________
   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: ____________
   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 pronunciation 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 7:50 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 Doden, 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

Printed Notary Name
June 14, 2022
My Commission Expires

©2019 National Association of Insurance Commissioners
Revised 03/26/18
Attachment 12-Form 11 NAIC Biographical Affidavit
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 [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: ____________________________

5. Foreign Student ID# (if applicable): ____________________________________________
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>
<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 1st 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 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. 876018
MY COMMISSION EXPIRES 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: 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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<tr>
<th>Graduate Studies</th>
<th>College/University</th>
<th>City/State</th>
<th>Dates Attended (MM/YY)</th>
<th>Degree Obtained</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.

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Attachment 12-Form 11 NAIC Biographical Affidavit  Page 63 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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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:
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?
      ________________________________

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Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

NAIC No. __________
 FEIN: 81-3059510

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.

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  
NAIC No.  
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 Anne Loomis

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

Revised 03/26/18
FORM 11

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: 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

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions.

6. Date of Birth: (MM/DD/YY): 
   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:

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<tr>
<th>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 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
Printed Notary Name

My Commission Expires

FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 70 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: John ______ Middle: Edward ______ Last: McEachern ______

2. a. Are you a citizen of the United States?
   Yes _xx_ No ______
   b. Are you a citizen of any other country?
   Yes ______ No _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:

| Name of Society/Association | Contact Name | Address of Society/Association | Telephone Number of Society/Association |

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
RFA OHA-4690-19-PacificSource Community Solutions-Marion Polk
Applicant Company Name: PacificSource Community Solutions NAIC No. NA
FEIN: 81-059510

9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [xx]

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 [xx]

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.
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  

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 ☒
RFA OHA-4690-19-PacificSource Community Solutions-Marion Polk
Applicant Company Name: PacificSource Community Solutions NAIC No. NA
FEIN: 81-059510

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 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 Meacham and:

who is personally known to me, or

who produced the following identification:

[Notary Public]

Catherine L. Gilchrist
Printed Notary Name
Sept 28, 2022

My Commission Expires

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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: 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 [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)</th>
<th>Reason (If none, indicate such)</th>
</tr>
</thead>
</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:

5. Foreign Student ID# (if applicable) :
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:

<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 __________, 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: __________ County of: __________

The foregoing instrument was acknowledged before me this __________ day of __________, 2019 by __________ and:

who is personally known to me, or

who produced the following identification: __________

[SEAL]

CATHARINE L. GUILCHRIST
COMMISSION #65500
NOTARY PUBLIC
STATE OF IDAHO
MY COMM. EXPIRES SEP 28, 2022

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 82 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.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Affiant’s Full Name (Initials Not Acceptable): First: Kenneth Middle: Paul Last: Provencher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a.</td>
<td>Are you a citizen of the United States?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes [X] No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Are you a citizen of any other country?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes No [X]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what country?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.</td>
<td>Affiant’s occupation or profession: President and CEO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Affiant’s business address: 110 International Way, Springfield, OR 97477</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business telephone: Business Email:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Education and training:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
<td>Degree Obtained</td>
<td></td>
</tr>
<tr>
<td>Graduate Studies</td>
<td>College/University</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
<td>Degree Obtained</td>
</tr>
<tr>
<td>Other Training: Name</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</td>
<td>Degree/Certification Obtained</td>
<td></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.

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>
</table>

6. List of memberships in professional societies and associations:

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 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): 

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Attachment 12-Form 11 NAIC Biographical Affidavit
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 [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,
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]

b. 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.

[ ] 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 Kenneth Provencher 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
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: 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.

<table>
<thead>
<tr>
<th>Beginning/Ending</th>
<th>Name(s)</th>
<th>Reason (If none, indicate such)</th>
</tr>
</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:** [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: 81-059510

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>
<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 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.

(Signature of Affiant)

State of: Oregon County of: Lane

The foregoing instrument was acknowledged before me this 

1st day of April 2019 by Kenneth Provender

who is personally known to me, or

who produced the following identification:

[SEAL]
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 [ ] No [X]

   If yes, what country?

3. Affiant’s occupation or profession: Retired

4. Affiant’s business address:

   Business telephone: _______ 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>
</tr>
</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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Revised 03/26/18

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 91 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>
</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.

<table>
<thead>
<tr>
<th>Beginning/Ending</th>
<th>Dates (MM/YY):</th>
<th>Employer’s Name:</th>
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<tr>
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<td>Address:</td>
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<td></td>
<td>Type of Business:</td>
<td>Offices/Positions Held:</td>
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<td>Supervisor/Contact:</td>
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</tbody>
</table>

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Attachment 12-Form 11 NAIC Biographical Affidavit

Page 92 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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Revised 03/26/18
FORM 11
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  

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
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

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 28th 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 28th day of March 2019 by Roger Saydack 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
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.

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<th>Beginning/Ending Date(s) Used (MM/YY)</th>
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<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

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RFA OHA-4690-19-PacificSource Community Solutions-Marion Polk

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:

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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 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: Oregon County: Lane

The foregoing instrument was acknowledged before me this 28 day of March, 2019 by Roger Saydack and:

X 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

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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: Patricia Middle: Jean Last: Schmitt

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 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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Attachment 12-Form 11 NAIC Biographical Affidavit Page 99 of 182
Applicant Company Name: PacificSource Community Solutions

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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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.

<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
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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.

   [ ]

   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 [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
Applicant Company Name: PacificSource Community Solutions
NAIC No. NA
FEIN: 81-3059510

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 [X] 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 [X] 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 [X] 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 [X] 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 [X] No

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit Page 103 of 182
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

[SEAL]  

Kristin E. Kernutt  
Notary Public  
My Commission Expires May 07, 2022
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

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>
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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): [Redacted]
State/Province: [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>
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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 Schmidt and:

☑ who is personally known to me, or

☐ who produced the following identification: __________________________

[Seal]

Kristin E. Kernutt
Notary Public
Printed Notary Name
My Commission Expires May 07, 2022

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Revised 03/26/18
FORM 11
BIOGRAFICAL 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 [X] 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: [ ] [ ]

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>Dates Attended (MM/YY)</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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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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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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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.

   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

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
Applicant Company Name: PacificSource Community Solutions

NAIC No. NA
FEIN: 81-3059510

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

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 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

Divya Sharma

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

Printed Notary Name

My Commission Expires

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Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

NAIC No: NA

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: 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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   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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FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions  
NAIC No: NA  
FEIN: 81-3059510

6. Date of Birth: (MM/DD/YY):  
   State/Province: 
   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:

<table>
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<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 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.

(state and county)  
(Please print)  
(Signature of Affiant)

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by (Printed Notary Name)

☐ who is personally known to me, or  
☐ who produced the following identification: 

[SEAL]

Notary Public  
Kristin E. Kernutt  
Printed Notary Name  
5/12/2022  
My Commission Expires May 07, 2022

©2018 National Association of Insurance Commissioners

Attachment 12-Form 11 NAIC Biographical Affidavit
Additional Work Experience

Beginning/Ending

Additional Licenses
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: 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:

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<tr>
<td>Other Training:</td>
<td>Name</td>
<td>City/State</td>
<td>Dates Attended (MM/YY)</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: 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.

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Revised 03/26/18
FORM 11

Attachment 12-Form 11 NAIC Biographical Affidavit

Page 117 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

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  

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<th>Question</th>
<th>Response</th>
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<td>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?</td>
<td>No</td>
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<tr>
<td>d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?</td>
<td>No</td>
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<tr>
<td>e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?</td>
<td>No</td>
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<td>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?</td>
<td>No</td>
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<tr>
<td>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?</td>
<td>No</td>
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<td>h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?</td>
<td>No</td>
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<tr>
<td>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?</td>
<td>No</td>
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<tr>
<td>j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?</td>
<td>No</td>
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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.

(State of: Oregon County of: Multnomah)

The foregoing instrument was acknowledged before me this 19th day of March, 2019 by

Claire Spaun-Barry

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

(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: 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 [ ] 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: 

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>
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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 15th day of March, 2023 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, 2023, by Kristin E. Kernutt

☐ who is personally known to me, or

☐ who produced the following identification:

(SEAL)

Kirstin E. Kernutt
Notary Public

My Commission Expires May 07, 2022

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Revised 03/26/18
RFA OHA-4690-19-PacificSource Community Solutions-Marion Polk
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

$41,706.5066

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 [X] No 

   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:

   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

Attachment 12-Form 11 NAIC Biographical Affidavit  Page 124 of 182
Applicant Company Name: PacificSource Community Solutions
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>
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<tr>
<th>Name of Society/Association</th>
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</table>

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 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): 09/10 - 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

Type of Business: Health Plan
Supervisor/Contact: Ken Provencher/President and CEO
Applicant Company Name: PacificSource Community Solutions
NAIC No.: NA
FEIN: 81-059510

Country: Postal Code: Phone: Offices/Positions Held: Supervisor/Contact:

Type of Business:

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?
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-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 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: [Signature of person acknowledged]

The foregoing instrument was acknowledged before me this 3rd day of April 2019 by Don Stevens and:

who is personally known to me, or

who produced the following identification: [Redacted]

Notary Public

[Seal]
**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: 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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<th>Beginning/Ending Date(s) Used (MM/YY)</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): [ ]
Applicant Company Name: Pacific Source Community Solutions

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>
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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 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: Dechutes

The foregoing instrument was acknowledged before me this 3rd day of April, 2019 by [Redacted], who is personally known to me, or [Redacted] who produced the following identification: ODL 4081352

[SEAL]

OFFICIAL STAMP
LAYNE K MILOWE
NOTARY PUBLIC-OREGON
COMMISSION NO. 948923
MY COMMISSION EXPIRES APRIL 24, 2020

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Revised 03/26/18
FORM 11

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 Conner 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 _______ No ______

   b. Are you a citizen of any other country?  
   Yes _______ No ______

   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: _______________ 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
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:** 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

Type of Business: Health Plan Supervisor/Contact: Ken Provencher/President and CEO

Beginning/Ending
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]
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: 81-059510

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]

ALISON AMBER GILLMOUTH

Printed Notary Name

My Commission Expires November 30, 2019

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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: 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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   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
Date of Birth: (MM/DD/YY): __________ Place of Birth, City: ____________
State/Province: __________ Country: USA

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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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 __________, 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 __________ day of __________, 2019 by Sharon Thompson and:

who is personally known to me, or

who produced the following identification:

[Seal]

Alison Amber Gillmouth
Notary Public
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.

(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: [Redacted]

   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

   NA

   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

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

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>NA</td>
<td></td>
<td></td>
<td></td>
</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 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
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:
   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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Revised 03/26/18
FORM 11
Attachment 12-Form 11 NAIC Biographical Affidavit
Page 142 of 182
Applicant Company Name: PacificSource Community Solutions

NAIC No: N/A
FEIN: 81-3059510

Yes [ ] No [x]
e. 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

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions
NAIC No. N/A
FEIN: 81-3059510

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 David Vinsm, 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
Applicant Company Name: PA
NAIC No: NA
FEIN: 81-3059510

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.

   Beginning/Ending
   Date(s) Used (MM/YY)    Name(s)    Specify: First, Middle or Last Name

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

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

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Revised 03/26/18
FORM 11
Applicant Company Name: PacificSource Community Solutions

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/YY)</th>
<th>Address</th>
<th>City</th>
<th>State/Province</th>
<th>Country</th>
<th>Postal Code</th>
</tr>
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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 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]

Notary Public

Kristin E. Kernutt
Printed Notary Name

5/7/2022

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: 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: ____________

       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
NAIC No. N/A
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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: 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>

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:

   [Space provided for 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:

   [Space provided for 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.

   [Space provided for listing licenses]

   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?
      [Space provided for details]
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
Applicant Company Name: PacificSource Community Solutions

NAIC No. N/A

FEIN: 81-3059510

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 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
Applicant Company Name: PacificSource Community Solutions

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
   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.
   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

5. Foreign Student ID# (if applicable): 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

Attachment 12-Form 11 NAIC Biographical Affidavit
Applicant Company Name: PacificSource Community Solutions

Date of Birth: (MM/DD/YY): [Obscured]
State/Province: [Obscured]
Place of Birth, City: [Obscured]
Country: USA

Name of Affiant's Spouse (if applicable): [Obscured]

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>
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<th>Postal Code</th>
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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]

Kristin E. Kernutt
NOTARY PUBLIC-OREGON
COMMISSION NO. 974438
MY COMMISSION EXPIRES MAY 07, 2022

Notary Public
Kristin E. Kernutt
Printed Notary Name
5/17/2022
My Commission Expires
Additional Work Experience

Beginning/Ending
Applicant Company Name: PacificSource Community Solutions

NAIC No.: N/A
FEIN: 81-3059510

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: 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>
<th>Degree Obtained</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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</thead>
</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
Applicant Company Name: PacificSource Community Solutions
NAIC No. N/A
FEIN: 81-3059510

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 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 additional work experience
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.

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?

   ______________________________________________________

©2019 National Association of Insurance Commissioners
Applicant Company Name: PacificSource Community Solutions

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

Attachment 12-Form 11 NAIC Biographical Affidavit
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

John Winter Jr.

and:

☐ who is personally known to me, or

☐ who produced the following identification:

[SEAL]

Kirstin E. Kernutt
Notary Public

Kristin E. Kernutt
Printed Notary Name

My Commission Expires May 07, 2022

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Attachment 12-Form 11 NAIC Biographical Affidavit

Page 162 of 182
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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<tr>
<th>Beginning/Ending</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
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 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 John Wiltshire

☑ 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
### Additional Work Experience

<table>
<thead>
<tr>
<th>Position</th>
<th>Organization</th>
<th>City, State</th>
<th>Beginning</th>
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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 [ ]  No [x]

     b. Are you a citizen of any other country?  Yes [x]  No [ ]

     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:

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 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):**

<table>
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<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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</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.

   NA

   Organization/Issuer of License: ____________________
   Address: ______________________________________

   City: __________________ State/Province: ___________
   Country: _______ Postal Code: ____________

   License Type: ___________ License #: ____________
   Date Issued (MM/YY): ____________
   Date Expired (MM/YY): ____________

   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): ____________

   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

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 ☒

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

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 Wright

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

| 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.

<table>
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<th>3. Affiant’s Social Security Number:</th>
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<th>4. Government Identification Number if not a U.S. Citizen: NA</th>
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<th>5. Foreign Student ID# (if applicable): NA</th>
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©2019 National Association of Insurance Commissioners
Applicant Company Name: PacificSource Community Solutions

6. Date of Birth: (MM/DD/YY) [Redacted]
   Place of Birth, City: [Redacted]
   State/Province: 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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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 Richard Wright, D.

☐ 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

Printed Notary Name
Kristin E. Kernutt
My Commission Expires
5/7/2022
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: 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: 
   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>
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</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.
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>
<tr>
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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.

```
<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer's Name:</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>City:</td>
</tr>
<tr>
<td>Country:</td>
<td>Postal Code:</td>
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<tr>
<td>Type of Business:</td>
<td>Supervisor/Contact:</td>
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<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer's Name:</th>
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<td>Address:</td>
<td>City:</td>
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<td>Type of Business:</td>
<td>Supervisor/Contact:</td>
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<table>
<thead>
<tr>
<th>Beginning/Ending Dates (MM/YY):</th>
<th>Employer's Name:</th>
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<tr>
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<tr>
<td>Address:</td>
<td>City:</td>
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<tr>
<td>Country:</td>
<td>Postal Code:</td>
</tr>
<tr>
<td>Type of Business:</td>
<td>Supervisor/Contact:</td>
</tr>
</tbody>
</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.

   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?
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
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 □
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 ______ day of ______, 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 ______ day of ______, 2019 by

[Name]

and:

☐ who is personally known to me, or

☒ who produced the following identification: Oregon Driver License

[SEAL]

Notary Public

Kim M. Krause

Printed Notary Name

June 29, 2020

My Commission Expires

© 2018 National Association of Insurance Commissioners.
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: 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.

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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

© 2019 National Association of Insurance Commissioners
Revised 03/26/18
Attachment 12-Form 11 NAIC Biographical Affidavit
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:

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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 [Redacted] day of April 1, 2019 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: Marion

The foregoing instrument was acknowledged before me this 1st day of April, 2019 by Charles Zadock and:

[ ] who is personally known to me, or

[ ] who produced the following identification: Oregon Driver's License

[SEAL]

OFFICIAL STAMP
KIM MARSHA KRAUSE
NOTARY PUBLIC-OREGON
COMMISSION NO. 961782
MY COMMISSION EXPIRES JUNE 09, 2019

©2019 National Association of Insurance Commissioners
Attachment 12-Form 11 NAIC Biographical Affidavit
Page 182 of 182
Independent Auditors' Report
Consolidated Financial Statements and
Supplemental Information
Years Ended December 31, 2015 and 2014
# PACIFICSOURCE AND SUBSIDIARIES

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<td>9-36</td>
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<td><strong>SUPPLEMENTAL INFORMATION</strong></td>
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<tr>
<td>Consolidated schedules of general and administrative expenses</td>
<td>37</td>
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<tr>
<td>Consolidating balance sheet</td>
<td>38</td>
</tr>
<tr>
<td>Consolidating statement of operations</td>
<td>39</td>
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</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
PACIFICSOURCE AND SUBSIDIARIES

Consolidated Balance Sheets

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
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<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
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<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>
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<tr>
<td>Prepaid income taxes</td>
<td>13,455,945</td>
<td>9,465,147</td>
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<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:**               |                 |
| Unpaid claims and claims adjustment expenses | $119,306,910    | $96,185,220    |
| Premium deficiency reserve      | -               | 4,960,000      |
| Accounts payable                | 5,251,434       | 5,460,156      |
| Accrued expenses                | 38,015,313      | 50,235,010     |
| Accrued pension liability       | 2,013,298       | 2,434,177      |
| Unearned premiums               | 9,647,669       | 7,996,378      |
| Accrued medical incentive pools and withholds payable | 48,626,193    | 34,489,082      |
| Accrued retro settlements       | 2,374,341       | 4,978,572      |
| Collections for others          | 3,850,868       | 4,616,759      |
| Notes payable                   | 14,315,396      | 717,508        |
| Deferred tax liabilities        | 650,000         | -              |
| **Total**                       | 244,051,422     | 212,072,862    |

| **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.

Attachment 12-Three Years of Audited Financial Reports
# Consolidated Statements of Operations

## Year Ended December 31

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREMIUMS:</strong></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><strong>Total</strong></td>
<td>1,207,466,558</td>
<td>1,215,064,829</td>
</tr>
<tr>
<td><strong>CLAIMS EXPENSE:</strong></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>9,188,549</td>
<td>14,196,099</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>(4,960,000)</td>
<td>(4,960,000)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,107,610,620</td>
<td>1,124,277,908</td>
</tr>
<tr>
<td><strong>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</strong></td>
<td>99,855,938</td>
<td>90,786,921</td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE REVENUES</strong></td>
<td>15,524,667</td>
<td>13,229,330</td>
</tr>
<tr>
<td><strong>GENERAL AND ADMINISTRATIVE EXPENSES</strong></td>
<td>107,837,281</td>
<td>111,776,217</td>
</tr>
<tr>
<td><strong>UNDERWRITING GAIN (LOSS)</strong></td>
<td>7,543,324</td>
<td>(7,759,966)</td>
</tr>
<tr>
<td><strong>OTHER INCOME (EXPENSE):</strong></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><strong>Total</strong></td>
<td>2,803,515</td>
<td>4,377,346</td>
</tr>
<tr>
<td><strong>INCOME (LOSS) BEFORE INCOME TAXES</strong></td>
<td>10,346,839</td>
<td>(3,382,620)</td>
</tr>
<tr>
<td><strong>INCOME TAX EXPENSE</strong></td>
<td>13,414,212</td>
<td>4,764,054</td>
</tr>
<tr>
<td><strong>TOTAL LOSS</strong></td>
<td>(3,067,373)</td>
<td>(8,146,674)</td>
</tr>
<tr>
<td><strong>LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS</strong></td>
<td>62,832</td>
<td>84,321</td>
</tr>
<tr>
<td><strong>NET LOSS</strong></td>
<td>$ (3,130,205)</td>
<td>$ (8,230,995)</td>
</tr>
</tbody>
</table>

See accompanying notes.
## Consolidated Statements of Comprehensive Loss

<table>
<thead>
<tr>
<th>Year Ended December 31</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>

### OTHER COMPREHENSIVE LOSS, NET OF TAXES:

<table>
<thead>
<tr>
<th>Description</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

| Defined benefit pension plan:                                               |              |              |
| 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 | $(94,492)    | (4,043,075)  |
| Amortization of net loss (net of tax of $356,000 in 2015 and $280,000 in 2014), included in general and administrative expenses | 350,794      | 420,659      |
| Defined benefit pension plan, net                                            | 256,302      | (3,622,416)  |
| Total other comprehensive loss                                              | $(1,998,138) | (1,617,505)  |

### COMPREHENSIVE LOSS

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPREHENSIVE LOSS</td>
<td>$(5,128,343)</td>
<td>$(9,848,500)</td>
</tr>
</tbody>
</table>

See accompanying notes.
### Consolidated Statements of Fund Balance

<table>
<thead>
<tr>
<th></th>
<th>Fund Balance</th>
<th>Unrealized Appreciation and Depreciation on Investments</th>
<th>Defined Benefit Pension Plan</th>
<th>Noncontrolling Interests</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unrealized Appreciation and</strong></td>
<td><strong>Defined</strong></td>
<td><strong>Unrealized</strong></td>
<td></td>
<td></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Appreciation and Depreciation</strong></td>
<td><strong>Benefit Depreciation</strong></td>
<td><strong>Appreciation on Investments</strong></td>
<td><strong>Benefit</strong></td>
<td><strong>Pension Plan</strong></td>
<td><strong>Noncontrolling</strong></td>
</tr>
<tr>
<td><strong>Fund Balance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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.
### Consolidated Statements of Cash Flows

#### Change in Cash and Cash Equivalents

<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></td>
<td>Net cash provided by operating activities</td>
<td>11,217,285</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></td>
<td>Net cash provided by investing activities</td>
<td>11,710,622</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></td>
<td>Net cash provided by (used in) financing activities</td>
<td>13,586,125</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)

See accompanying notes.
Reconciliation of Net Loss to Net Cash
Provided by Operating Activities

<table>
<thead>
<tr>
<th>Year Ended December 31</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:

- Income attributable to noncontrolling interest: 62,832 $ 84,321
- Depreciation and amortization: 7,649,977 9,770,484
- Deferred tax expense: 3,821,700 985,300
- Gain on sale of investments: (1,142,982) (1,777,423)
- Loss on disposal of property and intangible assets: - 383,083
- Change in premium deficiency reserve: (4,960,000) 4,960,000

Adjustments resulting from changes in:

- Accounts receivable: (7,039,417) (38,394,530)
- Accrued investment income: 149,216 104,059
- Prepaid expenses and deposits: (4,175,903) (440,287)
- Prepaid income taxes: (3,990,798) (5,910,951)
- Prepaid pension costs: - 3,699,390
- Unpaid claims and claims adjustment expenses: 23,121,690 (6,305,630)
- Book overdraft: - (5,745,948)
- Accounts payable: (208,722) (3,333,916)
- Accrued pension liability: 95,423 (3,598,239)
- Unearned premiums: 1,651,291 3,235,293
- Incentive compensation payable: 14,127,111 32,969,395
- Accrued retro settlements: (2,604,231) 1,086,312
- Accrued expenses: (12,219,697) 38,149,596

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:

![Diagram showing the organizational structure of PacificSource and its subsidiaries.]

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>Entity</th>
<th>2015</th>
<th></th>
<th>2014</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PacificSource</td>
<td>$449,002</td>
<td>0.0%</td>
<td>$425,888</td>
<td>0.0%</td>
</tr>
<tr>
<td>PSHP</td>
<td>573,339,466</td>
<td>46.9%</td>
<td>617,712,845</td>
<td>50.3%</td>
</tr>
<tr>
<td>PCHP and subsidiary</td>
<td>642,577,383</td>
<td>52.6%</td>
<td>602,740,588</td>
<td>49.0%</td>
</tr>
<tr>
<td>PSA</td>
<td>4,161,700</td>
<td>0.3%</td>
<td>4,172,523</td>
<td>0.4%</td>
</tr>
<tr>
<td>PHI and subsidiary</td>
<td>2,463,674</td>
<td>0.2%</td>
<td>3,242,315</td>
<td>0.3%</td>
</tr>
<tr>
<td>Gross revenue</td>
<td>$1,222,991,225</td>
<td>100.0%</td>
<td>$1,228,294,159</td>
<td>100.0%</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</td>
<td>$297,918</td>
<td>$(24,002)</td>
</tr>
<tr>
<td>Mortgage/asset backed securities</td>
<td>28,800,237</td>
<td>672,679</td>
<td>(84,272)</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>56,365,000</td>
<td>1,209,503</td>
<td>(244,463)</td>
</tr>
<tr>
<td><strong>Total debt securities</strong></td>
<td><strong>99,197,261</strong></td>
<td><strong>2,180,100</strong></td>
<td><strong>(352,737)</strong></td>
</tr>
<tr>
<td>Equity securities and mutual funds</td>
<td>28,948,079</td>
<td>4,306,139</td>
<td>(230,659)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$128,145,340</strong></td>
<td><strong>$6,486,239</strong></td>
<td><strong>$(583,396)</strong></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></th>
<th>Less than 12 Months</th>
<th>12 Months or More</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>
</tr>
<tr>
<td>Debt securities</td>
<td>$38,621,251</td>
<td>$(1,344,453)</td>
<td>$11,456,224</td>
<td>$(190,258)</td>
</tr>
<tr>
<td>Equity securities</td>
<td>4,268,380</td>
<td>(161,180)</td>
<td>3,179,007</td>
<td>(361,751)</td>
</tr>
</tbody>
</table>

$42,889,631 | $(1,505,633) | $14,635,231 | $(552,009) | $57,524,862 | $(2,057,642) |

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>Due in one year or less</th>
<th>Amortized Cost</th>
<th>$ 8,011,973</th>
<th>Fair Value</th>
<th>$ 8,003,084</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due in one to five years</td>
<td>39,591,674</td>
<td>39,948,228</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due in five to ten years</td>
<td>37,648,809</td>
<td>37,239,269</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due after ten years</td>
<td>6,525,609</td>
<td>6,154,962</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$ 91,778,065</td>
<td>$ 91,345,543</td>
<td></td>
</tr>
</tbody>
</table>

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

<table>
<thead>
<tr>
<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</td>
<td>$ 114,974,697</td>
<td>$ 2,296,403</td>
</tr>
<tr>
<td>Less December 31, 2014</td>
<td>128,145,340</td>
<td>134,048,183</td>
<td>5,902,843</td>
</tr>
<tr>
<td>Change in unrealized appreciation</td>
<td></td>
<td>$ (3,606,440)</td>
<td>$ 1,352,000</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.

Other Invested Assets.
### 3. Accounts Receivable

Accounts receivable at December 31 consisted of the following:

<table>
<thead>
<tr>
<th></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></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></td>
<td><strong>9,868,865</strong></td>
<td><strong>10,593,865</strong></td>
</tr>
<tr>
<td>Less accumulated amortization</td>
<td><strong>3,530,838</strong></td>
<td><strong>2,972,080</strong></td>
</tr>
<tr>
<td>Total</td>
<td><strong>$ 6,338,027</strong></td>
<td><strong>$ 7,621,785</strong></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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></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>
<tr>
<td>Projected benefit obligation, end of year</td>
<td>$ 31,457,623</td>
<td>$ 33,786,562</td>
</tr>
</tbody>
</table>

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>
<tr>
<td>Fair value of plan assets, end of year</td>
<td>$ 29,444,325</td>
<td>$ 31,352,385</td>
</tr>
</tbody>
</table>

(Continued)
9. Retirement Plans (Continued)

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net periodic benefit cost:</strong></td>
<td></td>
</tr>
<tr>
<td>Interest cost</td>
<td>$1,332,312</td>
</tr>
<tr>
<td>Expected return on plan assets</td>
<td>(1,943,683)</td>
</tr>
<tr>
<td>Amortization of loss</td>
<td>706,794</td>
</tr>
<tr>
<td>Settlement loss</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total net periodic benefit cost</strong></td>
<td>$95,423</td>
</tr>
</tbody>
</table>

**Amounts recognized in accumulated other comprehensive loss:**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net loss</td>
<td>$9,103,347</td>
</tr>
<tr>
<td><strong>Total accumulated other comprehensive loss</strong></td>
<td>$9,103,347</td>
</tr>
</tbody>
</table>

**Changes in other comprehensive loss:**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net loss</td>
<td>$190,492</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>(706,794)</td>
</tr>
<tr>
<td><strong>Total recognized in other comprehensive loss</strong></td>
<td>$ (516,302)</td>
</tr>
</tbody>
</table>

**Accumulated benefit obligation, end of year**

<table>
<thead>
<tr>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<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>2015</th>
<th>2014</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>
</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>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>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>100%</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 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><strong>Total current income tax expense</strong></td>
<td><strong>9,592,512</strong></td>
<td><strong>3,778,754</strong></td>
</tr>
<tr>
<td>Deferred tax expense</td>
<td>3,821,700</td>
<td>985,300</td>
</tr>
<tr>
<td><strong>Total income tax expense</strong></td>
<td><strong>$13,414,212</strong></td>
<td><strong>$4,764,054</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>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><strong>Total income tax expense</strong></td>
<td><strong>$13,414,212</strong></td>
<td><strong>$4,764,054</strong></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>Deferred tax assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal and state net operating loss carryforwards</td>
<td>$1,921,000</td>
<td>$3,503,000</td>
</tr>
<tr>
<td>Accruals</td>
<td>2,138,000</td>
<td>1,470,000</td>
</tr>
<tr>
<td>Defined benefit pension plan</td>
<td>786,000</td>
<td>969,000</td>
</tr>
<tr>
<td>Partnership difference</td>
<td>777,000</td>
<td>815,000</td>
</tr>
<tr>
<td>Discount of claims provision</td>
<td>527,000</td>
<td>433,000</td>
</tr>
<tr>
<td>Deferred compensation</td>
<td>512,000</td>
<td>542,000</td>
</tr>
<tr>
<td>Alternative minimum tax credit carryforwards</td>
<td>-</td>
<td>2,001,700</td>
</tr>
<tr>
<td>Contribution carryforwards</td>
<td>-</td>
<td>787,000</td>
</tr>
<tr>
<td>Goodwill</td>
<td>-</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>Total deferred tax assets</strong></td>
<td><strong>6,661,000</strong></td>
<td><strong>10,524,700</strong></td>
</tr>
<tr>
<td>Deferred tax liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property</td>
<td>(4,409,000)</td>
<td>(4,068,000)</td>
</tr>
<tr>
<td>Prepaids</td>
<td>(2,060,000)</td>
<td>(2,069,000)</td>
</tr>
<tr>
<td>Unrealized gains</td>
<td>(770,000)</td>
<td>(2,241,000)</td>
</tr>
<tr>
<td>Subsidiary equity income</td>
<td>(72,000)</td>
<td>(67,000)</td>
</tr>
<tr>
<td><strong>Total deferred tax liabilities</strong></td>
<td><strong>(7,311,000)</strong></td>
<td><strong>(8,445,000)</strong></td>
</tr>
<tr>
<td><strong>Net deferred tax (liabilities) assets</strong></td>
<td><strong>$ (650,000)</strong></td>
<td><strong>$ 2,079,700</strong></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>Lease Payments</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>
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<tr>
<td>Total debt securities</td>
<td>101,024,624</td>
<td>14,305,940</td>
<td>86,718,684</td>
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<tr>
<td>Available-for-sale equity securities:</td>
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<td></td>
<td></td>
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<tr>
<td>Mutual funds</td>
<td>33,023,559</td>
<td>33,023,559</td>
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</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, 2015</th>
<th>December 31, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quoted Prices in Active Markets for Identical Assets (Level 1)</td>
<td>Quoted Prices in Active Markets for Identical Assets (Level 1)</td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$7,873,616</td>
<td>$8,964,714</td>
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<tr>
<td>Balanced funds</td>
<td>9,780,871</td>
<td>10,394,681</td>
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<tr>
<td>Growth funds</td>
<td>6,334,291</td>
<td>6,290,238</td>
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<tr>
<td>Value funds</td>
<td>3,669,029</td>
<td>3,891,716</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,786,518</td>
<td>1,726,432</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$29,444,325</strong></td>
<td><strong>$31,352,385</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, 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.
## Consolidated Schedules of General and Administrative Expenses

<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>
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<tr>
<td>Employee benefits</td>
<td>7,828,719</td>
<td>7,631,659</td>
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<tr>
<td>Retirement plans</td>
<td>2,091,643</td>
<td>1,994,650</td>
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<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>
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<tr>
<td>Imaging expense</td>
<td>295,707</td>
<td>322,988</td>
</tr>
<tr>
<td>Insurance</td>
<td>801,067</td>
<td>714,868</td>
</tr>
<tr>
<td>Legal fees</td>
<td>361,210</td>
<td>407,014</td>
</tr>
<tr>
<td>Meals and entertainment</td>
<td>506,010</td>
<td>524,460</td>
</tr>
<tr>
<td>Office expenses and supplies</td>
<td>1,025,415</td>
<td>918,612</td>
</tr>
<tr>
<td>Postage</td>
<td>2,449,965</td>
<td>2,703,113</td>
</tr>
<tr>
<td>Printing expense</td>
<td>1,508,498</td>
<td>1,620,111</td>
</tr>
<tr>
<td>Professional dues</td>
<td>318,586</td>
<td>299,921</td>
</tr>
<tr>
<td>Purchased services</td>
<td>5,932,106</td>
<td>9,587,247</td>
</tr>
<tr>
<td>Recruiting</td>
<td>220,574</td>
<td>294,559</td>
</tr>
<tr>
<td>Rent - equipment</td>
<td>102,696</td>
<td>92,390</td>
</tr>
<tr>
<td>Rent - regional offices</td>
<td>1,273,791</td>
<td>1,249,995</td>
</tr>
<tr>
<td>Repairs and maintenance</td>
<td>840,059</td>
<td>841,266</td>
</tr>
<tr>
<td>Software licenses</td>
<td>4,658,381</td>
<td>4,284,161</td>
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<tr>
<td>Subscriptions</td>
<td>82,591</td>
<td>75,243</td>
</tr>
<tr>
<td>Surveys and studies</td>
<td>19,838</td>
<td>4,725</td>
</tr>
<tr>
<td>Taxes and licenses</td>
<td>660,472</td>
<td>987,711</td>
</tr>
<tr>
<td>Telephone</td>
<td>705,702</td>
<td>736,842</td>
</tr>
<tr>
<td>Travel</td>
<td>812,081</td>
<td>711,002</td>
</tr>
<tr>
<td>Utilities</td>
<td>290,556</td>
<td>282,851</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$107,837,281</strong></td>
<td><strong>$111,776,217</strong></td>
</tr>
</tbody>
</table>

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*Attachment 12: Three Years of Audited Financial Reports*
## Liabilities and Fund Balance

<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>Unpaid claims and claims adjustment expenses</strong></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>3,145,724</td>
<td>1,591,188</td>
<td>302,757</td>
<td>211,432</td>
<td>333</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accrued expenses</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>1,904</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>2,013,298</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>-</td>
<td>8,793,353</td>
<td>264,112</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provider incentive compensation and withholds payable</td>
<td>-</td>
<td>1,697,800</td>
<td>3,988,790</td>
<td>42,939,603</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>48,626,193</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>-</td>
<td>2,374,341</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Collections for others</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Notes payable</td>
<td>13,801,592</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<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>
<td>-</td>
<td>650,000</td>
</tr>
<tr>
<td>Intercompany payables</td>
<td>52,908,714</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>81,027,968</td>
<td>87,771,488</td>
<td>40,705,154</td>
<td>81,055,813</td>
<td>166,333</td>
<td>604,598</td>
<td>5,543,735</td>
<td>(53,714,767)</td>
<td>(327,738,675)</td>
</tr>
</tbody>
</table>

## Fund Balance:

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund balance, unrestricted</td>
<td>138,104,761</td>
<td>149,395,414</td>
<td>59,504,935</td>
<td>46,297,511</td>
<td>7,263,932</td>
<td>932,304</td>
<td>3,523,832</td>
<td>(266,917,929)</td>
<td>138,104,761</td>
<td></td>
</tr>
<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>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(1,121,791)</td>
<td>(4,404,045)</td>
<td></td>
</tr>
<tr>
<td>Noncontrolling interests</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>621,537</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>621,537</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>133,700,717</td>
<td>150,534,717</td>
<td>59,489,749</td>
<td>46,295,185</td>
<td>7,263,932</td>
<td>1,553,841</td>
<td>3,523,832</td>
<td>(268,039,720)</td>
<td>134,322,253</td>
<td></td>
</tr>
</tbody>
</table>

**Total** | $215,627,785 | $238,306,205 | $100,194,903 | $127,348,998 | $7,424,265 | $2,158,439 | $9,067,567 | (321,754,487) | $378,373,675 |
# Consolidating Statement of Operations
## Year Ended December 31, 2015

### PREMIUMS:

<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>Commercial</td>
<td>$</td>
<td>$ 564,891,771</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$ 564,891,771</td>
</tr>
<tr>
<td>Medicare</td>
<td>-</td>
<td>-</td>
<td>301,577,532</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>301,577,532</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>340,997,255</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>301,577,532</td>
<td>340,997,255</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,207,466,558</td>
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</table>

### CLAIMS EXPENSE:

<table>
<thead>
<tr>
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<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>Commercial</td>
<td>-</td>
<td>502,102,602</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(211,211)</td>
<td>501,891,391</td>
</tr>
<tr>
<td>Medicare</td>
<td>-</td>
<td>-</td>
<td>288,280,340</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>288,280,340</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>295,113,012</td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>-</td>
<td>13,596,678</td>
<td>4,500,650</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>18,097,328</td>
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<tr>
<td>Premium taxes and assessments</td>
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<td>9,188,549</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9,188,549</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>-</td>
<td>(4,960,000)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(4,960,000)</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>295,113,012</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(211,211)</td>
<td>1,107,810,620</td>
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</tbody>
</table>

### EXCESS OF PREMIUMS OVER CLAIMS EXPENSE:

<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>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</td>
<td>-</td>
<td>44,963,942</td>
<td>8,796,542</td>
<td>45,884,243</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>211,211</td>
<td>99,855,938</td>
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</table>

### ADMINISTRATIVE REVENUES:

<table>
<thead>
<tr>
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<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>Overall</td>
<td>6,195,212</td>
<td>8,447,695</td>
<td>2,596</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2,674,885</td>
<td>4,161,700</td>
<td>15,524,667</td>
</tr>
</tbody>
</table>

### GENERAL AND ADMINISTRATIVE EXPENSES:

<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>UNDERWRITING GAIN (LOSS)</td>
<td>6,195,056</td>
<td>(10,383,248)</td>
<td>(8,275,066)</td>
<td>(19,635,652)</td>
<td>(3,054,272)</td>
<td>2,595,937</td>
<td>12,017,932</td>
<td>(1,11,653,844)</td>
<td>- 7,543,324</td>
</tr>
</tbody>
</table>

### OTHER INCOME (EXPENSE):

<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>Investment income</td>
<td>(56,949)</td>
<td>3,444,002</td>
<td>1,164,563</td>
<td>948,255</td>
<td>-</td>
<td>-</td>
<td>16</td>
<td>(904,622)</td>
<td>5,095,265</td>
</tr>
<tr>
<td>Interest expense</td>
<td>(1,873,110)</td>
<td>7,035</td>
<td>(532,820)</td>
<td>1,231,180</td>
<td>-</td>
<td>-</td>
<td>(43,828)</td>
<td>940,622</td>
<td>(306,921)</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(665,944)</td>
<td>(68,415)</td>
<td>-</td>
<td>(15,000)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(747,359)</td>
<td>-</td>
</tr>
<tr>
<td>Miscellaneous (expense) income</td>
<td>(983,036)</td>
<td>(204,039)</td>
<td>(21,196)</td>
<td>(28,878)</td>
<td>270</td>
<td>9,230</td>
<td>(1,237,470)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Income from subsidiaries</td>
<td>(3,054,272)</td>
<td>2,595,937</td>
<td>12,017,932</td>
<td>942,477</td>
<td>-</td>
<td>-</td>
<td>(11,653,844)</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,631,311</td>
<td>6,264,230</td>
<td>12,628,479</td>
<td>2,135,557</td>
<td>94,716</td>
<td>270</td>
<td>(34,582)</td>
<td>(11,653,844)</td>
<td>2,803,515</td>
</tr>
</tbody>
</table>

### INCOME (LOSS) BEFORE INCOME TAXES:

<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>INCOME (LOSS) BEFORE INCOME TAXES</td>
<td>(436,255)</td>
<td>(4,119,418)</td>
<td>4,353,413</td>
<td>21,766,212</td>
<td>(156,789)</td>
<td>224,419</td>
<td>369,101</td>
<td>(11,653,844)</td>
<td>10,346,839</td>
</tr>
</tbody>
</table>

### INCOME TAX EXPENSE (BENEFIT):

<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>TOTAL INCOME (LOSS)</td>
<td>3,130,205</td>
<td>3,054,274</td>
<td>5,198,757</td>
<td>12,035,652</td>
<td>(3,046,839)</td>
<td>426,301</td>
<td>12,035,652</td>
<td>(3,046,839)</td>
<td>426,301</td>
</tr>
</tbody>
</table>

### LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS:

<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>LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### NET INCOME (LOSS):

<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>NET INCOME (LOSS)</td>
<td>(3,130,205)</td>
<td>(3,054,274)</td>
<td>5,198,757</td>
<td>12,035,652</td>
<td>(3,046,839)</td>
<td>94,247</td>
<td>426,301</td>
<td>(11,653,844)</td>
<td>3,130,205</td>
</tr>
</tbody>
</table>
## PACIFICSOURCE AND SUBSIDIARIES

### CONTENTS

<table>
<thead>
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<th>Section</th>
<th>Page</th>
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<td>1-2</td>
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<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

**December 31**  

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<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>$ 433,925,120</td>
<td>$ 378,373,675</td>
</tr>
</tbody>
</table>

|               |            |            |
| **LIABILITIES AND FUND BALANCE** |            |            |
| **LIABILITIES:** |            |            |
| Unpaid claims and claims adjustment expenses | $ 115,335,762 | $ 119,306,910 |
| Accounts payable | 5,990,994    | 5,251,434   |
| Accrued expenses | 42,319,383   | 38,015,313  |
| Accrued pension liability | 4,237,759    | 2,013,298   |
| Unearned premiums | 15,092,691   | 9,647,669   |
| Accrued medical incentive pools and withholds payable | 41,451,858  | 48,626,193  |
| Accrued retro settlements | 1,488,462    | 2,374,341   |
| Collections for others | 5,931,542    | 3,850,868   |
| Notes payable | 295,375     | 14,315,396 |
| Deferred tax liabilities | -          | 650,000     |
| **Total** | 232,143,826  | 244,051,422  |

|               |            |            |
| **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  |

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>$ 433,925,120</td>
<td>$ 378,373,675</td>
</tr>
</tbody>
</table>

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES

Consolidated Statements of Operations

<table>
<thead>
<tr>
<th>Year Ended December 31</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREMIUMS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$ 554,847,140</td>
<td>$ 571,401,872</td>
</tr>
<tr>
<td>Medicare</td>
<td>345,466,471</td>
<td>301,577,532</td>
</tr>
<tr>
<td>Medicaid</td>
<td>328,343,402</td>
<td>340,997,255</td>
</tr>
<tr>
<td>Total</td>
<td>1,228,657,013</td>
<td>1,213,976,659</td>
</tr>
</tbody>
</table>

| CLAIMS EXPENSE:         |            |            |
| Commercial              | 507,120,946 | 503,799,158 |
| Medicare                | 324,340,673 | 288,280,340 |
| Medicaid                | 281,674,358 | 295,113,012 |
| Commissions on premiums | 18,123,914  | 18,097,328  |
| Premium taxes and assessments | 5,405,447 | 9,188,549  |
| Change in premium deficiency reserve | - | (4,960,000) |
| Total                   | 1,136,665,338 | 1,109,518,387 |

| EXCESS OF PREMIUMS OVER CLAIMS EXPENSE | 91,991,675 | 104,458,272 |

| ADMINISTRATIVE REVENUES | 20,317,045 | 10,922,333 |

| GENERAL AND ADMINISTRATIVE EXPENSES | 116,616,541 | 107,837,281 |

| UNDERWRITING (LOSS) GAIN | (4,307,821) | 7,543,324 |

| OTHER INCOME (EXPENSE):    |            |
| Investment income          | 4,893,498  | 5,095,265  |
| Interest expense           | (438,489)  | (306,921)  |
| Charitable contributions   | (1,027,134) | (747,359)  |
| Miscellaneous income (expense) | 630,499 | (1,237,470) |
| Total                      | 4,058,374  | 2,803,515  |

| (LOSS) INCOME BEFORE INCOME TAXES | (249,447) | 10,346,839 |

| INCOME TAX EXPENSE | 9,656,311 | 13,414,212 |

| TOTAL LOSS           | (9,905,758) | (3,067,373) |

| LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS | 71,191 | 62,832 |

| NET LOSS             | $ (9,976,949) | $ (3,130,205) |

See accompanying notes.

Attachment 12-Three Years of Audited Financial Reports
## Consolidated Statements of Comprehensive Loss

**Year Ended December 31**  
**2016**  
**2015**

<table>
<thead>
<tr>
<th></th>
<th>$</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NET LOSS</strong></td>
<td>$(9,976,949)</td>
<td>$(3,130,205)</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 $623,000 in 2016 and $(866,000) in 2015)</td>
<td>840,246</td>
<td>(1,443,812)</td>
</tr>
<tr>
<td>Reclassification adjustment for gains and losses realized in net loss (net of tax of $20,000 in 2016 and $486,000 in 2015), included in investment income</td>
<td>(26,111)</td>
<td>(810,628)</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 $356,000 in 2015), included in general and administrative expenses</td>
<td>418,780</td>
<td>350,794</td>
</tr>
<tr>
<td>Defined benefit pension plan, net</td>
<td>(1,226,472)</td>
<td>256,302</td>
</tr>
<tr>
<td>Total other comprehensive loss</td>
<td>(412,337)</td>
<td>(1,998,138)</td>
</tr>
<tr>
<td><strong>COMPREHENSIVE LOSS</strong></td>
<td>$ (10,389,286)</td>
<td>$ (5,128,343)</td>
</tr>
</tbody>
</table>

See accompanying notes.
### Accumulated Other Comprehensive Income (Loss)

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Unrealized Appreciation and Depreciation 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.
## PACIFICSOURCE AND SUBSIDIARIES

### Consolidated Statements of Cash Flows

#### Change in Cash and Cash Equivalents

<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>
</tbody>
</table>

| **CASH FLOWS FROM INVESTING ACTIVITIES:** |            |            |
| Proceeds from sale of investments | 87,073,944 | 89,600,671 |
| Investments purchased            | (140,703,190) | (74,097,232) |
| Property purchased               | (4,440,246)  | (3,792,817) |
| Net cash (used in) provided by investing activities | (58,069,492) | 11,710,622 |

| **CASH FLOWS FROM FINANCING ACTIVITIES:** |            |            |
| Proceeds from contribution       | 100,000,000 | -          |
| Proceeds from notes payable      | -          | 13,801,592 |
| Payments on notes payable        | (14,020,021) | (203,704) |
| Redemption of common stock       | (118,267)  | (11,763)  |
| Net cash provided by financing activities | 85,861,712 | 13,586,125 |

#### CHANGE IN CASH AND CASH EQUIVALENTS

- 2016: $24,146,435
- 2015: $36,514,032

#### CASH AND CASH EQUIVALENTS, beginning of year

- 2016: $104,651,432
- 2015: $68,137,400

#### CASH AND CASH EQUIVALENTS, end of year

- 2016: $128,797,867
- 2015: $104,651,432

(Continued)

See accompanying notes.
Reconciliation of Net Loss to Net Cash
(Used in) Provided by Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>Year Ended December 31</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016</td>
</tr>
<tr>
<td>NET LOSS</td>
<td>$9,976,949</td>
</tr>
<tr>
<td>ADJUSTMENTS TO RECONCILE NET LOSS TO NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES:</td>
<td></td>
</tr>
<tr>
<td>Income attributable to noncontrolling interest</td>
<td>71,191</td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>5,757,569</td>
</tr>
<tr>
<td>Deferred tax expense</td>
<td>(2,209,000)</td>
</tr>
<tr>
<td>Gain on sale of investments</td>
<td>(1,208,350)</td>
</tr>
<tr>
<td>Change in premium deficiency reserve</td>
<td>-</td>
</tr>
<tr>
<td>Adjustments resulting from changes in:</td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>1,893,111</td>
</tr>
<tr>
<td>Accrued investment income</td>
<td>(364,495)</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>(840,429)</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>6,240,735</td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>(3,971,148)</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>739,560</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>2,619,623</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>217,989</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>5,445,022</td>
</tr>
<tr>
<td>Accrued medical incentive pools payable</td>
<td>(7,174,335)</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>(885,879)</td>
</tr>
<tr>
<td><strong>NET CASH (USED IN) PROVIDED BY OPERATING ACTIVITIES</strong></td>
<td>$ (3,645,785)</td>
</tr>
</tbody>
</table>

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>Entity</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>
</tbody>
</table>

Gross revenue          $1,248,974,058 100.0%  $1,224,898,992 100.0%

**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, 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 is 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 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><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><strong>$170,624,457</strong></td>
<td><strong>$5,761,735</strong></td>
<td><strong>(2,048,197)</strong></td>
<td><strong>$174,337,995</strong></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>$(1,098,332)</td>
<td>43,076,515</td>
</tr>
<tr>
<td><strong>Total debt securities</strong></td>
<td>87,906,585</td>
<td>1,101,931</td>
<td>$(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><strong>Total</strong></td>
<td><strong>$112,678,294</strong></td>
<td><strong>$4,354,045</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 $640,000 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>
<th></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>
</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>
</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>
</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>
<td><strong>$(845,471)</strong></td>
<td><strong>$ 63,616,911</strong></td>
</tr>
</tbody>
</table>

December 31, 2015

<table>
<thead>
<tr>
<th></th>
<th>Less than 12 Months</th>
<th>12 Months or More</th>
<th>Total</th>
<th></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>
</tr>
<tr>
<td>Debt securities</td>
<td>$ 38,621,251</td>
<td>$(1,344,453)</td>
<td>$ 11,456,224</td>
<td>$(190,258)</td>
<td>$ 50,077,475</td>
</tr>
<tr>
<td>Equity securities</td>
<td>4,268,380</td>
<td>(161,180)</td>
<td>3,179,007</td>
<td>(361,751)</td>
<td>7,447,387</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>
<td><strong>$(552,009)</strong></td>
<td><strong>$ 57,524,862</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>Due in one year or less</th>
<th>Amortized Cost</th>
<th>Fair Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></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><strong>Total</strong></td>
<td><strong>$ 147,973,616</strong></td>
<td><strong>$ 147,176,658</strong></td>
</tr>
</tbody>
</table>

The change in unrealized appreciation in fair value of securities available-for-sale is as follows:

<table>
<thead>
<tr>
<th>December 31, 2016</th>
<th>Amortized Cost</th>
<th>Fair Value</th>
<th>Unrealized Appreciation</th>
<th>Tax Effect</th>
<th>Net Unrealized Appreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 170,624,457</td>
<td>$ 174,337,995</td>
<td>$ 3,713,538</td>
<td>(1,492,000)</td>
<td>$ 2,221,538</td>
<td></td>
</tr>
<tr>
<td>Less December 31, 2015</td>
<td>112,678,294</td>
<td>114,974,697</td>
<td>2,296,403</td>
<td>(889,000)</td>
<td>1,407,403</td>
</tr>
<tr>
<td><strong>Change in unrealized appreciation</strong></td>
<td>$ 1,417,135</td>
<td>$ (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></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></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>

Less accumulated depreciation and amortization

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></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><strong>Total</strong></td>
<td><strong>9,868,865</strong></td>
<td><strong>9,868,865</strong></td>
</tr>
<tr>
<td>Less accumulated amortization</td>
<td>4,350,707</td>
<td>3,530,838</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,518,158</strong></td>
<td><strong>$6,338,027</strong></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>Description</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>Description</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>Notes payable to individuals, due in monthly installments of $20,634, including interest at the prime rate plus 2% adjusted annually, not to be less than 7% or exceed 10% (effective rate of 7% at December 31, 2016), collateralized by business assets, matures March 2018.</td>
<td>295,375</td>
<td>513,804</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 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>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$ 234,350</td>
</tr>
<tr>
<td>2018</td>
<td>$ 61,025</td>
</tr>
</tbody>
</table>

$ 295,375
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>
<tr>
<td>Projected benefit obligation, end of year</td>
<td>$ 34,474,251</td>
<td>$ 31,457,623</td>
</tr>
</tbody>
</table>

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>
<tr>
<td>Fair value of plan assets, end of year</td>
<td>$ 30,236,492</td>
<td>$ 29,444,325</td>
</tr>
</tbody>
</table>

(Continued)
10. Retirement Plans (Continued)

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net periodic benefit cost:</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>Total net periodic benefit cost</td>
<td>$217,989</td>
<td>$95,423</td>
</tr>
<tr>
<td>Amounts recognized in accumulated other comprehensive loss:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss</td>
<td>$11,109,819</td>
<td>$9,103,347</td>
</tr>
<tr>
<td>Total accumulated other comprehensive loss</td>
<td>$11,109,819</td>
<td>$9,103,347</td>
</tr>
<tr>
<td>Changes in other comprehensive loss:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net loss</td>
<td>$2,691,252</td>
<td>$190,492</td>
</tr>
<tr>
<td>Amortization of net loss</td>
<td>(684,780)</td>
<td>(706,794)</td>
</tr>
<tr>
<td>Total recognized in other comprehensive loss</td>
<td>$2,006,472</td>
<td>$(516,302)</td>
</tr>
<tr>
<td>Accumulated benefit obligation, end of year</td>
<td>$34,474,251</td>
<td>$31,457,623</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 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 used for net periodic benefit costs:</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>

<table>
<thead>
<tr>
<th>Assumptions used to determine benefit obligation:</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>
</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 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>Deferred tax assets:</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><strong>7,994,000</strong></td>
<td><strong>6,661,000</strong></td>
</tr>
<tr>
<td>Deferred tax liabilities:</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><strong>(6,258,000)</strong></td>
<td><strong>(7,311,000)</strong></td>
</tr>
<tr>
<td><strong>Net deferred tax assets (liabilities)</strong></td>
<td>$ 1,736,000</td>
<td>$(650,000)</td>
</tr>
</tbody>
</table>

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:

<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>$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 $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>Total</td>
<td>$6,725,091</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>Total</td>
<td>$40,490,467</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>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, 2016</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>$ 33,306,797</td>
<td>$ 33,306,797</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>39,952,456</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>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>
</tr>
<tr>
<td>Available-for-sale equity securities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mutual funds</td>
<td>27,161,337</td>
<td>27,161,337</td>
<td>-</td>
<td>-</td>
</tr>
<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>
</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>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>December 31, 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$8,403,416</td>
<td>$8,403,416</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>10,067,157</td>
<td>10,067,157</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,105,712</td>
<td>6,105,712</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,553,588</td>
<td>3,553,588</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,513,505</td>
<td>1,513,505</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Money market funds</td>
<td>593,114</td>
<td>593,114</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$30,236,492</td>
<td>$30,236,492</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>December 31, 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</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>
</tr>
<tr>
<td>Balanced funds</td>
<td>9,780,871</td>
<td>9,780,871</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>
</tr>
<tr>
<td>Value funds</td>
<td>3,669,029</td>
<td>3,669,029</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>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$29,444,325</td>
<td>$29,444,325</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, 2016.
# 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>$82,259</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>

Year Ended December 31
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

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>PS</th>
<th>PSHP</th>
<th>PCHP</th>
<th>PCS</th>
<th>PHI</th>
<th>IPN</th>
<th>PSA</th>
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<td>$ 120,509,363</td>
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<td>$ 5,004,979</td>
<td>$ 1,818,788</td>
<td>$ 10,837,095</td>
<td>(314,456,373)</td>
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<td>(28,762,251)</td>
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<tr>
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<td>(2,313,212)</td>
<td>(4,816,382)</td>
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<tr>
<td>Total</td>
<td>$ 247,036,548</td>
<td>$ 246,877,221</td>
<td>$ 120,509,363</td>
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<td>$ 5,004,979</td>
<td>$ 1,818,788</td>
<td>$ 10,837,095</td>
<td>(314,456,373)</td>
<td>433,925,120</td>
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</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 12—Three Years of Audited Financial Reports
Page 83 of 127
## Consolidating Statement of Operations

### Year Ended December 31, 2016

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<th>PCHP</th>
<th>PCS</th>
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<th>Eliminations</th>
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<td>281,674,358</td>
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<td>Commissions on premiums</td>
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<td>535,910</td>
<td>(4,10,395)</td>
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<td>NET (LOSS) INCOME</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>(4,10,395)</td>
<td>(9,976,949)</td>
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</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 Consolidating Statement of Financial Reports

Page 84 of 127
Independent Auditors' Report
Consolidated Financial Statements and Supplemental Information
Years Ended December 31, 2017 and 2016
# PACIFICSOURCE AND SUBSIDIARIES

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<tr>
<th>CONTENTS</th>
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<tbody>
<tr>
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<td>1-2</td>
</tr>
<tr>
<td>FINANCIAL STATEMENTS</td>
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<tr>
<td>Consolidated balance sheets</td>
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<td>Consolidated statements of operations</td>
<td>4</td>
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<td>Consolidated statements of comprehensive income (loss)</td>
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<td>Consolidated statements of changes in fund balance</td>
<td>6</td>
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<tr>
<td>Consolidated statements of cash flows</td>
<td>7-9</td>
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<td>Notes to consolidated financial statements</td>
<td>10-37</td>
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<td>SUPPLEMENTAL INFORMATION</td>
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<td>Consolidated schedules of general and administrative expenses</td>
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</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.

Kermit Stokes, CPA
Eugene, Oregon
May 17, 2018
### PACIFICSOURCE AND SUBSIDIARIES

#### Consolidated Balance Sheets

<table>
<thead>
<tr>
<th></th>
<th>December 31 2017</th>
<th>December 31 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSETS</strong></td>
<td>$541,311,382</td>
<td>$433,925,120</td>
</tr>
<tr>
<td>Investments</td>
<td>256,965,321</td>
<td>178,381,998</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>123,312,310</td>
<td>128,797,867</td>
</tr>
<tr>
<td>Trust funds</td>
<td>6,257,746</td>
<td>5,931,542</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>66,064,163</td>
<td>74,186,247</td>
</tr>
<tr>
<td>Prepaid expenses and deposits</td>
<td>45,975,655</td>
<td>12,592,742</td>
</tr>
<tr>
<td>Prepaid income taxes</td>
<td>18,429,285</td>
<td>7,215,210</td>
</tr>
<tr>
<td>Property, net</td>
<td>8,879,804</td>
<td>6,953,584</td>
</tr>
<tr>
<td>Goodwill</td>
<td>12,113,855</td>
<td>12,611,772</td>
</tr>
<tr>
<td>Intangible assets, net</td>
<td>3,313,243</td>
<td>5,518,158</td>
</tr>
<tr>
<td>Deferred tax assets</td>
<td>-</td>
<td>1,736,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$541,311,382</td>
<td>$433,925,120</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>LIABILITIES AND FUND BALANCE</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIABILITIES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unpaid claims and claims adjustment expenses</td>
<td>$131,198,344</td>
<td>$115,335,762</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>22,255,889</td>
<td>5,990,994</td>
</tr>
<tr>
<td>Accrued expenses</td>
<td>42,817,229</td>
<td>42,319,383</td>
</tr>
<tr>
<td>Accrued pension liability</td>
<td>4,328,462</td>
<td>4,237,759</td>
</tr>
<tr>
<td>Unearned premiums</td>
<td>14,320,998</td>
<td>15,092,691</td>
</tr>
<tr>
<td>Accrued medical incentive pools and withholds payable</td>
<td>47,585,378</td>
<td>41,451,858</td>
</tr>
<tr>
<td>Accrued retro settlements</td>
<td>539,961</td>
<td>1,488,462</td>
</tr>
<tr>
<td>Collections for others</td>
<td>6,257,746</td>
<td>5,931,542</td>
</tr>
<tr>
<td>Notes payable</td>
<td>61,154</td>
<td>295,375</td>
</tr>
<tr>
<td>Deferred tax liabilities</td>
<td>8,277,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>277,642,161</td>
<td>232,143,826</td>
</tr>
</tbody>
</table>

| **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.
### PREMIUMS:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>$704,949,785</td>
<td>$554,847,140</td>
</tr>
<tr>
<td>Medicare</td>
<td>357,594,116</td>
<td>345,466,471</td>
</tr>
<tr>
<td>Medicaid</td>
<td>313,506,831</td>
<td>328,343,402</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,376,050,732</td>
<td>1,228,657,013</td>
</tr>
</tbody>
</table>

### CLAIMS EXPENSE:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>607,321,294</td>
<td>507,120,946</td>
</tr>
<tr>
<td>Medicare</td>
<td>325,785,456</td>
<td>324,340,673</td>
</tr>
<tr>
<td>Medicaid</td>
<td>283,779,640</td>
<td>281,674,358</td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>20,746,112</td>
<td>18,123,914</td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>5,102,909</td>
<td>5,405,447</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,242,735,411</td>
<td>1,136,665,338</td>
</tr>
</tbody>
</table>

### EXCESS OF PREMIUMS OVER CLAIMS EXPENSE

133,315,321

### ADMINISTRATIVE REVENUES

18,936,454

### GENERAL AND ADMINISTRATIVE EXPENSES

115,692,243

### UNDERWRITING GAIN (LOSS)

36,559,532

### OTHER INCOME (EXPENSE):

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment income</td>
<td>9,399,243</td>
<td>4,893,498</td>
</tr>
<tr>
<td>Interest expense</td>
<td>(59,365)</td>
<td>(438,489)</td>
</tr>
<tr>
<td>Charitable contributions</td>
<td>(670,874)</td>
<td>(1,027,134)</td>
</tr>
<tr>
<td>Miscellaneous (expense) income</td>
<td>(4,299,491)</td>
<td>630,499</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,369,513</td>
<td>4,058,374</td>
</tr>
</tbody>
</table>

### INCOME (LOSS) BEFORE INCOME TAXES

40,929,045

### INCOME TAX EXPENSE

12,407,320

### TOTAL INCOME (LOSS)

28,521,725

### LESS INCOME ATTRIBUTABLE TO NONCONTROLLING INTERESTS

74,642

### NET INCOME (LOSS)

$28,447,083

See accompanying notes.
PACIFICSOURCE AND SUBSIDIARIES
Consolidated Statements of Comprehensive Income (Loss)

<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>OTHER COMPREHENSIVE INCOME (LOSS), NET OF TAXES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation of investments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrealized appreciation arising during year</td>
<td>3,449,236</td>
<td>840,246</td>
</tr>
<tr>
<td>(net of tax of $2,150,000 in 2017 and $623,000 in 2016)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassification adjustment for gains and losses realized in net income (loss)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(net of tax of $125,000 in 2017 and $(20,000) in 2016), included in investment income</td>
<td>201,451</td>
<td>(26,111)</td>
</tr>
<tr>
<td>Unrealized appreciation of investments, net</td>
<td>3,650,687</td>
<td>814,135</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 $212,000 in 2017 and $1,046,000 in 2016), included in general and administrative expenses</td>
<td>(334,773)</td>
<td>(1,645,252)</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>
<td>418,780</td>
</tr>
<tr>
<td>Defined benefit pension plan, net</td>
<td>215,515</td>
<td>(1,226,472)</td>
</tr>
<tr>
<td>Total other comprehensive income (loss)</td>
<td>3,866,202</td>
<td>(412,337)</td>
</tr>
<tr>
<td>COMPREHENSIVE INCOME (LOSS)</td>
<td>$32,313,285</td>
<td>$(10,389,286)</td>
</tr>
</tbody>
</table>

See accompanying notes.
### PACIFICSOURCE AND SUBSIDIARIES

**Consolidated Statements of Changes in Fund Balance**

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Unrealized Appreciation on Investments</th>
<th>Defined Pension Benefit</th>
<th>Noncontrolling Interests</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BALANCE, JANUARY 1, 2016</strong></td>
<td><strong>$ 138,104,761</strong></td>
<td><strong>$ 1,139,302</strong></td>
<td><strong>$ (5,543,347)</strong></td>
<td><strong>$ 621,537</strong></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><strong>Total</strong></td>
<td>67,918,454</td>
<td>814,135</td>
<td>(1,226,472)</td>
<td>(47,076)</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>
</tr>
<tr>
<td>Net income</td>
<td>28,447,083</td>
<td>-</td>
<td>-</td>
<td>74,642</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td>-</td>
<td>3,650,687</td>
<td>215,515</td>
<td>-</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>
</tr>
<tr>
<td>Contribution</td>
<td>29,500,000</td>
<td>-</td>
<td>-</td>
<td>-</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>
</tr>
<tr>
<td><strong>BALANCE, DECEMBER 31, 2017</strong></td>
<td><strong>$ 264,114,298</strong></td>
<td><strong>$ 6,884,124</strong></td>
<td><strong>$ (7,978,304)</strong></td>
<td><strong>$ 649,103</strong></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></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>42,723,384</td>
<td>(3,645,785)</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        |
| **CASH AND CASH EQUIVALENTS, end of year**       | $123,312,310       |

$128,797,867

(Continued)

See accompanying notes.
Reconciliation of Net Income (Loss) to Net Cash Provided by (Used in) Operating Activities

 Year Ended December 31

<table>
<thead>
<tr>
<th></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>
</tbody>
</table>

ADJUSTMENTS TO RECONCILE NET INCOME (LOSS) TO NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

NET CASH PROVIDED BY (USED IN) OPERATING ACTIVITIES       $42,723,384  $ (3,645,785)

(Continued)

See accompanying notes.
Supplemental Schedule of Noncash Investing and Financing Activities

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>Entity</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>
</tbody>
</table>

Gross revenue $1,394,987,186 100.0% $1,248,974,058 100.0%

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.
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><strong>Total</strong></td>
<td><strong>$ 256,965,321</strong></td>
<td><strong>$ 178,381,998</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 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><strong>202,713,014</strong></td>
<td><strong>1,347,133</strong></td>
<td><strong>(1,002,982)</strong></td>
<td><strong>203,057,165</strong></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><strong>$245,350,076</strong></td>
<td><strong>$10,839,095</strong></td>
<td><strong>$(1,199,870)</strong></td>
<td><strong>$254,989,301</strong></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><strong>147,973,616</strong></td>
<td><strong>789,361</strong></td>
<td><strong>(1,586,319)</strong></td>
<td><strong>147,176,658</strong></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><strong>$170,624,457</strong></td>
<td><strong>$5,761,735</strong></td>
<td><strong>$(2,048,197)</strong></td>
<td><strong>$174,337,995</strong></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>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>$ 83,650,918</td>
<td>$ (540,497)</td>
<td>$ 26,270,921</td>
</tr>
<tr>
<td>Equity securities</td>
<td>4,371,305</td>
<td>(136,913)</td>
<td>1,549,864</td>
</tr>
<tr>
<td></td>
<td>$ 88,022,223</td>
<td>$ (677,410)</td>
<td>$ 27,820,785</td>
</tr>
</tbody>
</table>

December 31, 2016

<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></td>
<td>$ 44,683,734</td>
<td>$ (1,202,726)</td>
<td>$ 18,933,177</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</th>
<th>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</td>
<td>$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</td>
<td>174,337,995</td>
<td>3,713,538</td>
<td>(1,492,000)</td>
<td>2,221,538</td>
</tr>
<tr>
<td><strong>Change in unrealized appreciation</strong></td>
<td></td>
<td></td>
<td><strong>$5,925,687</strong></td>
<td>(995,000)</td>
<td><strong>$4,930,687</strong></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><strong>Total</strong></td>
<td>$66,064,163</td>
<td>$74,186,247</td>
</tr>
</tbody>
</table>

Attachment 12-Three Years of Audited Financial Reports
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><strong>Total</strong></td>
<td>$29,765,974</td>
<td>$24,986,121</td>
</tr>
</tbody>
</table>

Less accumulated depreciation

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$20,886,170</td>
<td>$18,032,537</td>
</tr>
</tbody>
</table>

**Total** $8,879,804 $6,953,584

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><strong>Total</strong></td>
<td>$9,868,865</td>
<td>$9,868,865</td>
</tr>
</tbody>
</table>

Less accumulated amortization

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$6,555,622</td>
<td>$4,350,707</td>
</tr>
</tbody>
</table>

**Total** $3,313,243 $5,518,158

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>
</tbody>
</table>

All outstanding liabilities before 2016, net of reinsurance

Total unpaid claims and claims adjustment expenses $ 131,198,344

(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>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>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>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>Description</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>Description</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:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected benefit obligation, beginning of year</td>
<td>$34,474,251</td>
<td>$31,457,623</td>
</tr>
<tr>
<td>Interest cost</td>
<td>1,411,304</td>
<td>1,384,765</td>
</tr>
<tr>
<td>Benefits paid and administrative expenses</td>
<td>(1,000,772)</td>
<td>(1,028,250)</td>
</tr>
<tr>
<td>Actuarial loss</td>
<td>3,089,726</td>
<td>2,660,113</td>
</tr>
</tbody>
</table>

Projected benefit obligation, end of year | $37,974,509 | $34,474,251 |

Change in fair value of plan assets:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair value of plan assets, beginning of year</td>
<td>$30,236,492</td>
<td>$29,444,325</td>
</tr>
<tr>
<td>Actual return on plan assets</td>
<td>4,410,327</td>
<td>1,820,417</td>
</tr>
<tr>
<td>Benefits paid</td>
<td>(1,000,772)</td>
<td>(1,028,250)</td>
</tr>
</tbody>
</table>

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>Net periodic benefit cost:</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><strong>$442,218</strong></td>
<td><strong>$217,989</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amounts recognized in accumulated other comprehensive loss:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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><strong>$10,758,304</strong></td>
<td><strong>$11,109,819</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in other comprehensive loss:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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><strong>(351,515)</strong></td>
<td><strong>2,006,472</strong></td>
</tr>
</tbody>
</table>

| Accumulated benefit obligation, end of year               | $37,974,509   | $34,474,251   |

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>Assumptions used for net periodic benefit costs:</th>
<th>2017</th>
<th>2016</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>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>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount rate used in determining present values</td>
<td>3.7%</td>
<td>4.2%</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>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>Total current income tax expense</td>
<td>4,805,320</td>
<td>11,865,311</td>
</tr>
<tr>
<td>Deferred tax expense (benefit)</td>
<td>7,602,000</td>
<td>(2,209,000)</td>
</tr>
<tr>
<td>Total income tax expense</td>
<td>$ 12,407,320</td>
<td>$ 9,656,311</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>Total income tax expense</td>
<td>$ 12,407,320</td>
<td>$ 9,656,311</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>Deferred tax assets:</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>$6,110,000</td>
<td>$7,994,000</td>
</tr>
</tbody>
</table>

| Deferred tax liabilities: |            |            |
| Prepaids                | $(9,611,000) | $(1,661,000) |
| Unrealized gains        | (2,487,000) | (1,492,000) |
| Property                | (1,876,000) | (3,039,000) |
| Rebate guarantee        | (364,000)   | -          |
| Subsidiary equity income| (49,000)   | (66,000)   |
| **Total deferred tax liabilities** | $(14,387,000) | $(6,258,000) |

**Net deferred tax (liabilities) assets**  
$8,277,000 $1,736,000

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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment</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>Total</td>
<td>$16,202,411</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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment</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>Total</td>
<td>$37,637,423</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>Quoted Prices in Active Markets for Identical Assets (Level One)</th>
<th>Significant Other Observable Inputs (Level Two)</th>
<th>Significant Unobservable Inputs (Level Three)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>December 31, 2017</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>$ 32,546,589</td>
<td>$ 32,546,589</td>
<td>-</td>
</tr>
<tr>
<td>Mortgage/asset backed debt securities</td>
<td>54,796,361</td>
<td>-</td>
<td>54,796,361</td>
</tr>
<tr>
<td>Corporate debt securities</td>
<td>115,714,206</td>
<td>-</td>
<td>115,714,206</td>
</tr>
<tr>
<td>Total debt securities</td>
<td>203,057,156</td>
<td>32,546,589</td>
<td>170,510,567</td>
</tr>
<tr>
<td>Available-for-sale equity securities:</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>
</tr>
<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>-</td>
<td>73,917,405</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>
</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>Quoted Prices in Active Markets for Identical Assets (Level One)</th>
<th>Significant Other Observable Inputs (Level Two)</th>
<th>Significant Unobservable Inputs (Level Three)</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></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>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>12,330,581</td>
<td>12,330,581</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>7,340,551</td>
<td>7,340,551</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>4,154,931</td>
<td>4,154,931</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,598,365</td>
<td>1,598,365</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$33,646,047</td>
<td>$33,646,047</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>December 31, 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered investment companies:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed income funds</td>
<td>$8,403,416</td>
<td>$8,403,416</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Balanced funds</td>
<td>10,067,157</td>
<td>10,067,157</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Growth funds</td>
<td>6,105,712</td>
<td>6,105,712</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Value funds</td>
<td>3,553,588</td>
<td>3,553,588</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Real estate funds</td>
<td>1,513,505</td>
<td>1,513,505</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Money market funds</td>
<td>593,114</td>
<td>593,114</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>$30,236,492</td>
<td>$30,236,492</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 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.
SUPPLEMENTAL INFORMATION
<table>
<thead>
<tr>
<th>Expense</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>1,274,068</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.
### Consolidated Statement of Operations

#### Year Ended December 31, 2017

<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>Consolidated Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREMIUMS:</strong></td>
<td></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>$ 704,949,785</td>
<td>- $</td>
<td>- $</td>
<td>- $</td>
<td>- $</td>
<td>- $</td>
<td>- $</td>
<td>$ 704,949,785</td>
</tr>
<tr>
<td>Medicare</td>
<td>-</td>
<td>-</td>
<td>357,594,116</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</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>-</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>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>- 607,611,592</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(290,298)</td>
<td>- 607,321,294</td>
</tr>
<tr>
<td>Medicare</td>
<td>- 325,785,456</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>- 325,785,456</td>
</tr>
<tr>
<td>Medicaid</td>
<td>-</td>
<td>-</td>
<td>283,779,640</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>283,779,640</td>
</tr>
<tr>
<td>Commissions on premiums</td>
<td>- 16,129,117</td>
<td>-</td>
<td>4,616,995</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>- 20,746,112</td>
</tr>
<tr>
<td>Premium taxes and assessments</td>
<td>- 5,102,909</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>- 5,102,909</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>- 628,843,618</td>
<td>330,402,451</td>
<td>283,779,640</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>- 1,242,735,411</td>
</tr>
<tr>
<td><strong>EXCESS OF PREMIUMS OVER CLAIMS EXPENSE</strong></td>
<td>- 76,106,167</td>
<td>27,191,665</td>
<td>29,727,191</td>
<td>-</td>
<td>-</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>
<td></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>(45,067,770)</td>
<td>36,559,532</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>
<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>-</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>- 920,404</td>
<td>-</td>
<td>-</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>-</td>
<td>(670,874)</td>
<td>- (4,299,491)</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>-</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>- 111,963</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(45,067,770)</td>
<td>- (4,299,491)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>24,441,880</td>
<td>13,291,467</td>
<td>9,161,300</td>
<td>2,937,206</td>
<td>(385,954)</td>
<td>-</td>
<td>(8,616)</td>
<td>(45,067,770)</td>
<td>4,369,513</td>
</tr>
<tr>
<td><strong>INCOME (LOSS) BEFORE INCOME TAXES</strong></td>
<td>29,235,925</td>
<td>33,703,056</td>
<td>12,392,040</td>
<td>20,713,515</td>
<td>1,536,865</td>
<td>266,579</td>
<td>371,152</td>
<td>(45,067,770)</td>
<td>40,929,045</td>
</tr>
<tr>
<td><strong>INCOME TAX EXPENSE (BENEFIT)</strong></td>
<td>788,842</td>
<td>6,820,148</td>
<td>713,531</td>
<td>4,435,337</td>
<td>(453,394)</td>
<td>79,974</td>
<td>22,882</td>
<td>(45,067,770)</td>
<td>12,407,320</td>
</tr>
<tr>
<td><strong>TOTAL 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>186,692</td>
<td>348,270</td>
<td>(45,067,770)</td>
<td>28,521,725</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>
<td>- 74,642</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>
<td>$ 28,447,083</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 12-Three Years of Audited Financial Reports
Attachment 13 — Attestations

Applicant Name: PacificSource Community Solutions
Authorizing Signature: [Redacted]
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: ______________________________
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://hcp-lan.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: ____________________________

e. 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: 

Attachment 13-Attestations
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 Contract, 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 Contract, 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 broker, 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:

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?
☑ Yes □ No
If “no” please provide explanation:

ff. 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:

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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:

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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:

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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:

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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:

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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 (PDTS) 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: ___________________________

g. 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: ___________________________

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? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.
   ☒ 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: ________________________________________________
Attachment 14 — Assurances

Applicant Name: PacificSource Community Solutions

Authorizing Signature: [Redacted]

Printed Name: Kenneth P. Provencher

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)
   [x] 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]
   [x] 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

Attachment 14-Assurances Page 1 of 16
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 will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 - 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

Yes [ ] 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 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:
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

Attachment 14-Assurances
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
operating 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] 
[X] 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.
Attachment 15 – Representations

Applicant Name: PacificSource Community Solutions

Authorizing Signature: [Signature]

Printed Name: Kenneth P. Provencher

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 work stream 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 SFTPs 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.

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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 member’s 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-date claims feed, when appropriate.

- **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 than 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.