

ATTACHMENT 1 – Application Cover Sheet

Applicant Information - RFA # 3402

Applicant Name: PacificSource Community Solutions, Inc.

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

State of domicile: Oregon

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

Address: 110 International Way

City, State, Zip: Springfield, OR 97478

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

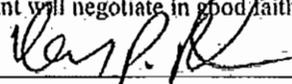
E-mail Address: rbusek@pacificsource.com

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

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

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

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

Signature:  Title: President and CEO Date: July 30, 2012

(Authorized to Bind Applicant)

ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

Applicant Name: PacificSource Community Solutions, Inc.

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

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

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

Attestations for Appendix A – CCO Criteria

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation A-1. Applicant will have an individual accountable for each of the following operational functions: <ul style="list-style-type: none"> • Contract administration • Outcomes and evaluation • Performance measurement • Health management and care coordination activities • System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO • Mental health and addictions coordination and system management • Communications management to providers and Members • Provider relations and network management, including credentialing • Health information technology and medical records 	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<ul style="list-style-type: none"> • Privacy officer • Compliance officer 				
Attestation A-2. Applicant will participate in the learning collaboratives required by ORS 442.210.	✓			
Attestation A-3. Applicant will collect, maintain and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities.	✓			

Attestations for Appendix B – Provider Participation and Operations Questionnaire

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Attestation B-1. Applicant will, as demonstrated with policies and procedures, (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070.	✓			
Attestation B-2. Applicant will comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans.	✓			
Attestation B-3. Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract.	✓			
Attestation B-4. Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Covered Services throughout the requested service area.				
Attestation B-5. Applicant will have all provider contracts or agreements available upon request.	✓			
Attestation B-6. As Applicant implements, acquires, or upgrades health information technology (HIT) systems, where available, the HIT systems and products will meet standards and implementation specifications adopted under section 3004 of the Public Health Services Act as added by section 13101 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5.			✓	PacificSource Community Solutions will work with contracted providers to implement HIT and EMRs as appropriate per state regulations and available opportunities.
Attestation B-7. Applicant's contracts for administrative and management services will contain the OHA required contract provisions.	✓			
Attestation B-8. Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.	✓			
Attestation B-9. Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines.	✓			
Attestation B-10. Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through: <ul style="list-style-type: none"> • Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week; • The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant; • Enrollee involvement in decisions regarding treatment, proper education 	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
<p>on treatment options, and the coordination of follow-up care;</p> <ul style="list-style-type: none"> • Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and • Addressing diverse patient populations in a culturally competent manner. 				
<p>Attestation B-11. Applicant will establish policies, procedures, and standards that:</p> <ul style="list-style-type: none"> • Assure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO, • Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; • Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; • Communicate and enforce compliance by providers with medical necessity determinations; and • Do not discriminate against Medicaid enrollees, including providing services to individuals with disabilities in the most integrated setting appropriate to the needs of those individuals. 	✓			
<p>Attestation B-12. Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future.</p>	✓			
<p>Attestation B-13. Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations.</p>	✓			
<p>Attestation B-14. Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the</p>	✓			

Attestation	Yes	No	Yes, Qualified	Explanation if No or Qualified
Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities).				
Attestation B-15. Neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services.	✓			

Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

Assurance B-1. Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a-week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140]	✓			
Assurance B-2. Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3160]	✓			
Assurance B-3. Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and	✓			

<p>procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and Corrective Action activities. Such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law. [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]</p>			
<p>Assurance B-4. Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.200 and 438.240; OAR 410-141-0200]</p>		✓	<p>Currently, PacificSource Community Solutions has a robust QI program and will incorporate race, ethnicity, and language demographics into outcomes tracking.</p>
<p>Assurance B-5. Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]</p>	✓		
<p>Assurance B-6. Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266]</p>	✓		

<p>Assurance B-7. Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; OAR 410-141-3280]</p>	✓			
<p>Assurance B-8. Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; and OAR 410-141-3300]</p>	✓			
<p>Assurance B-9. Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]</p>	✓			
<p>Assurance B-10. Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]</p>	✓			
<p>Assurance B-11. Applicant will maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor</p>	✓			

<p>providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 447.46 and OAR 410-141-0420]</p>			
<p>Assurance B-12. Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]</p>	✓		
<p>Assurance B-13. Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract]</p>	✓		
<p>Assurance B-14. Applicant will maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242 and 438.604; and Contract]</p>	✓		

Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

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

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

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

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

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

(Applicant Authorized Officer)

Signature:  Title: President and CEO Date: July 30, 2012

ATTACHMENT 7 –APPLICATION CHECKLISTS

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

-
- 1. Technical Application, Mandatory Submission Materials**
- a. Application Cover Sheet (Attachment 1)
 - b. Attestations, Assurances and Representations (Attachment 6).
 - c. This Technical Application Checklist
 - d. Letters of Support from Key Community Stakeholders.
 - e. Résumés for Key Leadership Personnel.
 - f. Organizational Chart.
 - g. Services Area Request (Appendix B).
 - h. Questionnaires
 - (1) CCO Criteria Questionnaire (Appendix A).
 - (2) Provider Participation and Operations Questionnaire (Appendix B).
 - (3) Accountability Questionnaire (Appendix C)
 - Services Area Table.
 - Publicly Funded Health Care and Service Programs Table
 - (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).[§]

*Responsive ✓
Responsive ✓
Memorandum
8-2-12*

2. Technical Application, Optional Submission Materials

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

- a. Transformation Scope Elements (Appendix H).
 - b. Applicant's Designation of Confidential Materials (Attachment 2).
-

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

3. Financial Application, Mandatory Submission Materials

APPENDIX E

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

APPENDIX F

- a. Base Cost Template
-



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NORTH CENTRAL PUBLIC HEALTH DISTRICT
"Caring For Our Communities"

419 East Seventh Street, The Dalles, OR 97058
Telephone: 541-506-2600 Fax: 541-506-2601
Website: www.wshd.org

July 20, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

As Director of North Central Public Health District, I would like to indicate my support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

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

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

North Central Public Health District expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

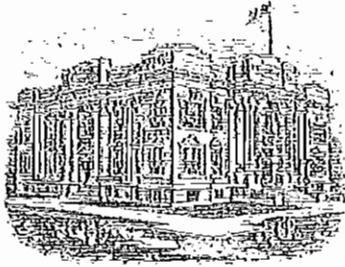
- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Teri L. Thalhofer, RN". The signature is written in a cursive, flowing style.

Teri L. Thalhofer, RN, BSN
Director, NCPHD



WASCO COUNTY

Board of County Commissioners

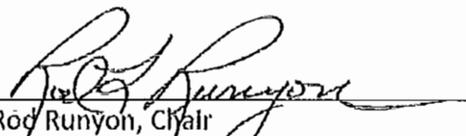
511 Washington Street, Suite 302
The Dalles, Oregon 97058-2237
(541) 506-2520
Fax: (541) 506-2521

Rod Runyon, *Chair of the Board*
Sherry Holliday, *County Commissioner*
Scott Hege, *County Commissioner*

- Improvement in quality of care within the community.
- Delivery of cost-effective care that will reduce health care costs overall.

Please accept this letter as formal recognition of our support for PacificSource Community Solution's application in helping the Columbia Gorge Region improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,


Rod Runyon, Chair
Wasco County Board of Commissioners



North Wasco County School District No. 21

Office of the Superintendent

July 2nd, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

North Wasco County School District #21 would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County. Through a rigorous evaluation process, the Columbia Gorge Health Council has chosen PacificSource Community Solutions as its CCO. The Council was impressed with PacificSource Community Solution's strong community presence and commitment to improving health care outcomes in the communities it serves. They see PacificSource Community Solutions as an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

Columbia Gorge Health Council sees PacificSource Community Solution's varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, as ideally suited for them to become the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

North Wasco School District respects and supports the decision made by Columbia Gorge Health Council and expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

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

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

Sincerely,

Candy Armstrong
Superintendent

3632 West 10th Street • The Dalles, OR 97058
541-506-3420 • Fax 541-298-6018
www.nwasco.k12.or.us

Hood River County Prevention Office
Alcohol, Tobacco & Other Drug Prevention

June 19, 2012

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

RE: Letter of support

PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

Hood River County's Prevention Office is in strong support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region. The committee tasked with review of the CCO applicants was incredibly thorough and have chosen the best candidate for our region.

Our communities have been impressed with PacificSource Community Solutions for their ongoing presence and commitment to improving health care outcomes. Given the newness of health care reform and the risk that must be borne by the organization we are even more impressed with their dedication to making our communities healthier places in which to live. They have shown themselves to be active partners, dedicating an enormous amount of time and manpower to help create the beginning of comprehensive health care system that is preventative and outcome based. They have aligned their work to reduce medical costs that meets or exceeds the objectives of House Bill 3650 and Senate Bill 1580.

PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for Hood River including physical health, addictions and mental health services, and oral health care with a focus on primary prevention.

As coordinator of Hood River County's Prevention Office it is of primary significance that PacificSource understands prevention from multiple perspectives and across the continuum of care illustrated in the Institute of Medicine Model. We work as a

Hood River County Prevention Office
Alcohol, Tobacco & Other Drug Prevention

network of prevention coalitions in primary community prevention which enhance the community norms that decrease addictions, mental, physical and dental diseases. PacificSource has demonstrated their commitment to focus on primary prevention to increase sustainable results and achieve better health outcomes while reducing health care costs.

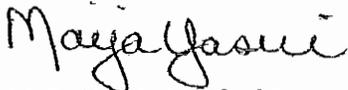
Hood River County Prevention Office expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective care that will reduce health care costs overall.
- ✓ Adoption of a prevention based system that yields long term sustainable outcomes

Please accept this letter as an indicator of our office's strong support for PacificSource's application to become a CCO in the Columbia Gorge Region.

Sincerely



Majja Yasui, Certified Prevention Specialist
Hood River County Prevention Coordinator
Hood River County Courthouse
309 State Street
Hood River, Oregon 97031
541-386-3335
Majja.yasui@co.hood-river.or.us



A PLANETREE HOSPITAL

1700 E 19th St.
The Dalles, OR 97058
Tel. 541-296-1111
Fax 541-296-7600
www.mcmc.net

July 18, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

Mid-Columbia Medical Center would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

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

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

Mid-Columbia Medical Center expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

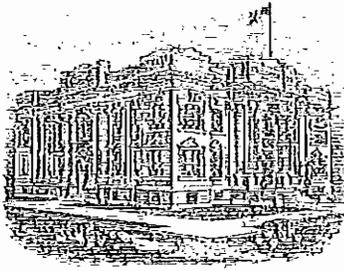
- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective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

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

Sincerely,

A handwritten signature in black ink, appearing to be 'W. Hamilton', is written over a horizontal line. The signature is cursive and somewhat stylized.

Dr. William C. Hamilton
Vice President, Medical Affairs



WASCO COUNTY

Board of County Commissioners

511 Washington Street, Suite 302
The Dalles, Oregon 97058-2237
(541) 506-2520
Fax: (541) 506-2521

Rod Runyon, *Chair of the Board*
Sherry Holliday, *County Commissioner*
Scott Hege, *County Commissioner*

July 18, 2012

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

RE: Letter of support for PacificSource Community Solutions CCO for the Columbia Gorge Region

Dear Ms. Hurst:

Wasco County has been actively involved in the decision making process to develop a Coordinated Care Organization (CCO) for the Columbia Gorge Region. A comprehensive set of criterion was developed and applied to the entities that had expressed interest in partnering with the Gorge communities. Through this process PacificSource Community Solution was selected as the entity to move forward to develop a technical application for a regional CCO. PacificSource has demonstrated a real engagement with the stakeholders in the region and has been willing to work toward mutually agreeable decisions on how to improve health in the Columbia Gorge Region, which would include Wasco, Sherman and Hood River Counties.

We believe PacificSource Community Solutions will be an active community partner that will focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580. We feel their experience as a health services contractor for commercial, Medicaid, and Medicare products make them well suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Wasco County expects that as the development of a local community health care system moves forward through the PacificSource CCO, it will bring significant value and improvement to the overall population health of the Columbia Gorge Region. It is our hope that the proposed application will produce result in the following outcomes:

- Improvement in health outcomes leading to improved population health.
- Improvement in health outcomes for those members experiencing health disparities.
- Accountability for the provision of integrated care.

Deschutes Rim Health Clinic

July 2, 2012

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

541.395.2911
Fax 541.395.2912
e-mail: info@deschutesrimhc.com
web: deschutesrimhc.com
1605 George Jackson Road
Maupin, Oregon 97037

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

White River Health District dba Deschutes Rim Health Clinic would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

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

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

White River Health District dba Deschutes Rim Health Clinic expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.



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

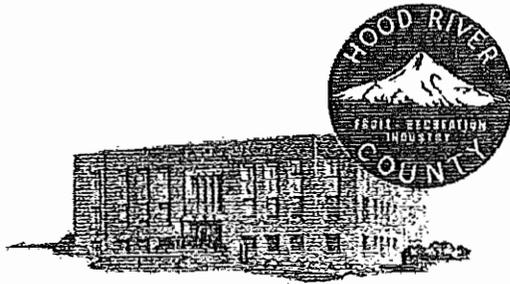
- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective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

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

Sincerely,

A handwritten signature in black ink, consisting of several overlapping loops and a long horizontal tail stroke extending to the right.

Sharon D. DeHart, PA-C
Clinic Manager
White River Health District dba Deschutes Rim Health Clinic
Maupin, Oregon



Commission on Children & Families

309 State Street, Hood River, Or 97031
541-386-2500 fax 541-386-2532

"To Promote the Well-Being of All Children and Families in Hood River County"

June 13, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

The Hood River County Commission on Children and families is very supportive of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River, Sherman, and Wasco Counties.

County representatives selected PacificSource Community Solutions to develop a CCO because of their strong community presence, commitment to improving health care outcomes and history providing health benefits. PacificSource Community Solutions is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with state statutes.

PacificSource has provided coverage for this area and we are looking forward to development of the Coordinated Care system with their partnership integrating physical health, addictions and mental health services, and oral health care with a focus on prevention. We will be working with partners to help make this partnership successful to achieve the following results:

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

Thank you for your consideration,

A handwritten signature in black ink, appearing to read "Allyson Pate".

Allyson Pate, Chair
Hood River County Commission on Children and Families



Columbia Gorge
EDUCATION SERVICE DISTRICT

400 East Scenic Drive, Suite 207
The Dalles, Oregon 97058
(541) 298-5155
Fax (541) 296-2965
www.cgesd.k12.or.us

July 12, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care
Organization for the Columbia Gorge Region

Dear Ms. Hurst:

The Board of Directors of the Columbia Gorge Education Service District would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

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

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

Columbia Gorge Education Service District expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region. In particular, we anticipate improvement in the health of the student populations which we serve, thereby enhancing the learning opportunities for these children.

Tammy L. Hurst
July 12, 2012
Page 2

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

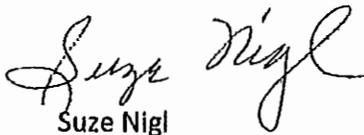
- ✓ Improvement in health outcomes leading to improved population health.
- ✓ Improvement in health outcomes for those members experiencing health disparities.
- ✓ Accountability for the provision of integrated care.
- ✓ Improvement in quality of care within the community.
- ✓ Delivery of cost-effective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

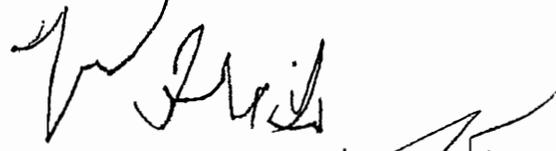
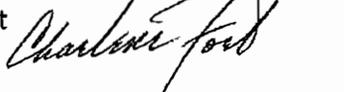
Please accept this letter as formal recognition of the value of this application in helping the Columbia Gorge Region improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,


Paul Zastrow
Director

Wayne Hyskey
Director


Suze Nigl
Director


Charlene Fort
Director 


Scott McKay
Director


Susan Gabay
Director


Clinton Johnson
Director

June 27, 2012

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

RE: Letter of support for PacificSource Community Solutions
Coordinated Care Organization for the Columbia Gorge Region

Dear Ms Hurst:

I have resided in Oregon in the Columbia River Gorge for 36 years and have been employed throughout that time in the field of social services. I am writing today to voice my enthusiastic support of the Coordinated Care Organization application being submitted by PacificSource for the Columbia Gorge counties of Sherman, Hood River, and Wasco.

Through my extensive range of work experience, from the elderly to the unemployed to the underserved, low income, and disadvantaged, access to quality medical and dental care have been pervasive issues of critical importance to me. I have followed the Governor's plan for development of CCOs throughout the state to address more than quality and cost of medical care but to improve overall health outcomes in the state.

I have also read with great interest about the innovative ways in which PacificSource is working in other communities. I also know that the Medicaid population in our counties are currently being currently served by PacificSource as their managed care organization. I believe that granting PacificSource to be the CCO

for our counties will be the best choice in bringing the intent and realization of the Governor's plan to fruition here in the Gorge.

I understand PacificSource has been responding effectively to our community leaders and has been at the "pre-application table" from the onset of this open public community process. During a fast paced rigorous time frame, PacificSource has consistently won our favor and confidence for breaking this new ground. I have always been proud of the "leading edge" in which Oregon has often positioned itself. I look forward to an optimistic future with PacificSource leading us in this historic transition in health care.

Sincerely,

A handwritten signature in cursive script that reads "Susan Gabay". The signature is fluid and elegant, with a long horizontal flourish extending to the right.

Susan Gabay
P.O. Box 151
Mosier, Or 97040

July 9, 2012

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

RE: Letter of Support for PacificSource Community Health Plans Coordinated Care Organization
for the Columbia Gorge

Dear Ms. Hurst:

Central Oregon Independent Practice Association (COIPA) would like to indicate our support of PacificSource Community Health Plans' application for a Coordinated Care Organization in the Columbia Gorge, which would include Hood River, Sherman and Wasco Counties.

COIPA is comprised of nearly 650 physicians and practitioners within a 40,000 square mile, twelve county geographic region consisting of Crook, Deschutes, Grant, Harney, Jefferson, Lake, Wheeler, Wasco, Sherman, Hood River, Skamania and Klickitat counties in Oregon. COIPA offers a collaborative, unique experience for providers to become involved in medical decisions that affect their practices, while improving efficiency and reducing healthcare delivery system costs for its members and their patients.

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

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

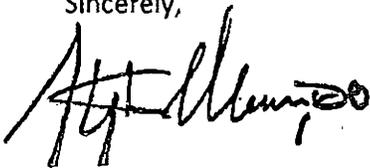
COIPA expects that the development of a local community healthcare system through PacificSource Community Health Plans Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge.

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

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

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

Sincerely,



Dr. Stephen Mann
COIPA Board President

June 13, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

The Hood River County Early Intervention Program would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region.

Hood River County Early Intervention Program expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region and in particular to the young children and families served by our program.

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

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

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

Sincerely,



Cassie Whitmire, M.A. SPED
Hood River County EI/ECSE program Coordinator



Extension Service Hood River County

Oregon State University, 2990 Experiment Station Drive, Hood River, Oregon 97031
T 541-386-3343 | F 541-386-3684 | <http://extension.oregonstate.edu/hoodriver/>

July 2, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

I manage the Family and Community Health Program in Hood River and Wasco Counties as a faculty member with Oregon State University Extension Service. As such, I am intimately aware of the challenges that our community faces. Many of our neighbors struggle with health disparities and the challenges of living and working in a rural environment with limited job opportunities and limited opportunities for low and no cost preventive health care options. I would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

We acknowledge and support PacificSource Community Solutions as they continue to build a strong community presence and commitment to improving health care outcomes in the Gorge. With their varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention. We are particularly pleased with the prevention focus and hope to work with PacificSource to develop this initiative further.

Oregon State University Extension expects that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

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



Extension Service Hood River County

Oregon State University, 2990 Experiment Station Drive, Hood River, Oregon 97031
T 541-386-3343 | F 541-386-3684 | <http://extension.oregonstate.edu/hoodriver/>

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

Sincerely,

A handwritten signature in black ink that reads "Lauren M. Fein". The signature is written in a cursive style.

Lauren Fein, MPH, Faculty
Family and Community Health Program
OSU Extension Service
Hood River and Wasco Counties



June 21, 2012

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



RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:



On behalf of The Next Door, Inc., I am writing this letter in support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.



Nuestra Comunidad Sana

Established in 1971, The Next Door is a private, nonprofit organization whose mission is to open doors to new possibilities by strengthening children and families and improving communities. We provide services under 25 different programs for over 3,500 people a year in seven counties throughout the Columbia Gorge. The programs of The Next Door fall under the following categories: 1) New Parent Services prevents child abuse and neglect and mentors parents whose children are at risk for foster care placement, 2) Big Brothers Big Sisters helps kids who are not in trouble stay that way by providing adult role models, 3) Youth & Family Services teaches youth to make informed, healthy choices about drugs and alcohol, 4) Nuestra Comunidad Sana assists disadvantaged Latino community members to access health care and develop healthy lifestyles, food security, and community leadership skills, and 5) Treatment Services guides adjudicated and behaviorally challenged youth.



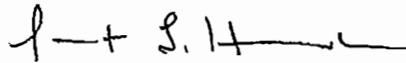
As a social service, child welfare and health promotion provider, The Next Door's work is integrally connected to physical, behavioral and oral health care in that we holistically assist our program participants. Nuestra Comunidad Sana was one of the first in the country to develop a Community Health Worker (known as a "Health Promoter") program specifically to address the health needs of our Latino community members.



As they have varied experience as a health services contractor for commercial products, Medicaid products, and Medicare products, PacificSource is suited to be the primary agent of Health System Transformation. We look forward to PacificSource Community Solution as our Coordinated Care Organization, as they embrace behavioral healthcare and meet the diverse and urgent needs of our children and families in true partnership with community based providers.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Janet L. Hamada". The signature is fluid and cursive, with a long horizontal stroke at the end.

Janet L. Hamada, MSW
Executive Director



**HOOD RIVER COUNTY HEALTH
DEPARTMENT**

1109 JUNE STREET
HOOD RIVER, OREGON 97031-2093
PHONE (541) 386-1115 • FAX (541) 386-9181

ENVIRONMENTAL HEALTH (541) 387-6885
WIC (541) 387-6882

July 13, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

Hood River County Health Department would like to indicate our support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

The health department has been an active participant in the development of the selection criteria, interviews, public meetings and the decision to select PacificSource Community Solutions as the best Coordinated Care Organization partner for the Columbia Gorge Region. PacificSource Community Solutions has demonstrated a strong community presence and commitment to improving health care outcomes in the communities it serves. One of the main criteria for selection was working with an entity that was seeking the region's input into the CCO transformation, not an entity that was coming in with an already set package and agenda. PacificSource Community Solutions has been very committed and active in providing support, expertise and ideas as we have moved forward in this process. There has been a real commitment to focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

Hood River County Health Department has experience with PacificSource and their varied contracts for health services, including their commercial products, Medicaid products, and Medicare products, PacificSource is ideally suited to be the primary agent of Health System Transformation through integration and coordination of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Hood River County Health Department expects to continue to be an active member in the development of a local community health care system working with PacificSource Community Solutions Coordinated Care Organization. This collaboration will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Ellen Larsen". The signature is fluid and cursive, written in a professional style.

Ellen Larsen, RN
Director



La Clínica del Cariño Family Health Care Center, Inc.

849 Pacific Avenue
Hood River, OR 97031
(541) 386-6380
Fax: (541) 308-8396

425 E 7th Street
The Dalles, OR 97058
(541) 296-4610
Fax: (541) 296-5813

www.LaClinicaDelCarino.org

July 27, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

La Clínica del Cariño Family Health Center, Inc would like to indicate its full support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County and Wasco County.

PacificSource Community Solutions has a strong community presence and commitment to improving health care outcomes in the communities it serves. PacificSource Community Solutions is an active community partner and has made local investments in innovative programs to improve population health outcomes and reduce medical costs that align with the objectives of HB 3650 and SB 1580.

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

As a Federally Qualified Health Center, La Clínica del Cariño provides medical, dental, chronic care and prevention services to four counties in the Columbia Gorge, including Hood River and Wasco Counties. We also maintain State PCPCH Tier 3 recognition and integrate CHWs in our health care teams and community education. We look forward to collaborating with PacificSource Community Solutions Coordinated Care Organization to improve the value, service and overall population health of the Columbia Gorge Region.

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

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

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

Sincerely,

Elise Venusti
Chief Executive Officer

BONNIE A. NEW, MD MPH
4045 Stonegate Dr.
Hood River, OR 97031
bnew1@live.com

June 25, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

I am writing as a resident of Hood River County, and as part of the broad health community, to indicate my support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region, to include Hood River, Sherman, and Wasco Counties.

I am a retired physician, now working as a community volunteer in social services and as an advocate for universal health care. I have had the opportunity to learn about our CCO process through community fora, and to participate in discussions about the form and function of the Community Advisory Council.

The potential benefits of the CCO approach about which I am most enthusiastic are the focus on preventive care and the concept of coordinating services around a primary care home. I hope these improvements will be accompanied by decreased costs, improved efficiency and satisfaction, and a decrease in healthcare disparities as planned. While I personally am skeptical that the necessary cost control can be achieved while private insurers are still in the larger picture raking off profits, it is clear that improvements in local service integration and delivery are important pieces of cost-effectiveness.

I support PacificSource's proposed CCO application because it aligned with the following needs of our community:

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

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

Sincerely,



Tina Castañares, MD

*3301 Kollas Road, Hood River OR 97031
541. 354-1666 Facsimile: (801) 846-1997
tina.castanares@gorge.net*

June 12, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

My letter is not on behalf of any one organization in which I serve, but I hope it will be useful if only because of the number of relevant involvements I've had over almost 30 years with public health and healthcare in the Columbia River Gorge.

My background includes: 25 years of practice as a founder, medical director, and family physician at La Clínica del Cariño Family Health Care Center (the region's sole federally-qualified community and migrant health center); 12 years as the Health Officer for Hood River County Health Department; experience as an Emergency Department physician at Skyline Hospital and Hood River Memorial Hospital and also as a practitioner at Wasco/Sherman County Health Department clinics for several years; service for four years as the Community Connections physician for OHSU/Doernbecher/CDRC's outreach clinic to special needs children and families in Hood River; and most recently medical directorship of Hospice of The Gorge and palliative care consultant throughout the Gorge (since 2003). I've delivered babies, cared for patients in hospitals, nursing homes and private residences, attended and assisted deaths, conducted outreach clinics, directed longtime Community Health Worker programs, and done community needs and assets planning in a number of settings. I was for over a decade on the board of Providence Hood River Memorial Hospital, and now am a Board member of La Clínica del Cariño and the advisory board of Nuestra Comunidad Sana, a social services Community Health Worker program of The Next Door, Inc. in Hood River and The Dalles.

Besides my work locally, I am the Chair of the Board of the Northwest Health Foundation, on which I have served for 8 years, and remain involved in various task forces and work groups for the state of Oregon and other regional groups. For example, I served on the Governor's Public Health Advisory Board and was also an original member of the Oregon Health Services Commission, which helped to realize the Oregon Health Plan in the early 1990s. I co-chaired the state's OHP expansion steering committee, and was also on the national Board of Trustees of the American Hospital Association for 4 years. I've visited over 60 community and migrant health centers nationwide as a consultant to HRSA, and was the principal grant writer for funds that eventually brought about the establishment of La Clínica's health center in The Dalles (as well as for the funds that are now permitting the construction of a new facility there).

I mention these involvements because I want to emphasize my abiding interest and familiarity with health reform, delivery systems, public health, care to the underserved, Medicaid policy, and the proper allocation of public dollars.

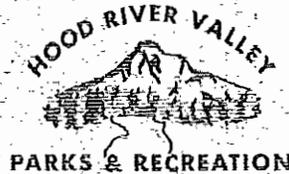
I've followed closely the deliberations of colleagues as we seek to create a wise, promising application for a CCO in our region. My support is for PacificSource Community Solution's application to include Hood River County, Sherman County, and Wasco County.

I find PacificSource Community Solutions to demonstrate a strong community presence and a convincing commitment to improving the public's health. It's a savvy entity with strong Medicaid benefit administration experience, good leadership and with a proper focus on meaningful health outcomes and bending the cost curve. These obviously are in alignment with SB 1580 and HB 3650. "Mental and dental" (behavioral and oral) health care and prevention, while newer to PacificSource, will be readily achievable in The Gorge due to the strengths of PacificSource's background, the partnerships and collaborations already well in place, and the commitment of all essential community stakeholders.

Sincerely,

A handwritten signature in black ink, appearing to read "Tina Castañares MD". The signature is fluid and cursive, with a large, stylized initial "T" and "C".

Tina Castañares, MD



June 13, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization
Columbia Gorge Region

Dear Ms. Hurst:

Hood River Valley Parks and Recreation District would like to submit this letter of support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge Region which would include Hood River County, Sherman County, and Wasco County.

The Park District is very interested in improvements to the physical health of our community and region. We have had great partnerships with area agencies, especially the Hood River County Health Department. Our past partnership with the County enabled the community to complete a Health Impact Assessment for a 30+ acre parcel to be used for recreation. The HIA looked at how to address chronic disease and obesity issues that were self-identified by the community.

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

Hood River Valley Parks and Recreation believes that the development of a local community health care system through the PacificSource Community Solutions Coordinated Care Organization will bring significant value and improvement to the overall population health of the Columbia Gorge Region and will tie in with the areas improvement to quality of life.

Please accept this letter as formal recognition of the support of our Park District for this application in helping the Columbia Gorge Region improve population health, increase member satisfaction, and reduce the cost of health care. If I can be of any further support for the CCO please don't hesitate to contact me at your convenience.

Sincerely,

Lori Stirn, District Director

HOOD RIVER COUNTY BOARD OF COMMISSIONERS



DAVID MERIWETHER, COUNTY ADMINISTRATOR

601 State Street • Hood River, OR 97031 • (541) 386-3970 • FAX (541) 386-9392

BOARD OF COMMISSIONERS

RON RIVERS - CHAIR
KAREN JOPLIN - DISTRICT NO. 1
MAUI MEYER - DISTRICT NO. 2
BOB BENTON - DISTRICT NO. 3
LES PERKINS - DISTRICT NO. 4

July 16, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge Region

Dear Ms. Hurst:

Hood River County has been actively involved in the decision making process to develop a Coordinated Care Organization for the Columbia Gorge Region. An exhaustive selection criterion was developed and applied to those entities that had expressed interest in partnering with the Gorge communities. From this process PacificSource Community Solution was selected as the entity to move forward toward a technical application with. PacificSource has demonstrated a real engagement with the stakeholders in the region and has been willing to work toward mutually agreeable decisions on how to improve health in the Columbia Gorge Region, which would include Hood River, Sherman, and Wasco Counties.

PacificSource Community Solutions is an active community partner with a focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580.

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

Hood River County expects that as the development of a local community health care system moves forward through the PacificSource Community Solutions Coordinated Care Organization, it will bring significant value and improvement to the overall population health of the Columbia Gorge Region.

A Small County with a big mission:
Providing Quality of Life for all.



Hood River Memorial Hospital
PO Box 149
Hood River, OR 97031

July 23, 2012

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

RE: Letter of support for PacificSource Community Solutions Coordinated Care Organization for the Columbia Gorge

Dear Ms. Hurst:

I am writing to express my support of PacificSource Community Solution's application for a Coordinated Care Organization in the Columbia Gorge. This CCO includes Hood River, Sherman and Wasco counties. As part of the Columbia Gorge Health Council, we support the decision to partner with PacificSource as its CCO.

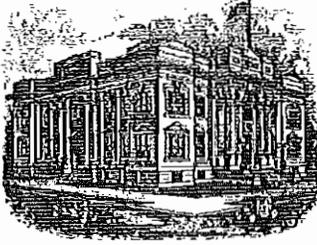
Hood River County is a place of enormous contrasts. The scenic beauty, the outdoor adventure sports and the boutiques and bistros of downtown obscure the realities of poverty, prejudice and unmet basic needs for so many in our community. Our own Community Assets and Needs Assessment revealed many people here live with daily concerns of chronic disease, access to care, preventive care and meeting the basic needs of everyday living.

PacificSource is ideally suited to work with the community to address these realities and improve integration and coordination of physical health, addictions and mental health services, and oral health care with a focus on prevention. Additionally, we share the goals of goal of improving health care outcomes and experiences while reducing costs.

A handwritten signature in black ink, appearing to read "Ed Freysinger".

Sincerely,

Ed Freysinger
Chief Executive
Providence Columbia Gorge Service Area



WASCO COUNTY

DEPARTMENT OF YOUTH SERVICES

Juvenile Justice Division
202 East Fifth Street
The Dalles, Oregon 97058-2220
(541) 506-2660
Fax: (541) 506-2661

Molly Rogers
Director

July 18, 2012

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

RE: Letter of support for PacificSource Community Solutions CCO for the Columbia Gorge Region

Dear Ms. Hurst:

Wasco County has been actively involved in the decision making process to develop a Coordinated Care Organization (CCO) for the Columbia Gorge Region. A comprehensive set of criterion was developed and applied to the entities that had expressed interest in partnering with the Gorge communities. Through this process PacificSource Community Solution was selected as the entity to move forward to develop a technical application for a regional CCO. PacificSource has demonstrated a real engagement with the stakeholders in the region and has been willing to work toward mutually agreeable decisions on how to improve health in the Columbia Gorge Region.

We believe PacificSource Community Solutions will be an active community partner that will focus on provision of care that improves health outcomes and reduces medical costs that align with the objectives of HB 3650 and SB 1580. We feel their experience as a health services contractor for commercial, Medicaid, and Medicare products make them well suited to be the primary agent of Health System Transformation through integration of health care for the community including physical health, addictions and mental health services, and oral health care with a focus on prevention.

Wasco County expects that as the development of a local community health care system moves forward through the PacificSource CCO, it will bring significant value and improvement to the overall population health of the Columbia Gorge Region. It is our hope that the proposed application will produce result in the following outcomes:

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

Please accept this letter as formal recognition of our support for PacificSource Community Solution's application in helping the Columbia Gorge Region improve population health, increase member satisfaction, and reduce the cost of health care.

Sincerely,

Molly Rogers

Molly Rogers, Director
Wasco County Youth Services

KENNETH P. PROVENCHER

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

EXPERIENCE

PACIFICSOURCE HEALTH PLANS, Eugene, OR 1995- Present

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

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

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

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

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

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

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

OREGON STATE UNIVERSITY, Corvallis, OR 1997 – 2005

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

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

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

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

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

UNITED HEALTH SERVICES, Binghamton, NY
1986 - 1988

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

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

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

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

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

KAISER PERMANENTE, Portland, OR
Summer, 1984

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

CENTRE COMMUNITY HOSPITAL, State College, PA
1980 - 1983

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

EDUCATIONAL TESTING SERVICE, Princeton, NJ
1979 - 1980

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

EDUCATION

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

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

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

CURRENT PROFESSIONAL, CIVIC AND VOLUNTEER ACTIVITIES

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

PAST PROFESSIONAL, CIVIC AND VOLUNTEER ACTIVITIES

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

Sujata S. Sanghvi, FSA, MAAA

110 International Way, Springfield, Oregon 97477

ssanghvi@pacificsource.com

Oregon Health Care Experience

September 2002 to Present

PacificSource Health Plans, Springfield, OR

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

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

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

January 2008 to Present

United Way of Lane County, Springfield, OR

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

Other Professional Experience

August 1999 to June 2002

Harvard Pilgrim Health Care, Wellesley, MA

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

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

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

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

June 1997 to July 1999

Prudential Health Care, Roseland, NJ

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

April 1995 – May 1997

Coopers & Lybrand, LLP, Boston, MA

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

October 1988 to March 1995

Blue Cross and Blue Shield of Massachusetts, Boston, MA

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

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

Education and Professional Designations

Harvard College

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

Actuarial Designations

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

Other

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

Erick Doolen

4036 NW Live Oak Place • Corvallis OR 97330

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

PROFESSIONAL EXPERIENCE:

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

Senior Vice President of Operations and Chief Information Officer. May 2010 – present

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

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

Chief Information Officer. September, 2005 – April 2010

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

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

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

Imaging and Printing Group Americas IT Director. January 2005 – August 2005

Responsible for information systems for the customer facing processes in the Americas. Worked with partner organizations to provide end-to-end IT solutions for customer support, supply chain, marketing, and sales. Managed over 90 people with \$30+M budget.

Worldwide Inkjet Supplies Factory Systems Director. February 2000 – December 2004

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

Manufacturing Engineering Manager: April 1996–December 1997

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

Manufacturing Systems Engineer May 1994 - March 1996

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

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

Technical Manager October 1991 - May 1994

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

Systems Engineer October 1987 - September 1991

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

PROFESSIONAL VOLUNTEERING:

Oregon Health Leadership Council's Administrative Simplification Executive Committee Co-Chair (January 2010 - present)

In support of the overall OHLC goal of controlling healthcare costs, the Administrative Simplification efforts have developed standards for electronic transactions, implemented a single sign-on solution for providers accessing health plan portals, and identified provider portal best practices. Efforts currently underway include establishing a central repository for credentialing and development of additional standards for electronic transactions.

Oregon Administrative Simplification Work Group member (March 2010 – June 2010)

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

Health Information Technology Oversight (HITOC) Council member (April 2012 – present)

Appointed by the Oregon Governor to serve on HITOC. This council is responsible for setting goals and developing a strategic health information technology plan and monitoring progress in achieving those goals. HITOC is currently coordinating Oregon's public and private statewide efforts in electronic health records adoption and the eventual development of a statewide system for electronic health information exchange.

HITOC Finance Workgroup member (February 2011 – present)

Workgroup is responsible for developing and recommending finance models to HITOC for funding of the Health Information Exchange services within Oregon.

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

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

JEFFREY W. EMRICK LCSW, CADC III

61712 Rigel Way • Bend, OR 97702
Phone: 541-728-4396/Email: jeffe282004@yahoo.com

PROFESSIONAL QUALIFICATIONS

ADMINISTRATOR/MANAGER/DIRECT CARE BEHAVIORAL HEALTHCARE PROFESSIONAL

Proficient in the researching, planning, designing, implementation, leading, managing behavioral healthcare programs that target a wide range of populations.

Professional Strengths

- Leading, administration, management and supervision of behavioral healthcare programs and staff.
- Design, development and implementation of behavioral healthcare programs.
- Program monitoring, quality assurance and development of programmatic and contract policies/procedures/protocols and practice guidelines.
- Community collaboration, networking and partnering to expand and create new programs in existing and emerging markets.
- Public speaking and program presentation.
- Familiar with most evidenced based best practices which target individuals with behavioral healthcare needs.

Academic Credentials

- MSW social administration track, The Ohio State University, Advanced Standing Alternate Plan, June 2001, GPA: 3.55/4.0
- BSW, Indiana University 2000, GPA: 3.6/4.0

Certifications and Licensures

- Certified Alcohol and Drug Counselor Level III (CADC III) with the Addiction Counselor Certification Board (ACCBO) of Oregon. Certificate #02-R-05
- Licensed Clinical Social Worker (LCSW) with the Oregon Board of Clinical Social Workers. License #L3798
- NPI #1093915324

PROFESSIONAL EXPERIENCE

Program Support Manager Public Health and Behavioral Health

Deschutes County Health Services
2577 NE Courtney Drive, Bend, Oregon 97701

February 2010 to Present

Summary of position: coordinate the planning, evaluation, service integration and program support activities of the Department. Department has 2 Divisions; Public Health and Behavioral Health Department. Focuses on linking the public health, behavioral health and support services functions of the Department. As a member of the Department management team, assumes leadership role in strategic and operational planning, quality improvement, audits, critical incidents and complaints as well as effective operation of medical records and reception staff. Coordinate organizational efforts in support of health care reform and the integration of behavioral health and primary care. Foster citizen involvement activities and community relations efforts. Hire staff and conduct annual performance reviews.

- Involved in the Central Oregon Regional reform efforts starting in Feb-Mar of 2009. Served on numerous committees in varying capacities and roles:
 - Work closely with the Department Director, developing the Central Oregon Health Board and assist the Director with other regional reform activities e.g. Central Oregon Health Council, Regional Health Improvement Plan.
- Currently have 6 direct reports and 14.80 FTEs which spans Public Health and Behavioral Health.
- Developed a business plan and manage OHP Chemical Dependency Fund 280. Revenues are projected to be \$100,000,000 in CY 2011-12
- Co-Leading Department wide Strategic Planning process.
- Worked with community Advisory Boards and staff to create a new quality management program and work plan. Developed quality management program and quality improvement work plan for Department. The quality program and plan merged Public Health and Behavioral Health Divisions into one program and plan. Implementation date is set for July 1, 2011. Hired 2 FTEs in Behavioral Health Department; Utilization Management Specialist and Medical Records Auditor.
- Participated in the Public Health Department's National Accreditation Beta Test Site review by the National Public Health Accreditation Board.
- Created a Project Management Plan to track progress and close out corrective actions in response to the State Public Health Triennial Review. Project Management Plan was presented to the County Administrator and Commissioners. At the request of the State Department of Public Health, an abstract was submitted in partnership with Clackamas County to the Oregon Public Health Association for review and consideration for presentation at their 67th Annual Conference at Oregon State University. Project Management Plan was presented at the conference.
- Lead Department community efforts to integrate primary care and behavioral health care. Provide technical assistance and consultation to Mosaic Medical in partnership with ABHA which resulted in Mosaic hiring a BHS care provider and currently in process of being certified by Deschutes county CMHP.
- Administrative oversight of all CMHP provider certification processes in partnership with AMH which includes compliance with ISSRs and quality of care.
- Administrative oversight of 12 MHO Deschutes County subcontracted providers in partnership with ABHA a subcontractor of the MHO which includes utilization management, quality of care and compliance. Developed panel provider cost report using paid claims data.
- Proficient in a data mining using Phtech Clinical Integration Manager (CIM).
- Created Peer Support Specialist Job Descriptions; Behavioral Health Division has hired two .5 FTEs Peer Support Specialist.
- Serve as the Department Compliance Officer.
- Developed a comprehensive corrective action and project management plan for Behavioral Health Division and leading all efforts to execute all correctives in response to external audit.

Utilization Manager

Accountable Behavioral Health Alliance (ABHA) a Mental Health Organization (MHO)
310 NW 5th Street Corvallis, Oregon 97330

May 2005 – February 2010

- Managed all aspects of adult mental health acute care utilization for Benton, Lincoln, Crook, Jefferson and Deschutes counties for Oregon Health Plan (OHP) member's capitated to ABHA. Duties included acute utilization management for indigent care for each region. I began to manage Deschutes County Chemical Dependency Organization under a subcontract between ABHA and Deschutes county May of 2006. Acute care UM reduced to Crook, Jefferson and Deschutes to accommodate new duties.

JEFFREY W. EMRICK LCSW, CADC III

Phone 541-728-4396/Email: jeffe282004@yahoo.com

- Monitored compliance with the ABHA Utilization Management Plan.

- Revised Notice of Action and Appeals process in Utilization Management Plan to meet MHO Agreement compliance standards for acute care.
- Conducted acute care utilization reviews evaluating medical necessity and coordinated issuing of Notice of Action process with ABHA Physician Advisor and Medical Director.
- Collected, analyzed and prepared utilization reports using Microsoft Excel. Created the Central Oregon regional comprehensive acute care utilization management report.
- Assisted crisis teams: obtain needed and appropriate acute care resources.
- Chaired Central Oregon Regional Acute Care Council which functioned as an executive oversight and planning group. Consisted of three Central Oregon counties, key stakeholders and providers.
- Development of the Brief Therapy Program at Deschutes County Mental Health serving indigent population. Provided direct services, clinical consultation and supervision to staff.
- Served as training consultant and resource in representing ABHA to all county partners.

Manager Deschutes County Chemical Dependency Organization (CDO)

DCHS 2577 NE Courtney Drive Bend, Oregon 97701

October 2006 – December 2010

- Managed and coordinated Division of Medical Assistance Program (DMAP) contract which establishes CDO as the outpatient chemical dependency treatment benefit plan for Oregon Health Plan (OHP or Medicaid). The plan had 13,000 enrollees with annual CY revenues of approximately \$450K to \$700K.
- Provided leadership and collaborated with stakeholders at state, regional and local level to identify, develop and implement improvements in service delivery and contract administration at all levels.
- Managed and coordinated all daily CDO plan operations including utilization management.
- Administrative and managerial oversight of the DMAP contract and 5 subcontracted providers with a focus on regulatory compliance and Medicaid fraud, waste and abuse. Developed provider contracts.
- Conducted contract compliance and claims validation audit of subcontractors for CY 2009. Claims validation audit activities resulted in a combined payment recovery of approximately \$23,000.
- Developed contract operational policies and procedures.
- Developed/prepared/analyzed all contract reports including and financial reports.
- Attended state contract meetings.
- Acted as plan liaison for state, provider and member relation activities including state quality assurance site visits.
- Coordinated and managed all CDO quality improvement and assurance activities including External Quality Review conducted by Accumentra.

Executive Director

The Turning Point of Paulding County Inc.

451 McDonald Pike Suite A

Paulding, OH 45879

May 2004 - April 2005

- Executive and administrative oversight of agency operations budget of \$400K and 9 staff.
- Improved agency relationships with the county court system and probation department, local school district and community mental provider which increased referrals and collections of agency fees, and expanded programs.
- Worked with a 7 member Board of Directors, revised board by laws, recruited new board members, and began process of strategic planning to expand programs and services.
- Executive representative to Tri County Alcohol Drug Mental Health Services Board.

JEFFREY W. EMRICK LCSW, CADC III

Phone 541-728-4396/Email: jeffe282004@yahoo.com

- Supervised agency administrative staff, including the Clinical Supervisor and Prevention Coordinator.

- Reorganized staffing patterns and clinical management of cases which increased the number of billed units of service by 40% over a 4 month period in comparison to prior FY benchmark.
- Developed policies and procedures which standardized administrative and clinical operations, revised agency client registration forms and clinical forms.
- Created and implemented aggressive agency fee collection plan as a part of a fiscal management strategy to prevent, reduce and level off client aging accounts (180 days past due) written off as bad debt. Plan recouped \$8k in 6 months on existing accounts and prevented new accounts from reaching 180 day threshold.
- Developed and implemented a comprehensive corrective action plan for the outpatient program and Drivers Intervention Program (DIP) in response to the Ohio Department of Alcohol Drug Addiction Services (ODADAS) recertification audit that took place in October of 2004. Both programs were re-certified by ODADAS as a result of the corrective action plan.
- Developed and implemented an organizational Quality Assurance/Risk Management Plan consistent with ODADAS regulatory requirements.

Vocational Program Manager
 New Choices Community School
 Dayton, OH 45410

December 2003 - May 2004

- Developed a Career Based Intervention Program for 150 inner city at risk youth ages 13 thru 16 (junior high school).
- Began to create a program manual of operation in accordance with the Ohio Department of Education (ODE) rules and regulations.
- Supervised staff coordinated and managed daily program operations.
- Researched and started to create a classroom curriculum according to the ODE standards.
- Assisted with the compilation of data required by ODE for program to receive state education dollars.
- Marketed program to the greater Dayton area business community in an effort to create partnerships with local business.

Adult Services Program Manager
 Tillamook Family Counseling Center (Outpatient MH/AoD)
 Tillamook, OR 97141

August 2001 - September 2003

- Administrative, managerial and clinical oversight of all Adult Services:
 - Crisis Services
 - Crisis Respite Services
 - Community Support Services/Day Treatment Services
 - Gambling Services
 - Domestic Violence Intervention Services
 - Outpatient Substance Abuse Treatment Services
 - Outpatient Mental Health Treatment Services
 - Outpatient Psychiatric Services
 - Pre-Commitment Services
 - Supported Employment Program Services
- Participated in the development and administration of \$3 million dollar organizational budget.
- Managed and supervised 16 professional staff which include: independently licensed clinical staff Psychologist, QMHPs/QMHAs/CADCs and contracted clinical staff.
- Interviewed and hired professional staff.

JEFFREY W. EMRICK LCSW, CADC III

Phone 541-728-4396/Email: jeffe282004@yahoo.com

- Coordinated daily program(s) and staff activities for all adult services and directly supervised and conducted performance appraisals on all adult service staff.
- Provided training and consultation to a wide array of community organizations and professionals regarding Tillamook Family Counseling Center services and how to utilize existing services and developed new services to meet community needs.
- Collaborated with key community and state level stakeholders to enhance and pilot new and ongoing service delivery initiatives and responded to different state Request For Proposals (RFPs):
 - Developed/implemented a pilot project using Essential Life Style Planning as a case management model of service delivery for clients with a severe and persistent mental illness (SPMI) in partnership with the Oregon Office of Mental Health and Addiction Services. The demonstration project evolved into the state developing a RFP's to bring other counties on board with this client driven model of service delivery.
- Review organizational administrative and management reports to evaluate, plan, develop and implement new and ongoing organizational programs and services:
 - Brought on a Supported Employment Program using an Evidenced Based Best Practice Tool Kit, which targeted clients that had a Severe and Persistent Mental Illness (SPMI).
 - Began process of assessing and restructuring adult outpatient substance abuse treatment services to adopt best practice technology using Trans Theoretical Model of change and motivational enhancement interventions specific to stage of consumer change which is key in the delivery of services to co-occurring disorders client base population.
 - Worked to move all adult outpatient MH and A&D services in the direction of a co-occurring disorder service delivery model.
- Develop organizational and programmatic policies and procedures:
 - Developed policies, procedures and clinical protocols for crisis services and crisis respite services. Provided direct crisis services and conducted pre-commitment investigations.
 - Participated with other senior management staff in the development and implementation of the Quality Assurance Plan, Utilization Management Plan consistent with state and other regulatory requirements and organizational needs.
- Participated with senior management staff in monitoring and managing all aspects of Quality Assurance Plan, and Utilization Management Plan of all clinical services practice modes funded primarily by public Medicaid managed care capitation.
- Member of Mid-Valley Behavioral Healthcare Network (MVBCN) co-occurring disorder work group. The group received direct consultation from Dr. Ken Minkoff. The group was tasked with developing a fully integrated system of care designed to deliver services to individuals whom had a co-occurring disorder in the MVBCN managed care network. Also attended Alcohol Tobacco and other Drug Abuse Directors meetings for MVBCN. Served on MVBCN Quality Improvement Committee.

Graduate Internship

Bureau of Mental Health Services: Office of Correctional Healthcare
Ohio Department of Rehabilitation & Corrections (ODRC), Central Office
Columbus, OH

June 2000 - June 2001

- Participated in the evaluation of training needs and development of lesson plans for clinical supervision, mental health liaison and programming to manage juvenile offenders in an adult institution.
- Collated Suicide Back to Basic Survey data used to evaluate ODRC suicide prevention policy.
- Assisted with researching, developing and writing proposal for pilot dual diagnosis treatment program for incarcerated offenders.

JEFFREY W. EMRICK LCSW, CADC III

Phone 541-728-4396/Email: jeffe282004@yahoo.com

- Attended and participated in senior management meetings.

Undergraduate Internship

Preble Counseling Center
Eaton, OH

1999 - 2000

- Researched, developed and wrote The Family Stability Crisis Intervention Program for Family and Children First Council of Preble County including program's description, practice guidelines, clinical protocols and forms.
- Presented training to community service providers regarding purpose and utilization of program.

Clinical Supervisor (1997-2000) & Counselor (1992-1997)

Preble County Recovery Center
Eaton, OH

1992 – 2000

- Managed day-to-day operations of programs and activities and supervised clinical staff. Created supervision protocols, agency forms and policies and procedures for organization and programs; conducted quality assurance audits; and, monitored programs to ensure compliance with regulatory standards.
- Evaluated staff's performance, and monitored productivity.
- Collaborated with and formed partnerships with other community service providers, which expanded agency programming, filled service gaps, and contributed to increased productivity and billable service units.
- Developed and introduced in-service training programs for clinical staff, as well as community service providers and educators.
- Created, implemented, managed and supervised an intensive adolescent outpatient treatment program. Wrote operations manual which included program description, clinical philosophy, procedures and protocols compliant with state regulations, program outcomes, and determined schedules and activities. The clinical intervention model was a Solution Focused, Structural-Strategic Family Therapy approach. The target population was involved in the juvenile justice system, and most had co-occurring disorders. I developed an in-house psychiatric component for clients that required psychotropic medication intervention to ensure seamless service delivery.
 - Carried a case load of 35 individuals and families.
 - **Program received national Harold E. Hughes "1998 Exceptional Service Award" as The Exceptional Rural Program, for innovation, service to a specialized group, potential for program replication, community support and networking, and management excellence.**
- Created 3-hour workshop on treating adolescents in the juvenile justice system and their families; presented the training at the annual Ohio Drug & Alcohol Study Institute (ODASI) conference.
- Designed and presented management trainings for private company that created and maintained a drug-free workplace.
- Revised and standardized agency's clinical documentation to meet quality assurance standards.
- Served as Crisis Management Consultant, providing 24-hour assistance to Preble County Crisis Hotline staff for chemical dependency clients; also provided 24-hour direct crisis management to Preble County Recovery Center's clients.

Contract Service Provider

1992 – 1997

- Program Development - Inpatient Psychiatric & Detoxification Unit, Reid Hospital.
- Educational Consultants - Drug & Alcohol Services.

JEFFREY W. EMRICK LCSW, CADC III

Phone 541-728-4396/Email: jeffe282004@yahoo.com

- Trainer, Presenter - Ohio Drug & Alcohol Studies Institute Conference.
- Contract Consultant Tillamook Family Counseling Center (September 2003)

Intensive Outpatient Treatment Coordinator

Darke County Recovery Services
Greenville, OH

1990- 1992

- Conducted research; designed, implemented and managed adult intensive outpatient treatment program.
- Provided direct clinical services, managed caseload and coordinated program activities.

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

CURRICULUM VITAE

EDUCATION

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

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

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

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

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

EMPLOYMENT HISTORY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LEADERSHIP & GOVERNANCE POSITIONS

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

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

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

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

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

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

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

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

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

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

CERTIFICATIONS & LICENSURE

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

Oregon License, MD 15926, 1989-present

GRANT SUPPORT

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

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

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

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

PUBLICATIONS

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

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

"Development and Implementation of an Information Management and Information Technology Strategy for Improving Healthcare Services: A Case Study", Journal of Health Information Management, vol.15, no. 3, fall 2001

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

MEMBERSHIPS

Oregon Academy of Family Physicians

American Academy of Family Physicians

Diplomat, American Board of Family Physicians

American Medical Association

Lane County Medical Society

PROFESSIONAL AFFILIATIONS

Provider communication and education on Community Health Plan strategy

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

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

Presentations and lectures available upon request

Peter F. Davidson, CPA

110 International Way,
Springfield, OR 97477

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

Management Experience

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

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

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

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

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

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

Certified Public Accounting **1987 – 1994**
Managed tax, consulting and compensation services for a base of clients in the field of healthcare and technology.

DAN A. STEVENS
2965 NE CONNERS AVENUE
BEND, OR 97701

EDUCATION

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

PROFESSIONAL & COMMUNITY AFFILIATIONS

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

PROFESSIONAL EXPERIENCE

PacificSource Health Plans 2010 – present

Senior Vice President, Government Programs

Chief Operating Officer, PacificSource Community Health Plans

PacificSource Health Plans is a not-for-profit community health plan, serving nearly 300,000 members in the Pacific Northwest through Commercial, Medicare, and Medicaid programs.

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

Regional Director, Provider Network Development, Providence Health Plans 2007 – 2010

Administrator, Providence Preferred Oregon

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

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

Assistant Administrator, Providence Portland Medical Center, Portland, OR 2002 – 2006

480 bed tertiary medical center with an active medical staff of >1,500 physicians; \$400 million in revenue

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

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

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

Administrator, Medicine Service Lines, Providence Portland Service Area

1997-2002

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

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

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

Senior Research Analyst, Providence Portland Service Area

1995-1997

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

PacificSource Community Solutions Fiscal Agent Functions

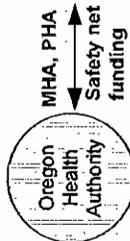
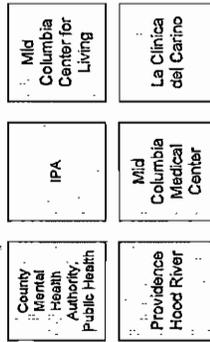
1. CCO fiscal agent, based upon binding Joint Management Contract with GHC
2. Maintains appropriate State and Federal licensure for CCO and other involved lines of business
3. Risk bearing entity. Meets financial solvency, compliance, and other state requirements (Quality, appeals, reporting)
4. Provides traditional MCO services such as provider network maintenance, credentialing, eligibility, claims, customer service; some CM, UM
5. Contracts with downstream entities as needed for critical CCO services
6. Integrated analytics to support managing a global budget, and CCO performance monitoring

Columbia Gorge Regional CCO

Columbia Gorge Health Council (CGHC)

- Community Advisory Council (50% Consumers)
- Operations Council
- Clinical Advisory Council

Providers have dual role in both governance and provision of care



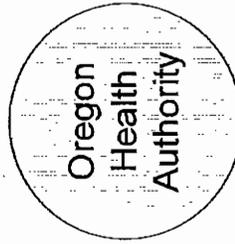
CGHC Governance Functions

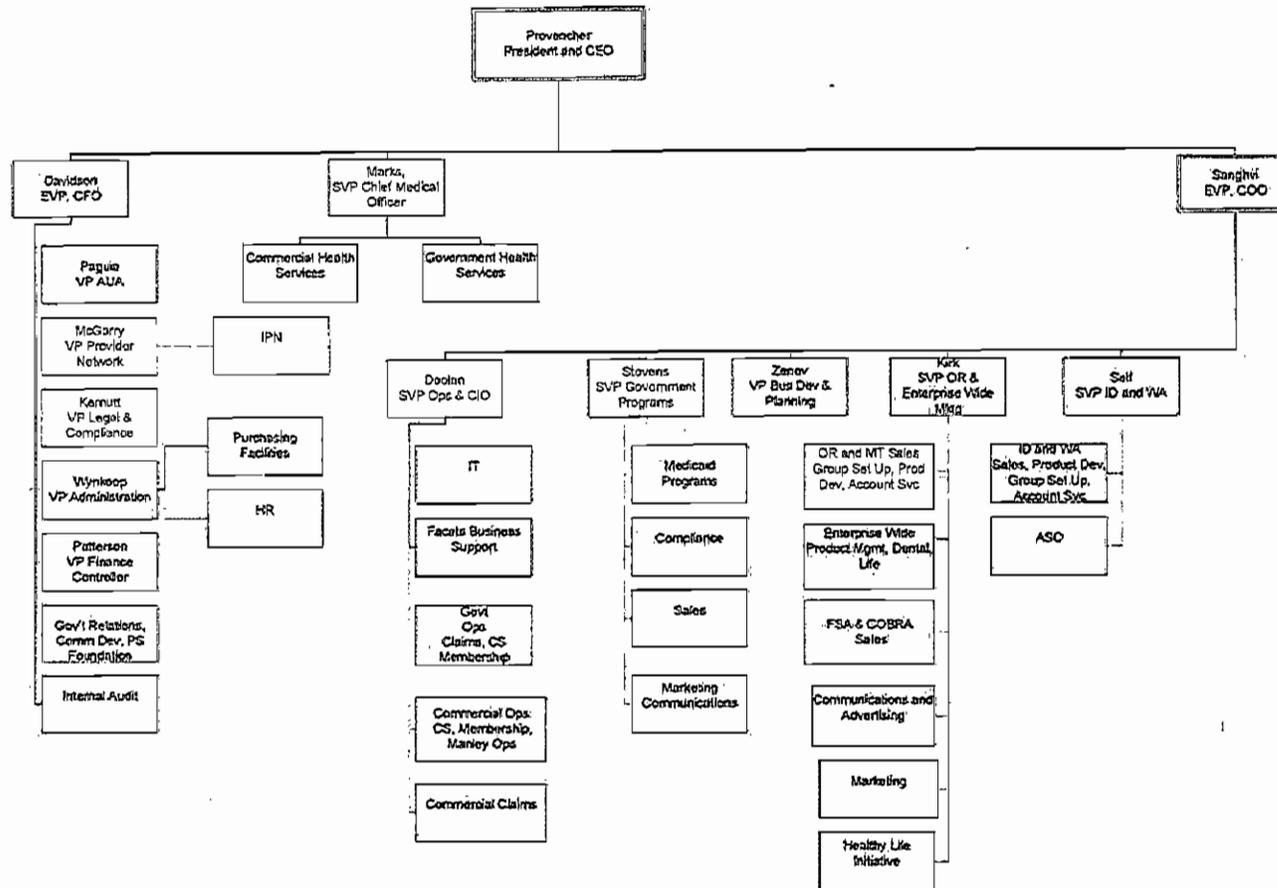
1. Governance entity specific to CCO
 - Policy
 - Strategy
 - Quality
2. Through Joint Management Contract, delegates PacificSource to serve as fiscal agent for CCO
3. Creates principles and framework for management of global budget
4. Creates and oversees shared risk framework, and decisions around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

Binding Joint Management Contract for CCO Governance

CCO contract on behalf of CGHC
(dependent on Joint Management Contract with CGHC)

PacificSource Community Solutions





#29

Service Area Description	Zip Codes	Maximum Number of Members- Capacity Level
Hood River County	97014, 97031, 97041, 97044	3800
Wasco County	97001, 97021, 97037, 97040, 97057, 97058, 97063	5000

APPENDIX A – CCO Criteria Questionnaire

A.1: Background Information about the Applicant:

- a. PacificSource Community Solutions, Inc. (PSCS) is a corporation domiciled in the State of Oregon.
- b. PSCS affiliates include the following: La Clinica del Cariño, Hood River County, Wasco County, Central Oregon IPA, Providence Hood River Memorial Hospital, Mid-Columbia Medical Center, and Mid-Columbia Center for Living.
- c. PSCS's effective date for serving Medicaid populations in this service area would be November 1, 2012.
- d. PSCS is not invoking alternative dispute resolution with respect to any provider at the time of this application.
- e. At this time, PSCS is not requesting any changes or negotiating any terms or conditions in the Core Contract. PSCS recognizes that there are parts of the contract mandated by CMS Medicaid or CMS Medicare. As the PSCS CCO evolves, PSCS respectfully requests the opportunity to revisit the contract if necessary to negotiate any terms or conditions outside of those portions mandated by Medicaid or Medicare. It is during this evolution that the applicability of requirements such as the ISSRs within the new delivery system can be evaluated and discussed in terms of future applicability.
- f. The proposed service area by zip code is as follows: Hood River County including 97014, 97031, 97041, 97044 and Wasco County including 97001, 97021, 97037, 97040, 97057, 97058, and 97063.
- g. The primary address for the proposed service area for Pacific Source Community Solutions is 110 International Way, Springfield, OR 97477.
- h. The service area will include Hood River County and Wasco County. PSCS has contracts with counties and county health departments to provide covered services for Medicaid members. As the CCO develops, PSCS will expand its agreements to coordinate the public health care services as listed in ORS 414.153 with county health departments, other publicly supported programs, and other providers contracted with PSCS.
- i. PSCS has a contract with OHA as a Fully Capitated Health Plan and a Mental Health Organization. PSCS had these contracts as of October 1, 2011.
- j. PSCS is the identical organization with the current MCO contract and has not undergone any legal status change since October 1, 2011.
- k. PSCS currently includes a Fully Capitated Health Plan (FCHP) and a Mental Health Organization (MHO).
- l. PSCS is completing this application for the counties listed above. The counties listed above are currently included in the FCHP service area that is the subject of the current PSCS FCHP contract with OHA. The counties listed on this application are not inclusive of all the counties covered by PSCS currently.
- m. PSCS is a wholly owned subsidiary of PacificSource Community Health Plans, Inc. (PCHP). PCHP is a wholly owned subsidiary of PacificSource Health Plans.

PacificSource Health Plans either directly or through its subsidiaries participates in Healthy Kids Connect and Public Employees Benefit Board. (Please see attached Attachment A.1.m ~ PacificSource Health Plans Corporate Chart).

- n. As indicated on the organization chart referenced above, PacificSource Community Health Plans (PCHP), the parent company of PSCS, currently has a contract with Medicare as a Medicare Advantage Plan. The service area for PCHP MA-PD Plan is Crook County, Deschutes County, Grant County, Hood River County, Jefferson County, Klamath County*, Lake County*, Sherman County, Wasco County, Wheeler County, and Lane County. Klamath County and Lake County are partial counties as indicated by “*”.
- o. PSCS does not hold a current certificate of insurance from the State of Oregon Department of Consumer and Business Services, Insurance Division.
- p. (1) PSCS has developed an OHP capitation methodology as a part of its contracting model with providers for its OHP population. This OHP capitation methodology removes volume-of-service based on financial incentives and replaces it with incentives that reward primary care (including those that have successfully applied for Patient Centered Primary Care Home (PCPCH) recognition status) and for providing “the right care at the right time at the right place”. This new agreement further provides shared savings incentives for PCPCH primary care providers as well as specialty providers for appropriate management of care as measured by performance in a specialty care fund, a hospital fund, and a prescription drug fund. In addition, PSCS has existing payment methodologies including these Medical Home Incentive Payments which align quality and best practice metrics that are designed to promote high quality care alongside cost efficient care. PSCS has partnered with Central Oregon IPA (COIPA) who is investing in new informational capabilities which are anticipated to lead to community-wide evidence-based best practices, and will provide a data-based solution to variations in care in the PSCS Medicaid population.
(2) PSCS will demonstrate the experience and capacity for the coordination of the delivery of physical health care, mental health and chemical dependency services, oral health care and covered DHS Medicaid-funded LTC services. This experience will be further demonstrated in other sections in the application.
(3) PSCS will engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the entity’s enrollees and in the entity’s community. This engagement is described in various sections following this section.
- q. Please see resumes for the following individuals listed below attached.
 - Chief Executive Officer ~ Kenneth Provencher
 - Chief Financial Officer ~ Peter Davidson
 - Chief Medical Officer ~ Tom Ewing, MD
 - Chief Administrative Officer ~ Sujata Sanghvi
 - Chief Information Officer ~ Erick Doolen
 - Chief Operations Officer ~ Dan Stevens

- Behavioral Health Manager ~ Jeff Emrick
- r. Please see organizational chart which shows the relationships of the various departments. (Please see attached, PacificSource Community Solutions Organizational Chart).
 - s. PSCS is deferring submission of the following documents until PSCS's readiness review under Section 6.7.1.
 - Joint Management Agreement.
 - Columbia Gorge Health Council Bylaws
 - Articles of Incorporation

A.II. Community Engagement in Development of Application

The PSCS CCO application effort is supported by the community it represents as is evidenced by the governance description provided in Section 1. Multiple community partners have been involved with PSCS staff to develop the CCO application, participate on the CCO workgroups and have authored sections of the application. The development of better integrated care systems and care infrastructure has been active in the Columbia Gorge Region for several years. It is this history that has been the foundation for the community engagement in the development of the upcoming CCO model for the Columbia Gorge Region.

History: Residents of the Columbia Gorge Region Counties frequently move across county lines for work and education, as well as when they seek health care. In addition, the two counties of Hood River and Wasco have a long history of collaboration to achieve economies of scale, share resources, and serve their citizens better. As an example, commissioners from multiple counties worked together in the 1980's and founded the Mid-Columbia Center for Living (MCCFL) to serve as a single, joint community mental health agency for the region. The agency's service area aligns well with that of this CCO, and the creation of MCCFL has brought county commissions from the counties together through the Tri-County Mental Health Board. As a result, a strong, closed-loop process using needs assessments to identify new innovative programs with special programs or grant funds was created as well as a robust connection with schools, employers, state agencies, and drug courts. As a further example of county collaboration, the County Health Departments of Wasco County, Sherman County, and Gilliam County have merged to form the North Central Public Health District (NCPHD) to serve their respective counties.

In the health care and social services, a similar spirit of cooperation has long been evident. In 1986, a group of health providers and community volunteers established La Clinica del Cariño with the opening of its first clinic in Hood River. La Clinica was founded as a Migrant Health Center and soon after, earned status as a designated Community Health Center. It continues to be the only FQHC in the Columbia Gorge Region, serving Hood River, Wasco and Sherman Counties, as well as Skamania and Klickitat Counties in Washington. In 1996, La Clinica del Cariño opened its second clinic in The Dalles. In May 2012, ground-breaking occurred for a new 20,000 square foot clinic in The Dalles which will incorporate medical, dental, and pharmacy services with education and community meeting space.

Collaborative projects undertaken recently by the health care providers in Hood River County include the Gorge Dental Access Coalition and the Better Health for Busytown project. Gorge Dental Access Coalition began providing vouchers for dental care for low-income, uninsured children ages 0-18 in 2009. It is supported by local dentists who provide discounted care, Providence Hood River Memorial Hospital Foundation which provides funding, and the Hood River County Health Department which administers the program. Administration of the program includes budgeting, enrollment, referral, and coordination with oral health providers.

The Better Health for Busytown project began in late 2010 with a series of informal meetings and discussions among a diverse group of people engaged in health care, public health and social services in Hood River County. This project has had many successes to date including:

1. Launching the Gorge Access Program with the goal of providing universal access to a primary care medical home and other medical care for low-income, uninsured people, regardless of documentation status.
2. Securing grant monies for consolidated data analysis on use of the health care systems in the county and region.
3. Fostering relationships across social service agencies and behavioral health, physical health, and public health providers that had not previously existed.

In 2009, Gorge Health Connect formed as the Columbia Region's Health Information Exchange. Board members of Gorge Health Connect include cross county representation from the following organizations: Columbia Gorge Community College, Mid-Columbia Medical Center, Providence Hood River Memorial Hospital, Mid-Columbia Center for Living, Columbia River Women's Clinic, La Clinica del Cariño, Mid-Columbia Surgical Specialists, Hood River County Health Department and North Central Public Health District. Since its creation, Gorge Health Connect has successfully implemented the Direct Project in the Columbia Gorge Region in 2011. The Direct Project in most basic terms is a system for secure e-mail for physicians, their colleagues, and their patients.

Additional incentives for advancing current care coordination activities across the region occurred with the passage of CCO legislation and with the increased focus on the Triple Aim. As a result, a stakeholder group in Wasco County began meeting in late 2011 to begin a dialogue across key constituents. Meetings were soon expanded to include Hood River County participants in early 2012 creating a comprehensive cross-county, cross-discipline, and cross-organizational effort. As the group evolved, participation focused on identified representation from health care institutions and county government in April 2012, and the group engaged with representatives from the Oregon Health Authority and the Governor's Office. The group agreed on short and long-term group goals and created descriptions of desired outcomes from the CCO development process. The group created a comprehensive process for the selection of a CCO partner based on both qualitative and quantitative components. PSCS was selected as the CCO partner the community wanted to move forward with in the development of the CCO model.

Section 1 – Governance and Organizational Relationships

A.1.1. Governance

A.1.1.a. Description of CCO Governance

The Columbia Gorge Region CCO will be formed by a joint management agreement (JMA) between the Columbia Gorge Health Council (CGHC), a non-profit corporation, and PacificSource Community Solutions (PSCS), an affiliate company of PacificSource Health Plans. The CGHC will perform governance duties related to the CCO and carry out the operational activities described in the JMA.

The governing board of the CGHC will be comprised of one representative from each of the following institutions:

- Providence Hood River Memorial Hospital
- Mid-Columbia Medical Center
- La Clinica del Cariño Family Health Center (FQHC)
- Central Oregon IPA
- Hood River County
- Wasco County
- Pacific Source Community Solutions
- Chair, Community Advisory Council
- Primary Care Provider
- Behavioral Health Provider
- Community Members At Large (2)

In addition, the CGHC governing structure will include two advisory committees that will play an integral role in key governance functions of the CGHC, the Community Advisory Council (CAC) and the Clinical Advisory Panel (CAP).

Prior to the CCO readiness review, CGHC and PSCS will enter into a JMA to define governance and operational roles according to the following basic guidelines.

Governance functions to be fulfilled by CGHC include:

- Oversight of CCO strategic plan and annual work plan.
- Establishment CCO performance metrics.
- Creation of principles and framework for annual CCO budget, principles around global budget management, and shared savings/community reinvestment principles.
- Endorsement and enforcement of the CCO quality plan and community standards of care for CCO enrollees.
- Accountability for Community Needs Assessment, Community Health Improvement Plan and plans to address significant health disparities in the region including the needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services.

- Accountability for healthcare transformation including care model innovation, and strategies to enable meaningful integration of behavioral health, physical health, oral health, and the long term care delivery system.
- Evaluation of PSCS in its role of CCO legal entity.
- Assistance in resolving disputes among CCO contractors, providers, and other stakeholder organizations.
- Assurance of transparency and accountability to the local community and to CCO members.

The CCO legal entity functions to be fulfilled by PacificSource Community Solutions include:

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

The governance structure of the CCO is designed to fulfill the governance requirements of ORS 414.625. Please see Attachment A.1.1.a Governance Structure Visio.

The first seven institutions with representation on the governing board are the main health care providers in the service area and are at financial risk for servicing the OHP population. Collectively, they comprise 7 of the 12 board positions and are therefore the majority. The governing board will also include two community representatives and a representative from the CAC to ensure accountability to the voice of patients, local social service organizations and county government. Representation from physical health and mental health providers will bring a robust clinical perspective to governing board decisions. Finally, the two advisory committees will play a key role in CGHC governance and operational functions.

A.1.1.b - A.1.1.d Community Advisory Council

PacificSource is working with CGHC and its community partners to develop a Community Advisory Council (CAC) to meet the requirements of ORS 414.625. The CAC will be broad based, and its chair will be a voting member of the CGHC governing body. There will be consistent communication between the governing body and the CAC to ensure transparency and accountability for the governing body's consideration of recommendations from the CAC. Through the CAC, the specific needs of members with severe and persistent mental illness and members receiving DHS Medicaid-funded LTC services will be communicated to the CGHC Governing body. The CAC will be seated and chartered prior to the CCO effective date. A planning workgroup has been developing

strategies related to the selection process, development of bylaws and other activities as related to the CAC. The mission of the CAC as developed by the planning workgroup is as follows: the CAC will meaningfully participate in the direction and accountability of the CCO by representing the strengths, needs, preferences, and experiences of the recipients of the CCO services and their communities. It is anticipated that the CAC will seek to improve the quality and efficiency of the healthcare delivery for and the health outcomes of community members with a focus on coordination, integration, prevention, accountability, elimination of disparities and lower costs.

A.1.2. Clinical Advisory Panel

PSCS in collaboration with the CGHC will establish a Columbia Gorge Region Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. The CAP will serve as a subcommittee of the Columbia Gorge Health Council (CGHC). The role of the CAP will be to provide clinical oversight and leadership to community clinical integration efforts, clinical quality improvements projects and improvements in the local health care system and delivery. The CAP will also serve a role in coordination of the quality committees of the health plan, CGHC and the Central Oregon IPA (COIPA) as they relate to the CCO.

The CAP will consist of 15 – 17 voting members plus 2 co-chairs with voting privileges. Co-chairs will be nominated by the CAP for appointment to the positions of the Practicing Primary Care Providers and Practicing Behavioral Health Providers serving on the Governance Board. There will be a liaison between the CAP and the Community Advisory Council (CAC). Nine required representative seats will serve on the CAP. Those seats will include representatives from:

- Primary Care (3) – across the continuum from pediatrics to internal medicine, include at least one representative of RHC.
- Behavioral Health (Co-chair along with physical health provider representative).
- Federally Qualified Health Clinic.
- Public Health.
- Provider at large.
- Oral Health.
- PSCS Medical Representative.

Six to eight additional voting members will represent as many of the following disciplines as possible: Pharmacy, Long Term Care, Specialty Care, Alternative Medicine/Therapies, Hospice/End of Life, Visiting Health, Hospitalist, OT/PT/Speech, Emergency Medicine, OB/GYN, Alcohol/Drug Dependency, and Oral Health.

Members of the CAP will be involved in quality improvement planning for their representative organizations whenever possible. The co-chairs will be clinical members of the Governing Board. The CAP will include members that are representative of all county regions, as well as representative of providers of underserved populations. Duties may be split between subgroups that would gain input from others outside of the CAP.

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

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

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

A.1.4.a. Mid-Columbia Center for Living (MCCFL) is a C-190 Inter-Governmental entity created by three Local Mental Health Authorities (LMHA): Hood River County, Sherman County, and Wasco County. Under an Inter-Governmental agreement (IGA), MCCFL is the Community Mental Health Program (CMHP) and the Community Development Disabilities Program (CDDP) for the Columbia Gorge Region. In addition, MCCFL is the provider of Alcohol and Drug Treatment and Problem Gambling Treatment. MCCFL's governing board is comprised of one County Commissioner from each of the respective counties within the Columbia Gorge Region.

There is agreement in principle between MCCFL and PSCS to enter into a contract. This contract will include an agreed upon scope, delegated functions, MCCFL global payment and reporting framework. This contract will be based on a matrix of assigned responsibilities between the Columbia Gorge Health Council (CGHC), PSCS as CCO fiscal agent, the MCCFL, and the participating counties. The contract will ensure that the LMHAs/CMHP role and responsibilities are fully integrated within the Columbia Gorge Region. A contract also provides further assurances that critical CMHP safety services and supports are not compromised. For a complete listing of services provided by MCCFL, please see the Provider Table in Appendix B.

It is further agreed that the CMHP will participate actively in:

- CCO transformation process,
- Outcome based investments,
- Movement to improve care coordination and integration,
- Development of person centered primary care homes, and
- Shared services that require both OHP and State General Fund resources to be successful.

A.1.4.b. Through PSCS's contract with MCCFL, PSCS continues to support MCCFL's long history of working with area hospital systems, public safety and social services organizations and residential programs to serve and support people transitioning for extended or long-term psychiatric care programs.

MCCFL has dedicated central intake mental health professionals who are able to complete same day mental health assessments. It is an expectation that referrals from acute hospitalization take immediate priority and are expected per MCCFL policy to be seen within five business days upon discharge from higher levels of care.

MCCFL has a dedicated Adult Services Coordinator who works with AMHI transitions across the placement continuum. Care coordination can begin at any level of care from outpatient to acute, as a member moves up or down in acuity. The Adult Services Coordinator's primary role is to utilize the resources of AMHI to transition clients to less restrictive care, specifically focusing on moving Oregon State Hospital residents.

A.1.4.c. PSCS will support the current CMHP model of coordination with Community Emergency Service Agencies described below. This model demonstrates strong community collaboration and partnerships which form a tightly coordinated mental health crisis response system. PSCS will also work with and through Local Public Safety Coordinating Councils and their participating members.

Acting as the CMHP, MCCFL is the convener and chairs two different Crisis Committees in the Columbia Gorge Region (Wasco & Sherman/Hood River). These meetings are attended by law enforcement agencies, probation departments, regional Jail NORCOR, first responder emergency medical services staff, hospital emergency department staff, Aging and People with Disabilities staff, Developmental Disabilities staff, Eastern Oregon Disabilities Brokerage Program staff and Providence Gorge Counseling staff. Specific individuals who are of mutual concern to all entities are discussed and a coordinated crisis plan is developed. The meetings are also used to identify systemic challenges and to formulate collaborative systemic solutions which meet the needs of individuals experiencing a mental health crisis.

MCCFL also convenes and chairs a bi-monthly adult multidisciplinary team. This meeting is attended by local Developmental Disabilities, Eastern Oregon Disabilities Brokerage Program and Aging and Persons with Disabilities. MCCFL participates in the Wasco and Hood River Child multidisciplinary team meetings. These meetings are attended by the Columbia Gorge Region's local District Attorney's Office, child welfare, juvenile probation, city and county law enforcement, public health, victim's advocacy, Children Advocacy Center and CASA volunteers. Recent calls received by Child Protective Services for potential abuse are discussed and addressed.

MCCFL has developed a mass casualty response plan in collaboration with local stakeholders. MCCFL attends quarterly regional Disaster Management agreements/meetings to plan for potential mass casualty incidents. These meetings are attended by representatives from emergency management services, Providence and Mid-Columbia Medical Center hospital, law enforcement, public health, and pastoral services.

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

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

- DHS Children's Adults and Families field offices in the service area;
- Oregon Youth Authority (OYA) and Juvenile Departments in the service area;
- Department of Corrections and local community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the service area, including for individuals with mental illness and substance abuse disorders;
- School districts, education service districts that may be involved with students having special needs, and higher education in the service area;
- Developmental disabilities programs;
- Tribes, tribal organizations, urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives;
- Housing;
- Community-based family and peer support organization;
- A& D Prevention;
- Public Health;
- Helping Hands Against Violence ~ Hood River County;
- Helping Hands;
- Other social and support services important to communities served.

Connections to these resources for members of the CCO will happen directly through connections of Community Health Workers, public health staff, and other consumer advocates in the health care system and their community services networks. Connections will also happen through the networks and relationships of the Columbia Gorge Health Council and community partners and affiliates to existing advisory boards. These connections will include: County Local Alcohol and Drug Planning Committees, Mental Health Advisory Boards, Commissions on Children and Families, Local Public Safety Coordinating Councils, Emergency Food and Shelter Advisory Boards, Family Court Advisory Boards, and local hospital boards to name a few.

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

Community Health Assessment: The Columbia Gorge Community Advisory Council (CAC) Workgroup has gathered existing community assessments from Providence Hood River Memorial Hospital, Mid-Columbia Medical Center, Hood River County Health Department, North Central Public Health, Barrett Park Health Impact Assessment, Head Start, and Mid-Columbia Center for Living. In order to better assess needs, inventory assets, and plan for services for the region, the CAC has adopted a plan to combine these assessment and planning efforts including a broad

spectrum of community partners. These partners include but are not limited to those agencies listed above.

The tool that will be used for the next and subsequent assessments is the Mobilizing for Action through Planning and Partnerships (MAPP) Tool from National Association of County and City Health Officials. Qualitative information will also be gathered through questionnaires, interviews and focus groups from throughout the Columbia Gorge Region. Special effort will be made to gather input from diverse racial and ethnic groups represented in the demographic data, from populace receiving services through the long term care system and those with severe and persistent mental illness (SPMI). By collaborating in this manner, it is expected that there will be increased efficiencies in the work to conduct the assessment, but more importantly, involved organizations will share the workload, involve their stakeholders, learn together and work together to act accordingly for the advancement of the community.

In order to meet the goals of a comprehensive assessment the following structure will be used:

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

PSCS will work with the OHA, including the Office of Equity and Inclusion, to further identify the components of the community health assessment. PSCS will further partner with the local public health authority, hospital system, local mental health authority and other community partners. PSCS will be discussing the status of the current community health assessment with local APD offices to identify areas of partnership and collaboration. The assessment will be analyzed in accordance with OHA's race, ethnicity and language data policy once the policy is made available. Standardized data systems, as available will be used to collect data used in the assessment process. PSCS and its community partners will collaborate with other regions and the state to ensure standard definitions and design.

The work is expected to occur in two main phases:

- Planning and quick wins.
- Enhancing and automating data collection through Gorge Health Connect, available state supported data sources and other HIE efforts underway across the state, possibly merging with other regions into a state-wide database.

In addition, a smaller group of data stakeholders from Hood River County and Wasco County will begin working to analyze data from the counties to create a comprehensive health report including

information on disparities, race and ethnicities, and language needs in the two counties. This regional community health assessment will be an ongoing process led by the Hood River County and North Central Public Health Departments (NCPHD) yearly. There will be quarterly strategic planning sessions with county partners to analyze the data and assess strategies. Data from public sector and private sector are also being used to identify the needs in the community. An effort will be made to continue to add partners to the table who may not be involved in the initial process such as the LTC system.

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

Stakeholders in support of this regional effort include: Providence Hood River Hospital, Mid-Columbia Medical Center, La Clinica del Carifio Family Health Care Center (FQHC), United Way, North Central Public Health Department, Hood River County Health Department, Hood River County, Sherman and Wasco County Commissions on Children and Families, Wasco County Community Health Improvement Plan, Region 9 Education Service District, Mid-Columbia Center for Living, Central Oregon Independent Practice Association, Hood River County School District, South Wasco School District, The Dalles School District 12, City of Cascade Locks, Hood River Park and Recreation, Next Door Inc, Hood River County Juvenile and Community Corrections Department, Gorge Ecumenical Ministries, DHS, City of Dufur, City of Hood River, City of The Dalles, AAA, Columbia Gorge Children's Advocacy Center, Arlington Medical Center, Deschutes Rim Health Clinic, OSU Extension Service, North Wasco Parks and Recreation District, Mid-Columbia Economic Development District, North Central Education Service District, Mid-Columbia Children's Council, Columbia Gorge Community College, Waste Management, and Mid-Columbia Producers, Opportunity Connections.

Health Improvement Plan: A data/assessment workgroup composed of community partners will meet to review the data gathered. Discussions incorporating experience and professional knowledge will be used to determine priorities for the Columbia Gorge Region CCO service area. The priority areas chosen for the Health Improvement Plan will be vetted through the CGHC.

A recent assessment for Hood River County, done jointly by Providence Hood River Memorial Hospital and the Hood River County Health Department identified the following priority areas:

Areas as identified by recipients of care in Hood River County:

- Chronic disease support and management,
- Access to primary care,
- Preventive health care,
- Basic needs, and
- Community based behavioral health.

Areas as identified by providers of care in Hood River County:

- Basic needs,
- Community based behavioral health,
- Preventive care,
- Access to primary care, and
- Access to health insurance.

The findings from this work have led to strong community, public health, and health system support for the development of the Gorge Access Program. This program will provide a medical home and primary care provider for uninsured persons and their families that meet the income requirement up to 200% of FPL. Individuals will be screened for enrollment in the program. Screening will include eligibility for Oregon Health Plan, SNAP program and needs for housing and other social services. For a co-pay, individuals will be able to see a primary care provider and have lab work and simple imaging performed. Referrals to specialists will be made as appropriate for the same co-pay. This program is slated to begin in mid-June and after a soft start, it is hoped that it will expand to other areas in the Columbia Gorge Region. PSCS in collaboration with its public health partners will be tabulating and reporting out on the services provided by this program.

Staff of NCPHD completed a community assessment and Community Health Improvement plan using the CHANGE tool created by the CDC. Staff convened a Community Health Action and Response Team (CHART) to identify priorities. Priorities identified include:

1. Reduce tobacco use and exposure to environmental tobacco smoke.
2. Increase access to and consumption of fresh fruits and vegetables.
3. Coordinate effective communication of tailored, accurate and actionable health information to Wasco, Sherman and Gilliam County residents across their lifespan.
4. Enhance system to support “Workplace Wellness” (“Healthy Behaviors”) programs.

In addition, the following priorities were identified based on demographic data:

- Employ methods to decrease unintended pregnancy.
- Improve customer service to family planning clients.

Staff from the Columbia Gorge Region counties will work in collaboration to write a Health Improvement Plan. The created plan will be based on the engagement of multiple community partners and will be approved by CGHC. The plan will provide guidance for developing coordinated care plans in the Columbia Gorge Region while focusing on prevention and the Triple Aim that align with the care strategies being developed by PSCS.

Section 2 – Member Engagement and Activation

A.2.1. Member and Family Partnerships

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

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

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

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

PSCS will work with its partners to develop community terms of engagement that can be consistently applied across providers, services and settings. Member engagement will be fostered through shared decision-making within the Clinical Advisory Panel and the Community Advisory Committee. Tools will be developed along with population based clinical guidelines to improve the member's care and to help the member evaluate health care decisions. The following methods based on research and best practice will be supported through the program when possible:

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

A.2.1.b. PSCS and its subcontractors approach each interaction with a member as a chance to educate and empower. PSCS believes that members can be hindered and disadvantaged in managing their care due to a lack of knowledge and confidence and lack of empathy from their health care organization. PSCS places a focus on understanding and actively supports each member in overcoming barriers. PSCS ensures that each member is educated on the PSCS's quality initiatives and other community resources available to the member. The claim and authorization system can be used to measure member activation rates. The time is measured from the first day of enrollment to the first date of service on a claim, first call to Customer Service or the first referral to a provider. The claim and authorization system has the ability to flag members with certain chronic diseases or complex needs based on both claims and referral data. Any staff member who interacts with a member with a chronic disease or complex need can be notified of the condition so they can ensure the member's needs are addressed appropriately. This notification allows staff the opportunity to provide members with focused instruction or education.

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

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

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

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

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

PSCS will provide plain language narrative that informs members about what they should expect from the PSCS with regard to their rights and responsibilities (Please see Attachment A.2.1.b Plain Language Narrative). As conversations continue in the development of the CCO, this narrative will evolve. Once the Community Advisory Council (CAC) is activated, it is expected that the CAC will monitor and measure member activation. The process of how this is to be accomplished will be determined by the CAC with assistance from PSCS staff and community partners.

Section 3 – Transforming Models of Care

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

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

- **Technical assistance:** PSCS will provide assistance, resources, and supportive services for clinics who are working to become “PCPCH Recognized”, clinics that have already received PCPCH recognition, and clinics who are working toward advancement of tiers. In addition, PSCS will offer assistance, resources, and supportive services for clinics who are implementing other quality improvement efforts in collaboration with PSCS. This assistance can include practice facilitation and/or coaching, participation in learning collaboratives, online learning modules, and other resources that support practice transformation and result in better health, better care, lower costs and enhanced member experience. Presently, several clinics in the Columbia Gorge Region have already achieved PCPCH Recognition. These clinics are able to collaborate with one another as well as with practices who have not yet applied in order to provide technical assistance and share best practices for application, advancement of tier level, and practice transformation. Sharing of information among provider practices is currently being facilitated by the Central Oregon Independent Practice Association (COIPA) and other community partners including PSCS. The Oregon Health Authority has partnered with Northwest Health Foundation and HRSA to fund a PCPCH Center (Center) which intends to provide technical assistance and opportunities for providers to participate in a learning collaborative, learning networks, and online learning to support practice transformation. It is expected that the Center will provide assistance with strategic planning and financial coordination which will be available to providers in the Columbia Gorge Region.
- **Tools for coordination:** In coordination with traditional case management services, PSCS currently provides and will continue to provide, PSCS case managers who are well trained and are currently in “co-management” in collaboration with clinic-based case managers. PSCS intends to further build upon these relationships and collaboration further through the PSCS/PCPCH model. PSCS

encourages care coordination through the use of Transitional Care Coordinators (ENCCs), PSCS Nurse Case Managers, and an electronic referral system to keep primary care managers involved with and well-informed about the specialty care being received by their members. Data analysis is being used to identify and support opportunities to improve quality/coordination of care.

- **Management of provider concerns.** When concerns are brought to PSCS Provider Network Department, the appropriate team researches the issue and contacts the provider. Often, PSCS Provider Network will work with multiple departments within the company to research and address the provider's concern. During the research process, the provider is kept informed of the progress/status. In addition, PSCS's community partner, COIPA, currently provides support for provider members and serves as a liaison between providers and various community resources, including other providers, payers, the hospital system, etc.
- **Relevant Member data.** For PCPCH clinics, PSCS is currently providing a list of clinic assigned members and identifying which members have ACA qualified condition eligible claims. This activity will assist clinics in identifying members that may be ACA qualified. In addition to that information, PSCS is providing some additional information about the member such as Ingenix ERG prospective risk score, total medical and pharmacy costs of the member for the past 12 months, date of most recent ER visits, total ER visits in the last year, date of most recent inpatient stay and count of inpatient stays in the last year, and the DRG for the most recent stay to help assist clinics with managing PSCS members. PSCS is also a data supplier to Quality Corp and has worked with them to add PSCS's Medicaid lines of business to the reporting of quality improvement measures which include member specific results that providers can access through an online portal. Currently, an agreement between COIPA, TransUnion, and PSCS allows data reports to be developed using OHP member claims. These reports identify and track quality initiatives and give providers an additional resource for population management and tracking of utilization.
- **Training and tools necessary to communicate in a linguistically and culturally appropriate fashion with Members and their families.** Provider Directories noting the provider's languages will be provided to members to ensure members can choose a Primary Care Provider that is fluent in the member's primary language. Materials will be written in 6th grade reading level and will also be translated into Spanish, since the thresholds as identified by OHA are

met for this need in the Columbia Gorge Region. If members need other informational materials in another form, PSCS will provide them with the pertinent information. Examples include:

- Other Languages
- Large Print
- Computer Disk
- Audio Tape
- Oral Presentation
- Braille

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

PSCS will provide members with newsletters that include pertinent benefit information, resources, access to care, and other important information about their health. These newsletters will be available in Spanish and other formats noted above. PSCS has a website for members where they can access information 24 hours a day, 7 days a week. The website is Section 508 compliant and is written at a 6th grade reading level.

A.3.1.b. PSCS will continue to engage its members through a number of outreach initiatives. Contact will be made via print materials, member access via the PSCS website, direct outreach to the member either through clinical or non-clinical staff at PSCS, and through initiatives that are communicated in conjunction with PSCS provider partners. Through these vehicles, members will be made aware of program changes and transformation activities and their impact on provider capabilities. PSCS will assist its providers in developing methods of member engagement.

A.3.1.c. PSCS will partner with the provider community to implement a network of PCPCHs that will include a plan to encourage use of PCPCHs by members and a plan to encourage providers to move toward higher tiers. PSCS is in full support and alignment when working with clinics currently tiered for PCPCH and is also assisting those clinics who are currently working to apply for recognition. Currently in the Columbia Gorge Region area, five clinics have been awarded PCPCH recognition. For clinics that are attempting to apply but may fall short of the “must haves”, PSCS is willing and able to support requests for assistance to ensure these clinics have the capabilities to meet standards required for PCPCH recognition. PSCS has internal resources well versed in PCPCH standards and requirements

at all tiers and are ready and able to engage with clinics regardless of their current readiness and level of engagement in PCPCH. For those clinics that have applied and been recognized for Tier 1, 2 or 3, PSCS is able to supply rosters of Medicaid members in their area that are attributed to their clinic as well as indicators of what ACA criteria these members/patients may meet to be able to assist them with the appropriate identification. PSCS is able to identify member saturation and will reach out to clinics in areas of high member concentration to promote and support PCPCH recognition. For those not yet recognized, PSCS is ready to work with them to ensure they are capable of applying and becoming recognized. This will ensure that clinics serving these populations are engaged and are collaborating with PCPCH standards and expectations. As the number of PCPCH recognized clinics increase, PSCS and its partners can begin to work with each network to ensure that the needs of each member population's needs are addressed appropriately and across all aspects of care to ensure that targets and benchmarks are obtainable and reached within 5 years and beyond.

The Mid-Columbia Outpatient Clinics (MCO) is a collection of six outpatient primary care clinics, organized as a department of Mid-Columbia Medical Center (MCMC). As a pilot project, one of the clinics, Columbia Crest Family applied for and received certification as a Tier 3 PCPCH. Under the direction of a PCPCH Project Coordinator, the remaining five will organize in a similar fashion and apply for certification by October 1, 2012. As part of this transformational initiative, and responding to patient surveys describing a need for broader services, the hospital employed a diabetes nurse educator, a clinical pharmacist to assist with chronic pain management, a medical social worker and a clinical psychologist to spend a half day a week each in the clinic, seeing patients and connecting services alongside the primary care provider team.

The model has been well received and has demonstrated improvements in quality indicators for chronic disease management and has proven instrumental in managing chronic pain while limiting prescription drug abuse and diversion. The program has been expanded and is the cornerstone of the integrated, networked PCPCH transformation at MCMC. Currently, all six of the primary care clinics share two diabetes nurse educators, two medical social workers, a psychologist and a psychiatrist, as well as a pediatric nurse practitioner trained in mental and behavioral disorders, and two clinical pharmacists. The employed physicians have been organized into teams with a central Nurse Care Coordinator who assists with streamlining coordinated care for high needs patients and families.

The ability of these care providers to augment the primary care medical team has not only improved guideline compliance for chronic disease management, they have become instrumental in restructuring a patient centered approach through improved access to the right care at the right time, avoiding unnecessary emergency visits, and connecting patients to the services they need most. Patients receive individual counseling, personalized education and written care management plans under the direct supervision

of their own provider at the time of service, all at the physical location of their medical home. As soon as behavioral health counseling or social services needs are identified, primary care providers can schedule a consultation visit within their own clinic within 24 hours. Within the next year, the MCOC PCPCH Initiative will incorporate NCQA guidelines for including specialty clinics as part of a *Medical Home Neighborhood*, beginning with cardiology, urology and orthopedics using our shared electronic medical record as a platform for coordination.

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

A.3.1.d. PSCS's PCPCH delivery system will coordinate PCPCH providers and services with DHS Medicaid-funded LTC providers and services. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers who are coordinating tasks and communications and are well trained in providing coaching in transitions and assistance for LTC providers. PSCS intends to build upon these relationships and collaboration further through the CCO/PCPCH model. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications if PSCS members require LTC outside their immediate service area.

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

- Committees on quality, appropriate utilization, transitional care, end-of-life care, and disease management.

- Community Health Information assessments to assess cost and utilization with a goal of reductions in variations of care.
- Alignment of provider incentives, through new reimbursement models which reduce the reliance on per service, volume based reimbursement, and increase payment methodologies which provide investment for high quality, cost-effective care.

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

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

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

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

Medicaid Line of Business: PSCS is engaged with the Central Oregon IPA in a patient-centered model as defined and administered by the Oregon Health Authority.

Grant Funding for Medical Home and PCPCH: In addition, the safety net providers are core participants in the PCPCH initiative, and have further participated in grant funding and other shared savings from

PacificSource for initiatives which support medical home development and increased capability for integration of dental and behavioral health capabilities. Through the co-promotion of safety net providers' increased capability, PacificSource has and will continue to encourage and expand the use of these providers by the communities they serve.

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

A.3.2.c. PacificSource will require timely two-way communication and coordination between its patient-centered primary health care providers and other contracting health and services providers for comprehensive care management. Once PCPCH clinics are tiered and members are attributed, PacificSource will set up an introduction of a communication requirement/outline between the care management team and the clinics. This requirement will ensure communication is open and utilized to its fullest capacity between all entities. Whenever possible, PacificSource will facilitate coordination between clinics EHR/EMR systems to most efficiently transfer information as well. These relationships will be built from the beginning and will be a top priority to ensure collaboration is enhanced with communication that is effective and timely. PacificSource has the ability to communicate with clinics through their methods of preference which maybe a combination or one of the following: Phone, In Person, Fax and Email. PacificSource's electronic referral system allows for e-submission and review of referrals. Through this system, many referral responses are received same day. The system also allows for specialty providers to route additional referral requests back to PCPs for approval.

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

A.3.3. Access

A.3.3.a. PSCS will take steps to assure that coordinated care services are geographically located in settings that are as close to where members reside as possible, are available in non-traditional settings and ensure culturally-appropriate services, including outreach, engagement, and re-engagement of diverse communities and under-served populations (e.g., members with severe and persistent mental illness) and the delivery of a service array and mix is comparable to the majority population. PSCS assures network adequacy through regular assessments of providers who are open to new members, as well as monitoring wait times for members to get access to their designated provider. Members have the choice of who they want as their dedicated primary care provider, but if a member does not make a selection, PSCS ensures geographic proximity for assignment to a primary care home.

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

PSCS supports the use of Community Health Workers (CHWs) and other non-traditional providers. In the Columbia Gorge Region, La Clinica del Carifio, Providence Hospice of the Gorge, Hood River County Health Department, Heart of Hospice, Breast Health Program, Celilo Cancer Program, NCPHD and the Next Door, Inc. currently employ CHWs who work close with the OHP population. PSCS aims to further develop this model and is currently seeking other opportunities to engage CHWs. In terms of Personal Health Navigators, PSCS employs Transitional Care Coordinators who function in a member advocate/navigator role in helping members with medical system question/navigation, transportation, primary care assignment, and other forms of personal assistance. Interpreters are available both within PSCS and in conjunction with customer service staff through a contract with interpretation services vendors, as well as in the provider community, particularly within the safety net providers. This will assist in making sure members get culturally-appropriate care reflective of the diverse community both PSCS and PSCS provider partners serve. Members with severe and persistent mental illness and who otherwise are regarded as underserved, benefit from exceptional needs care coordination (ENCC) services made available to them. PSCS staff and Community Health Workers in the Columbia Gorge Region are dedicated to making sure they

receive personalized, coordinated care tailored to their unique needs. There are no referral requirements for such members.

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

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

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

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

A.3.4. Provider Network Development and Contracts

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

A.3.4.b. In collaboration with MCCFL and the Local Mental Health Authorities in the Columbia Gorge Region, PSCS will develop mental health and chemical dependency service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. PSCS will work with community partner organizations to identify resources specific to mental health and chemical dependency that can be provided in an outpatient setting. PSCS has developed strategies to divert members with non-medically necessary inpatient care, decrease length of stay, and prevent readmissions.

Through PSCS's contract with the MCCFL as the CMHP, PSCS will continue to support MCCFL's outstanding community development work in the area of alternatives to inpatient utilization. Currently MCCFL crisis teams screen and authorize all voluntary psychiatric hospitalizations. MCCFL is the designee to conduct psychiatric holds and there are currently no secure psychiatric facilities in the Columbia Gorge Region. MCCFL is directly involved and makes all decisions about involuntary mental health holds and transfers. Regardless of age or whether the admission is voluntary or involuntary, MCCFL staff will develop care coordination and transitional plans which will move members out of hospitals into lower levels of care in the community.

MCCFL has a memorandum of understanding with both local hospitals to function as behavioral health consultants so that decisions for potential high-level care and safety planning are made by trained MCCFL crisis workers. MCCFL also contracts with Columbia Care (Creekside) for 24/7 crisis respite services. Two dedicated crisis respite beds are purchased by MCCFL. These beds are used as alternative to psychiatric hospitalizations. MCCFL has a collaborative Memorandum of Understanding (MOU) with the local regional Jail ~ NORCOR, city and county police departments. Under the MOU, MCCFL allows law enforcement officers to transport individuals experiencing a mental health crisis related to co-morbid criminal or alcohol and drug intoxication to the work release building instead of the emergency room. This innovative approach has been shown to reduce ER utilization.

MCCFL utilization management (UM) team performs all utilization management functions for acute, sub-acute and psychiatric residential treatment services regardless of payer source. MCCFL has a contract with Eastern Oregon Human Services Coalition (EOHSC). EOHSC has an agreement in place with PhTech.

The MCCFL manages the authorization and claims payment process for indigent acute care and crisis services using a case management program called CIM through PhTech. PSCS also has an agreement with PhTech for authorization and claims payment services which are managed through CIM as well. By having agreements with the same TPA through PhTech, authorization and claims payment processes occur through one TPA for acute care provides a level of care integration that is unique. For more information on EOHSC follow the link:
<http://www.eohsc.info/index.html>.

In addition, PSCS utilizes a robust reporting system (Thompson Reuters) that utilizes claims experience to identify members at risk for readmission and targeted care coordination, disease management and case management services. Using this data, PSCS care coordination team will provide telephonic care coordination and follow up to reduce readmissions. Where appropriate, members will be enrolled in case management including case management of mental health and chemical dependency conditions. Reporting of readmissions, urgent care and ED visits using claims history is utilized to report on each Primary Care Medical Home contracted with PSCS. This data is used to inform process improvement and quality improvement opportunities with the PSCS provider network.

A.3.4.c. PSCS will develop a behavioral health provider network that supports members in the most appropriate and independent setting, including their own home or independent supported living. PSCS in collaboration with MCCFL will contract with the current network of mental health & chemical dependency providers to ensure that PSCS members have continued access to these services. This network is further addressed in RFA 3402 Application Appendix B. All PSCS Nurse Case Managers receive regular training on the availability of these services in the community to ensure that members who are identified with mental health & chemical dependency needs are connected with the appropriate clinicians and do not have to rely on intensive inpatient services for their care. PSCS in collaboration with the Local Mental Health Authorities assures network adequacy through regular assessments of providers who are open to new members, as well as monitoring wait times for members to get access to their designated provider.

In terms of non-traditional care, PSCS is working with the community to develop, fund and promote Community Health Workers (CHWs) within the provider community as well as within the safety net providers in PSCS's provider network. In addition, PSCS has provided grant funding to enable a community health assessment to determine to what extent and in what domains non-traditional care workers are best deployed in a community where those providers have not yet been deployed. These CHWs engage with the members both in the inpatient as well as outpatient setting, to ensure members that most benefit from these engagements have access across the continuum of care. In terms of Personal Health Navigators, PSCS employs Transitional Care Coordinators who function in a member advocate/navigator role in helping members with medical system and behavioral system question/navigation, transportation, primary care assignment, and other forms of personal assistance. Interpreters are available both within PSCS and in conjunction with customer service staff via a contract with interpretation services vendors, as well as in the provider community, particularly within the safety net providers, to assist in making sure members get culturally-appropriate care reflective of the diverse community both PSCS and PSCS's provider partners serve. Members with severe/persistent mental illness and who otherwise are regarded as underserved, benefit from exceptional

needs care coordination services made available to them, with PSCS staff, peer support specialists and Community Health Workers dedicated to making sure they receive personalized/coordinated care for their care needs. There are no referral requirements for such members.

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

Care Coordination:

A.3.5.a. PSCS will support the flow of information between providers, including DHS Medicaid-funded LTC care providers, mental health crisis services, and home and community based services, covered under the State's 1915(i) State Plan Amendment (SPA) for members with severe and persistent mental illness, in order to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care. PSCS maintains an electronic database for documenting member eligibility, claims payment, referral status, authorization status and any special eligibility categories that a member may qualify for. This database is a product of PSCS's claims & eligibility sub-contractor, PhTech. Through a web-based portal, PSCS providers are able to view the current status and historical record of authorizations and referrals.

Services that are funded by agencies outside of PSCS can be more difficult to coordinate. In order to facilitate communication and information flow between LTC providers, mental health crisis services and providers of home and community based services; the PSCS Medical Services staff receives periodic training on the contacts and availability of community resources. This includes in-person presentations by community partners to inform PSCS of services offered to members. The contact information for these providers is maintained on an internal Sharepoint site dedicated to the Medical Services staff. This is maintained by the Medical Services Manager. These resources are used to support case management and care coordination activities.

PSCS Health Services staff will work closely with MCCFL staff to ensure integrated services to all our members, especially those members who have a severe and persistent mental illness (SPMI). Current care coordination activities underway include but are not limited to the following:

- MCCFL and the local FQHC La Clinica del Cariño hold a monthly multidisciplinary case staffing meeting. Individuals are mutually chosen from each entity and a collaborative identification of the problem and work/care/treatment plan is created;
- MCCFL plans to build a new facility adjacent to La Clinica del Cariño in The Dalles. The intent is to have an integrated health campus which will result in better care coordination and integration;

- MCCFL reviews all applications and authorizes services for local psychosocial rehabilitation programs and partnerships which are services that target individuals who suffer from a SPMI. In the Columbia Gorge Region, these partnerships include Creekside Residential Treatment Facility, Court Royal Supportive and Transitional Housing Program, and Celilo Gardens Transitional Housing Program;
- MCCFL coordinates and collaborates with local foster home provider The Next Door, Inc., and the Department Human Services to provide two therapeutic foster care beds in the Columbia Gorge Region service area. The focus of these placements is either preserving local kids in a community based placement or moving local children out of higher levels of care back to into their communities. MCCFL also works closely in monthly meetings with the local Department of Human Services child welfare offices to authorize behavioral health services for local children placed out of the area as part of the Behavioral Rehabilitation Services. The focus in both of these meetings is to return local children placed out of the home back in our community.

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

The Integrated Care Management (ICM) team consists of PSCS case managers, PSCS care coordinators, physical health providers, behavioral health therapists and community health workers. The ICM team meets each week to coordinate care for high-needs members who have both behavioral health and physical health needs. This often includes members meeting the SPMI definition. These members are identified through data analysis that targets elevated risk scores, high claims experience and other clinical intelligence rules. The coordinated effort of this multi-disciplinary team is able to identify gaps in a member's care that can lead to poor health and quality of life outcomes. Often times the intervention of this group is to ensure that members get connected with community resources and/or a medical home. Since its inception in the 4th quarter of 2011, the ICM team has coordinated care for approximately 50 members. For those who have been in the program at least 6 months, the prospective risk scores have declined from an average of 11.2 to 7.9. PSCS is committed to building on this success by expanding the ICM team model to reach more members in 2012-2013. This will include the following changes:

- adding new care coordinators,
- streamlining workflows,
- improving data aggregation,
- enhancing member engagement on the ICM team, and
- utilizing a distributed model that takes the team to the member and providers.

A.3.5.b. PSCS will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and community prevention and self-management programs. PSCS is rooted in the community governance and the integration of physical health, behavioral health and public health. This is represented in the membership of the Columbia Gorge Health Council (CGHC), Clinical Advisory Panel and the tight integration of the CGHC and the Central Oregon IPA (COIPA). These community collaborations have allowed, and will continue to reinforce, partnerships between public health initiatives focused on community prevention and member self-management and physical and behavioral health initiatives.

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

A.3.5.d. PSCS will work with providers to implement uniform methods of identifying members with multiple diagnoses and who are served with multiple healthcare and service systems. PSCS will implement intensive care coordination and planning model in collaboration with member's primary care health home and other service providers such as Community Developmental Disability Programs and brokerages for members with developmental disabilities that effectively coordinates services and supports for the complex needs of these members. PSCS will identify members with complex medical and social needs through the following uniform methods:

- Robust reporting software used to identify high-needs members. PSCS currently use a software engine purchased from Ingenix; however, this is being transitioned to a Thomson Reuters application during 2012. These reporting systems integrate member demographics, disease burden and claims history to

identify members who are likely to require high resource levels in the near future. This data is overlaid with Clinical Intelligence Rules which help to identify members with interveneable conditions.

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

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

- o Patient Centered Medical Home.
- o Complex Care strategy which resulted from the previously documented Opportunity Conference.
- o Integrated Care Management team (previously documented above).
- o Community Health Workers.
- o Referrals to other community-based resources as necessary.

A.3.5.e. PSCS will meet state goals and expectations for coordination of care for members with severe and persistent mental illness receiving home and community based services covered under the State's 1915(i) SPA and members receiving DHS Medicaid-funded LTC services, given the exclusion of DHS Medicaid-funded LTC services from global budgets.

PSCS will work closely with MCCFL to ensure comprehensive coordination of care for the behavioral health care population including youth, adults, and families with SPMI. The MCCFL will be delegated responsibility for coordinating care for the SPMI population. As agreed, appropriate contractual requirements of the CCO contract will be evaluated and potentially transferred to the MCCFL, with oversight & monitoring maintained by PSCS. The MCCFL is contracted with the County Mental Health Programs for the direct provision of care. The compliance with all contractual requirements for the SPMI population will be monitored by the PSCS Compliance Department in coordination with the Behavioral Health Department. To ensure that services provided by the MCCFL to the SPMI

population are closely coordinated with the physical health and mental health services provided by PSCS and their provider network, the PSCS Behavioral Health Manager (or designee) and the MCCFL Executive Director (or designee) will maintain standing positions on each of the other's respective quality committees and other committees as appropriate.

A.3.5.f. PSCS will use evidence-based or innovative strategies within the delivery system network to ensure coordinated care, including the use of non-traditional health workers, especially for members with intensive care coordination needs, and those experiencing health disparities. MCCFL provides extensive case management services for adults and family care coordinators for youth. The local FQHC in the Columbia Gorge Region employs Community Health Workers to care for the OHP population. PSCS supports this role and is currently seeking opportunities to expand the reach of CHWs beyond the FQHC. Further description of the evidence-based and innovative strategies for care coordination is included in Section A.3.5.a.

A.3.5.g. PSCS will adhere to current industry standards that ensure access to care and systems in place to engage members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO. PSCS and its subcontractors approach each interaction with a member as a chance to educate and empower. PSCS has a belief that members can be hindered and disadvantaged in managing their care due to a lack of knowledge and confidence and lack of empathy from their health care organization. PSCS places a focus on understanding each member's situation and supporting each member in addressing it. PSCS ensures that each member is educated on the plan's quality initiatives and any other community resource available to them. The claim and authorization system can be used to measure member activation rates. The time is measured from the first day of enrollment to the first date of service on a claim, first call to Customer Service or the first referral to a provider.

A.3.5.h. PSCS will provide access to primary care to conduct culturally and linguistically appropriate health screenings for members to assess individual care needs or to determine if a higher level of care is needed. PSCS will engage members in culturally and linguistically appropriate ways. The enrollment system has the ability to track a member's race, ethnicity and primary language. This allows PSCS to ensure all materials sent to the members are provided in the member's primary language. It also allows customer service staff to route calls from a member to a native speaker or to prepare a language line interpreter. The customer service department will employ native Spanish speakers and utilize a language line service for all other languages.

Comprehensive transitional care:

A.3.5.i. PSCS will address appropriate transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, skilled nursing care, residential or outpatient treatment for mental health or chemical dependency or other care settings. PSCS will address transitional services and supports for children, adolescents and adults with serious behavioral health conditions facing admissions or discharge from residential treatment settings and the state hospitals. PSCS Medical Services team enforces evidence based Utilization Management policies for members admitted to the hospital, skilled nursing facilities and those receiving home health care. The Utilization Management process ensures that all members transitioning to or from these care settings are identified prospectively. As mentioned above, the PSCS Nurse Care Managers have dual roles for Utilization Management and Case Management for physical health conditions and serious behavioral health conditions. This model ensures that the members identified as requiring transition to a new care setting receive case management to ensure that all necessary services and support are in place prior to the members move. All case management activity is documented in a proprietary Sharepoint application that was built on NCQA case management standards. This ensures consistent case management occurs across nurses and clinical situations.

A.3.5.j. PSCS and local APD office will approach coordination and communication in a multi-layered fashion. The local APD office will provide a copy of the CA/PS assessment that is used with LTC members to PSCS. PSCS and local APD office will coordinate staffing when appropriate. PSCS will maintain contact with assigned APD case manager or diversion transition worker. Meetings between PSCS and the local APD office will occur on a regular basis to assist in coordination of care for members. In coordination with traditional case management services PSCS currently provides and will continue to provide, case managers who are experienced in coordinating tasks and communications and well-trained in providing coaching in transitions and assistance with LTC providers. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications if PSCS members require transitions of care in a LTC outside this service area. In addition, an Advanced Illness Management Committee is being planned with representatives from the hospital, palliative care, home health, in-home care, hospice, and primary care to develop evidence-based guidelines for advanced illness management, with the intention of educating and improving coordination of member care and communication between PCPs, Specialists, and ER providers.

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

Individual Care Plans:

A.3.5.1. PSCS will create standards and procedures that ensure the development of individualized care plans, including any priorities that will be followed in establishing such plans for those with intensive care coordination needs, including members with severe and persistent mental illness receiving home and community based services covered under the State's 1915(i) SPA. The care plans of community partners will be integrated into the process. As described above, the Case Management and Care Coordination software application used by PSCS Medical Services staff ensures a structured workflow and standardized questions. Every member engaged in Case Management or Care Coordination receives a single record in the application, which includes an individualized care plan. This application ensures consistent documentation and enables reporting of process and outcomes. Members enrolled in case management can be tracked over time and have their treatment plan adjusted according to their current needs. (Please find attached screen shots of the Case Management and Care Coordination software in Attachment A.3.5.1 Case Mgt Screens). PSCS will also address individualized care plans in provider contracts and educational materials.

A.3.5.m. PSCS will have a universal screening process that assesses individuals for critical risk factors that trigger intensive care coordination for high needs members; including those receiving DHS Medicaid-funded LTC services. In addition, the local APD office will provide a copy of the CA/PS assessment for LTC members when appropriate. PSCS and the local APD staff will mutually identify critical risk factors as appropriate. All members qualified as Exceptional Needs Care Coordination (ENCC) members will receive a wellness survey within 30 days of enrollment with PSCS. The survey is based on the standardized Short Form 12. Upon completion, all surveys are scored and logged in an electronic database. Using national SF12 norms, members are ranked for severity of physical health and mental health needs. The PSCS Care Coordinators conduct telephonic screenings for high-risk members using a care coordination screening application built in

Sharepoint. This care coordination screening assessment is based on NCQA standards. PSCS members who are interested in Case Management and have complex clinical needs, will be assigned to a Nurse Case Manager for longitudinal case management.

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

A.3.5.o. PSCS will reassess high-needs members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner. All members engaged in PSCS Case Management and Care Coordination services are entered into a proprietary application that tracks their plan of care longitudinally. The medical services staff responsible for maintaining these care plans represents the same staff conducting utilization management. When members are identified through the Utilization Management process with new clinical needs, the medical services staff will update their care plan as appropriate. Additionally, the medical services staff maintains a close relationship with the local provider network and can update a plan of care based on physician referral if the member is not captured through the utilization management process.

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

build these relationships and collaboration further through the CCO/PCPCH model. PSCS will identify local LTC providers in the service area of application and assist with coordination and communications.

A.3.6. Care Integration

Mental Health and Chemical Dependency Services and Supports

A.3.6.a. PSCS will develop a sufficient provider network, including providers from culturally, linguistically and socially diverse backgrounds for members needing access to mental health and chemical dependency treatment and recovery management services. The provider network will serve members in all age groups and all covered populations. PSCS is a unique health plan contractor in that it is currently both a Fully Capitated Health Plan contractor and a Mental Health Organization contractor with the State of Oregon. PSCS is truly an integrated health plan. PSCS's plan ensures members have access to the full continuum of behavioral health care services and supports.

PSCS will establish an integrated provider network which spans both physical and behavioral health. PSCS's integrated behavioral health provider network will be composed of services that are culturally and linguistically relevant to the local community and PSCS membership demographics.

PSCS expects to make adjustments to PSCS behavioral health provider network as dictated by four factors;

- Needs of PSCS membership,
- Alternative service delivery strategies ,
- Alternative payment models , and
- Willingness of current providers under contract with GOBHI to contract with PSCS.

The driving principles of PSCS behavioral health provider network development strategy is that PSCS's provider network must be localized and the provider workforce should reflect the community and PSCS membership demographics. PSCS will make every attempt to enter into contracts with the existing provider network currently contracted through GOBHI.

As noted above, MCCFL is the CMHP for the Columbia Gorge Region and is the provider of Mental Health, Chemical Dependency and Problem Gambling treatment services. MCCFL is currently a sub-capitated CMHP Mental Health service provider with under contract with GOBHI. MCCFL is currently a sub-capitated outpatient chemical dependency treatment provider under contract with PSCS. There are current provider contracts exclusive to MCCFL and executed under MCCFL authority as the CMHP and would remain exclusive to MCCFL. These are also current MOU or LOUs

exclusive to MCCFL and executed under MCCFL authority as the CMHP and would remain exclusive to MCCFL. There are current provider network contracts exclusive to the MHO and executed under GOBHI and would be exclusive to PSCS once contracts are completed with PSCS.

A.3.6.b. MCCFL will provide care coordination, treatment engagement, preventive services, community-based services, behavioral health services, and follow-up services for members with serious mental health conditions and chemical dependency conditions requiring medication-assisted therapies, residential and hospital levels of care including members with limited social support systems. MCCFL will transition members from acute care hospitals, including state hospitals and residential care settings, to the most appropriate, independent and integrated community-based settings. PSCS's integrated approach to care management is iterative and in a continuous state of evolution. PSCS in partnership with MCCFL and behavioral healthcare providers will work together to achieve optimal health care outcomes by "... bridging the gap between the healthcare delivery system and public community health systems, because psychosocial and environmental factors contribute roughly 80 percent to an individual's overall health in ways the health care system is not designed to address. To this end, effective care coordination must integrate the efforts of healthcare organizations with those of the communities in which members live and work. Although the healthcare system can and should provide appropriate medical care, maximizing the use of community resources can offer critical support to individuals and families in the prevention and management of diseases¹". PSCS's innovative integrated care management strategies and models describe below are built on the ideals describe above.

MCCFL will receive a global payment from PSCS to carry out care coordination services for our members. MCCFL will be responsible and accountable to provide comprehensive care coordination for PSCS members receiving all behavioral health services for which they receive a global payment. This includes service and supports MCCFL provides as a CMHP and agreed to under the Financial Assistance Agreement with Addictions and Mental Health Division (AMH) and in their contract with PSCS. Additionally, MCCFL will create seamless transitional care pathways which will move PSCS members from the state hospital-acute hospital and residential care settings into the least restrictive community based setting. MCCFL in partnership with the PSCS, will be responsible and accountable to ensure PSCS members have access to and receive all medically necessary behavioral health services and supports to maintain their independence in the community.

PSCS's current care management team consists of Nurse Case Managers (NCM) and Transitional Care Coordinators (TCC). The work is targeted at members with physical health care needs and chronic health conditions. The care management team

¹ Care Coordinating Convening Meeting Synthesis Report September 2010. National Priorities Partnership Convened by the National Quality Forum.

assesses the members healthcare needs including their psychosocial needs. These members often have unmet psychosocial needs and behavioral health care needs or, they are currently receiving behavioral health treatment. Their healthcare is uncoordinated and their psychosocial needs are rarely addressed by the healthcare system. In an effort to improve care management for these members, PSCS has developed and implemented innovative models of care management which bridge the systemic gaps between the healthcare systems and needed psychosocial supports.

PSCS has developed the Integrated Care Management model (ICM). The model is community based approach to care management. The ICM team meets weekly and is composed of PSCS's CMT and community behavioral health providers. PSCS will add a Behavioral Health Utilization/Care Manager within 60-90 days and potentially add a Behavioral Health Transitional Care Coordinator to create a multidisciplinary integrated Case Management Team within PSCS.

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

A.3.6.c. PSCS will integrate care and service delivery to address mental health and chemical dependency issues by proactively screening for and identifying members with them, arranging and facilitating the provision of care, development of crisis intervention plans as appropriate, and coordinating care with related health services including DHS Medicaid-funded LTC services and other health services not funded by the Applicant. This includes members from all cultural, linguistic and social backgrounds at different ages and developmental stages. As described in A.3.6.a and A.3.6.b, PSCS will develop a fully operational integrated service delivery system that addresses the physical, mental health and chemical dependency treatment needs of PSCS members. MCCFL is the Columbia Gorge Region CMHP and is certified by AMH. Other network providers are under a direct contract with the CMHP or will be under a direct contract with PSCS. All facilities under a direct contract with PSCS are certified by AMH to perform work specific to their contract.

All behavioral health facilities certified by AMH are governed by OAR 309-032-1500 (Integrated Services and Supports Rule [ISSR]). Specifically, OAR 309-032-1525(3)(d)(B)(C)(D)(F) requires comprehensive screening and the provision of appropriate services or referral to qualified professionals for the provision of care. Behavioral health provider contracts also mandate compliance with the ISSRs.

If the care management team identifies a behavioral health care need, a direct referral to the appropriate behavioral health provider is made. The care management team receives regular trainings and education on available community resources.

Additionally, the transitional care coordinators perform data mining to identify members who present as high risk. Often, these members are in need of behavioral health services. The transitional care coordinator will make direct referrals or they will bring the case to the ICM. The ICM ensures these members are connected to needed behavioral health services.

PSCS will engage in provider education and encouraging PCPCHs and the hospital EDs to implement the EBP Screening Intervention and Brief Treatment (SBIRT). PSCS will plan to increase efforts around implementation of SBIRT in these settings. PSCS on behalf of PSCS members will work through the MCCFL to gain access to critical services and supports which may not be funded through the PSCS plan. Mid-Columbia Center for Living and PSCS will work together in the development of care plans and access to services and supports for DHS Medicaid-funded LTC services.

A.3.6.d. PSCS will organize a system of services and supports for mental health and chemical dependency as described in previous sections, including:

- o integrated prevention services at the clinical and community level;
- o integration of primary care across systems;
- o qualified service providers and community resources designed and contracted to delivery care that is strength-based, family-focused, community-based, and culturally competent;
- o network of crisis response providers to serve members of all ages; and
- o recognized evidence-based practices, best emerging practices and culturally competent services that promote resilience through nationally recognized integrated service models.

The Community Health Improvement Plan will be used as the framework to develop integrated preventative services. Under this framework, initiatives which target behavioral health prevention at the community and clinical level including primary care will be developed and implemented. Integration of behavioral healthcare into the primary care setting is underway.

As described in previous sections, PSCS has a robust provider network in place. The CMHPs currently provide behavioral health 24/7 crisis services which serves members of all ages. PSCS's behavioral health providers offer a variety of approved

Addictions and Mental Health Division (AMH) Evidenced-Based Practices and Processes (EBPs). For a complete listing of AMH approved EBPs and practices please follow the link:

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

Oral Health

A.3.6.e. PSCS will have a formal contractual relationship with appropriate DCOs who serve PSCS members in the Columbia Gorge Region service area by July 1, 2014. Discussions are currently occurring to define how dental care will be integrated and how roles will evolve. Potential elements of the plan moving forward will be: emergent/urgent access to dental; prevention; and general dental care screening in schools, Head Start, and public health programs including Women, Infants and Children's (WIC) programs. PSCS with its community partners will further develop a plan to coordinate dental care with behavior health, physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting members at the right time, to the right place, and for the right care.

A.3.6.f. PSCS and its community partners will coordinate care for members' oral health needs, prevention, and wellness as well as facilitating appropriate referrals to dental care. It will be critical to establish a 24 hour/ 7 days a week after-hours on-call system to meet the emergency and urgent oral health needs of members and provide access that is local. Prevention and general oral health care provided by dental hygienists screening children in schools, the Head Start, and WIC programs for cavities and by applying fluoride varnish to the children's teeth will be considered. Coordination of care will occur between oral health, behavior health, and physical health and the hospitals to reduce the use of emergency rooms, operating rooms and medications by diverting members to appropriate care in a timely manner. Oral health needs for children and pregnant women will be prioritized. Oral health education will be aggressively marketed to families through family services groups such as Head Start, WIC, The Next Door, etc. Local dental providers participate in local Give Kids a Smile Day. Local dental providers have worked with Gorge Dental Access Coalition to provide oral health intervention to local children living in Hood River. The program is supported by Providence Hood River Memorial Hospital Foundation with funds raised for the program through the local Bed Pan Open Golf Tournament. The program provides vouchers for care. The dental providers often offer discounted rates for children in this program. La Clinica del Cariño has a dental hygienist that screens children and applies sealants in the schools.

Hospital and Specialty Services

A.3.6.g. PSCS will have agreements with hospitals and specialty care providers to address coordination and referrals to PCPCHs and performance expectations as well as transition plans. PSCS communication agreements are put in place and routinely coordinated between the Hospital, PCP Clinics and PSCS case managers on a regular basis. With incorporation of PCPCHs, PSCS intends to continue to improve upon this process and will be facilitators, partners and supporters of this coordination of timely care and notifications. It is intended that the Hospital Agreements will be available at Readiness Review.

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

A.3.7.a. PSCS has begun discussions with the local APD office. Moving forward; PSCS and the local DHS APD office will begin communicating on a regular and interval basis to create a “multi-disciplinary” approach to coordination of member’s care. It is anticipated that PSCS and the local APD office will participate in care conferences, hospital transition meetings, diversion/transition and case management efforts. Currently, PSCS and the local APD office are developing a MOU to address coordination of care, availability of best practices to members in a LTC setting, and development of a model for better coordination of care between PSCS and the LTC system that reflects the values of the community.

A.3.8. Utilization management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4 - Health Equity and Eliminating Health Disparities

A.4.1. PSCS and its providers will work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. Currently, PSCS works closely with its providers in the Columbia Gorge Region service area to provide the best possible culturally appropriate care. Partnerships with FQHCs, RHCs, and other provider entities skilled at the multiple cultures within their communities give PSCS a foundation to succeed in this area. PSCS uses culturally variable communication to reach and engage members, and acts as a resource for identifying and providing access to the most culturally appropriate care in the community. PSCS has additionally collaborated in the community to invest in the development of additional capability of PSCS provider partners to increase access to those providers that provide such culturally-appropriate care. Examples of these investments include the creation of a new provider reimbursement model used in PSCS's service areas that no longer links higher reimbursement with providing more services. This new model allows primary care providers the opportunity to invest in the care that is culturally appropriate for the member population. Another investment example includes PSCS grant funding which is invested in those providers needing financial assistance in building new capabilities, as well as new and continuing shared savings models whereby new capability investments are paid for by cost reductions that result from the reduction of unnecessary/inefficient provision of care. The reduction of health disparities and improvement of the well-being of members will be conducted at a community level, and by engaging with local care providers and reviewing community care experiences formed by the many Community Health Assessments that have taken place in the Columbia Gorge Region Service Area as noted in Section A.16. From these many point of analysis, a community health improvement plan can be jointly created with the community providers that A) has community-wide buy-in and B) can assess if further community data should be assessed to identify further health improvement initiatives, and mutually craft strategies to achieve them.

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

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

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

PSCS has some experience in the past year with reporting on members with mental health conditions. Client Process Monitoring System data (CPMS) is submitted by behavioral health providers to the state. This data includes demographic information and behavioral health utilization data. It is used for monitoring providers' utilization rates and calculating measures for Quality Improvement Report (outcome measures of clients). This data source is can be used to assess utilization and performance.

Epidemiological data on Alcohol, Drugs, Mental Health and Gambling is available from the Addictions and Mental Health Division website. This site includes information and data for 50 state measures and 41 county measures that can help local communities better understand substance use and mental health of their population.

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

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

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

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

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

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

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

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

Section 5 - Payment Methodologies that Support the Triple Aim

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

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

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

Section 6 - Health Information Technology

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

A.6.1.a. PSCS plans to improve HIT in the areas of data analytics, quality improvement, member engagement through HIT (using tools such as email, personal health records, etc.) and other HIT. PSCS is also actively working with providers to encourage the adoption of EHRs and supports the area HIE efforts through Gorge Health Connect, Inc. (GHC), an existing Health Information Organization (HIO). The current membership of GHC includes a significant segment of the care community in the region including Mid-Columbia Medical Center, Providence Hood River Memorial Hospital, Mid-Columbia Center for Living, Columbia River Women's Clinic, La Clinica del Cariño, Mid-Columbia Surgical Specialists, North Central Public Health District (Wasco, Sherman, Gilliam Counties), and Hood River County Public Health Department. GHC is a 501c3 non-profit organization whose mission is to deliver a secure and trusted health information exchange platform to improve health and wellness in the greater Mid-Columbia Region. The HIE will allow PSCS to identify those members for whom they are accountable; possess master patient indexes that link a member's medical record numbers among PSCS providers; provide registry capabilities so PSCS can track the care provided to PSCS members; and assess the degree to which PSCS and its providers are appropriately managing cohorts of members.

The adoption rate for Electronic Health Records (EHR) in Hood River and Wasco counties is very high (approaching 90%). PSCS's community partners Providence Hood River Memorial Hospital (PHRMH) and Mid-Columbia Medical Center

(MCMC) are currently providing EHR platforms for the community hospitals and all employed providers. There is a very high rate of primary care providers employed by MCMC in Wasco County. Columbia River Women's Clinic, North Central Public Health District, Columbia Gorge Family Medicine, and La Clinica del Cariño have successfully implemented EHR systems and Mid-Columbia Surgical Specialists is evaluating systems at this time. Mid-Columbia Center for Living does not currently have robust EHR capabilities which have created challenges in communicating between physical and mental health EHR systems.

A.6.1.b. PSCS will promote adoption of Electronic Health Record Systems and coordinate these efforts with the Regional Extension Center (REC) for Oregon ~ O-HITEC. The purpose of O-HITEC is to furnish assistance. This assistance is defined as education, outreach, and technical assistance to help providers in Oregon to select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. Ensuring alignment of efforts with O-HITEC will be a key enabler of success for the PSCS network providers to adopt and achieve meaningful use of EHRs. There are also providers within the PSCS network that are not eligible professionals under the EHR Incentive Program, such as mental health providers, longer term care facilities, etc. who will need additional assistance to implement EHR technology.

PSCS will continue to monitor EHR adoption and identify methods to further increase usage that are consistent with the Triple Aim goals. Opportunities being explored include establishing eligibility criteria for funding of medical home development based on having an established and robustly-used EHR. PSCS may also consider future incentives for differential reimbursement for providers depending on those practices which have and robustly use their EHR.

A.6.1.c. PSCS, with its community partners, will facilitate meaningful use and HIE. PSCS, with its community partners, will leverage the Direct-enabled Health Information Service Provider (HISP) services of GHC. The initial focus will be to support the infrastructure for the basic exchange of health information among stakeholders, moving on to more sophisticated analytics and efforts to improve quality and member engagement.

Integrating behavioral health into the GHC infrastructure will be a critical step to improving health and lowering costs. Although behavioral health is a critical component of a person's overall health, mental health and substance use treatment information is currently not integrated with physical health information. This creates significant gaps in health records, potentially leading to fragmented, lower quality care. Being able to access and share complete member health information, including both behavioral and physical treatment records across clinical practice areas, enables the creation of a longitudinal member record, which can be valuable in providing a complete picture of an individual's overall health.

There is a growing demand throughout the healthcare community to share data with members. Member engagement is critical for the success of PSCS and could include open access for any member through a member portal; the personal health record can be updated and will be available for the member's providers. This will be particularly helpful for members with co-occurring diseases or who visit multiple providers throughout the PSCS network. Further member engagement could be facilitated using Direct messaging to a member's Personal Health Record (PHR) as well as the member portals of healthcare providers.

PSCS has been working with various providers to fulfill meaningful use criteria through investments in grant funding to support capability, staff, and workflow development to achieve meaningful use standards, and will continue to do so in the future. PSCS may also consider future incentives for differential reimbursement for providers who provide information to, and robustly participate in community-based HIE, or an HIO, though those incentives are not currently established.

**This section redacted
Per ORS 192.410 - 192.505**

Care Coordination-Medical Home Assessment



Appendix B
Pharmacy Contract Information
Redacted per ORS 192.410 -194.505

APPENDIX B – Provider Participation and Operations Questionnaire

Section 1 - Service Area and Capacity

PacificSource Community Solutions is applying for the areas as listed in the Appendix B – Table B-1. Please see attached, Appendix B - Table B-1 (Participating Provider Table) and Appendix B - Service Area and Capacity Table.

Section 2 - Standards Related To Provider Participation

Standard #1 - Provision of Coordinated Care Services

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

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

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

ADDITIONAL QUESTIONS ABOUT SPECIFIED INTEGRATED CARE SYSTEM COMPONENTS

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

PSCS shall ensure those Members who have special health care needs such as those who are aged, blind, disabled, or who have high health care needs, multiple chronic conditions, mental illness or chemical dependency or who are children/youths placed in a substitute care setting by Children, Adults and Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF) have access to primary care and referral providers with expertise to treat the full range of medical, mental health and chemical dependency conditions experienced by these Members. As PSCS develops a relationship with local DCOs, oral health will become part of this process. The providers and facilities identified in the Participating Provider Table or referral provider/facility (Standard #1 Table), will be identified by special skills or sub-specialties necessary to provide a comprehensive array of medical services to Members with Special Care Needs or Members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency. In order to reduce costs to health care associated with chronic disease, PSCS will refer members to the Living Well Program which is administered by Mid-Columbia Council of Governments. Efforts are being made to provide this program in Spanish. Specifically designed for people living with multiple chronic conditions both mental and physical, Living Well is an evidence-based chronic disease self-management program that consists of six weekly two-hour workshops that teach tools for living a healthy life with chronic health conditions in a culturally and linguistically appropriate

manner. The Living Well Program is an effective intervention for addressing the needs of PSCS members who incur the highest costs and use the most services, with significant return on investment. PSCS's collaboration with the Living Well Program will include:

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

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

PSCS has executed agreements with publicly funded providers for authorization of and payment for point-of-contact services (i.e. immunizations, sexually transmitted diseases and other communicable diseases) and for cooperation with the local mental health authorities.

Publicly Funded Health Care and Service Programs Table

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

(a) As members of the Columbia Gorge Health Council, the two counties (Hood River and Wasco) have been involved in the development of the CCO application. Each county has assisted in the writing of sections of the application have been active members in the CCO Steering Workgroup Committee overseeing the process. The Public Health Directors will be in discussions with Pacific Source staff in the development of additional services that public health may provide to improve the health of the citizens of these two counties.

(b) Current contracts for public health services are in place for Hood River and Wasco Counties. Additional opportunities may develop as the CCO evolves which will be pursued.

(c) PSCS is in process of finalizing new agreements with these counties.

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

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

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

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

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

(a) PSCS will provide services as included in the Integrated Service Array. PSCS will enter into a service contract with the Mid-Columbia Center for Living (MCCFL). Under the service contract, MCCFL will further develop and administer the Columbia Gorge Region Integrated Service Array (ISA) in accordance with OAR 309-032-1500 (Integrated Services and Supports Rules). The ISA provider network will include both traditional and non-traditional services and supports which are provided in a variety of settings. Care coordination for the ISA population will be performed by MCCFL as the local CMHP for both the Columbia Gorge Region Counties in collaboration with other providers as appropriate.

(b) It is anticipated that MCCFL will administer the ISA as part of an agreement with PSCS in the manner consistent with the following approach. The Columbia Gorge Region counties will invest in training, coaching and monitoring to achieve full-fidelity wrap around services based on system of care principles, with a team creating a family-driven plan for each child in partnership with other child-serving systems. As a result, it is

expected that the Columbia Gorge Region will reduce the percentage of children needing psychiatric residential care, shorten the length of stay, and create a menu of community-based supports that enable children to be maintained in permanent homes in the community. Individuals and families served in the Columbia Gorge Region will also receive services as part of the ISA with wrap around as the primary model used for team facilitation and care coordination. MCCFL will determine the ISA eligibility and partner with all local child serving agencies through the wrap process and Community Care Coordination Committees. Trainings in wraparound and team facilitation have occurred and the services and supports will be provided when documented as a need in the individual's wrap around plan of care. Psychiatric Residential Treatment Services, sub-acute and acute levels of care are utilized in a manner that best meets the needs of the individual and as medically necessary.

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

Standard #7A– Mental Illness Services

(a) PSCS will provide community-based mental health services to members, including members receiving home and community-based services under the State's 1915(i) SPA. PSCS intends to contract with the current community behavioral health (including mental health) provider network in partnership with the Mid-Columbia Center for Living. The current behavioral health provider network consists of one local Community Mental Health Program which serves as the (CMHP) for both Columbia Gorge Region Counties. MCCFL provides a wide array of mental health and chemical dependency treatment and recovery services and supports. MCCFL also provides most of the home and community-based mental health services to members who qualify for these services under the State Plan 1915(i) wavier.

(b) PSCS will screen all eligible members for mental illness to promote prevention, early detection, intervention and referral to mental health treatment – especially at initial contact or physical exam, initial prenatal exam, when a member shows evidence of mental illness, or when a member over-utilizes services. Behavioral health providers are governed by OAR 309-032-1500 (Integrated Services and Supports Rule [ISSR]). Specifically, OAR 309-032-1525(3)(d)(B)(C)(D)(F) requires comprehensive screening and the provision of appropriate services or referral to qualified professionals for the provision of care. Additionally, PSCS will emphasize and encourage screening for and early detection of behavioral health disorders in all primary care settings and at the initial prenatal exams where possible. PSCS has a robust reporting software used to identify high-needs members (who maybe over utilizing certain services). These reporting systems, use predictive modeling algorithms to integrate member demographics, disease burden and claims history to identify members who are likely to require high resource levels in the near future. This data is overlaid with Clinical Intelligence Rules which help to identify members with intervenable conditions.

Standard #7B – Chemical Dependency Services

(a) PSCS will provide community-based chemical dependency services to members, including members receiving home and community-based services under the State's 1915(i) SPA. All services will be provided through the current community behavioral health (including chemical dependency) provider network in partnership with the Mid-Columbia Center for Living. MCCFL provides a wide array of mental health and chemical dependency treatment and recovery services and supports. MCCFL also provide most of the home and community-based mental health services to members who qualify for these services under the State Plan 1915(i) wavier.

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

Standard #8 – Pharmacy Services and Medication Management

**This section redacted
Per ORS 192.410 - 192.505**

This section redacted
Per ORS 192.410 - 192.505

Standard #9 – Hospital Services

(a) PSCS will assure access for Members to inpatient and outpatient hospital service as follows. Urgent care services including mental health crisis or emergencies are covered 24 hours a day, 7 days a week whether in-area or outside the service area. Urgent care services do not require prior authorization. Members are directed to call their PCP with an urgent care condition or go to an urgent care office nearby. The PCP office will be available 24 hours a day, 7 days a week. For mental health crisis, members are directed to call the mental health crisis line, 911, or go directly to the emergency room. Emergency services do not require prior approval. For physical emergency medical conditions, members are directed to call 911 or go to the emergency room. If members are not sure their condition is an emergency, they are encouraged to call their PCP's office that can help direct their care.

Physical Health and Mental Health Emergencies are described in the PSCS member handbook and by PSCS customer service team. For outpatient services requiring prior authorization, requests will be received and processed according to regulatory timelines and notice requirements. An organizational determination to provide, authorize or discontinue a service to a member is made as expeditiously as possible. All prior authorization requests are date-stamped with the date the request is received. Compliance with required timelines is reviewed monthly by Corporate Quality Assurance and periodically by Internal Audit. If prior authorization timelines are found to be outside established guidelines, an action plan for correction is developed by the manager of Medical Services and reviewed by the Medical Director once completed.

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

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

Adverse events and Hospital Acquired Conditions (HACs) are identified through utilization management, case management, claims review, reports from physicians, and member complaints.

- Adverse Events: Adverse Events are defined as incidents in which harm resulted to an enrolled member or harm could have potentially occurred through receiving health care. Reviews of the events are performed by the health plan medical director, the QAUMPT Committee and/or an appropriate consultant. Events are logged and tracked over time. The completed reviews are peer protected and considered at the time of practitioner recertification. Frequent or severe events attributable to a single provider or facility will be subject to corrective action per policy and procedure. An annual report is reviewed by the QAUMPT Committee.

- Hospital Acquired Conditions (HACs): The PSCS claims payment system is configured to stop payment and trigger clinical review for claims received which meet the definition of HACs, as defined by Medicare. All incidents of Adverse Events and/or HACs identified through the prior authorization and referral processes are reported to the Health Services Quality Improvement team. The Quality Improvement team reviews and compiles rates of Adverse Events and HACs for reporting to the Quality Assurance Utilization Management and Pharmacy & Therapeutics Committee (QAUMPT). The Adverse Event and HAC's rates are used to inform the

contracting and credentialing process to ensure that PSCS maintains a high-quality network of providers and hospitals. PSCS has reported Medicare HAC's and Serious Reportable Adverse Events to CMS for the past two years. Policies and procedures have been developed and the process has been reviewed by a certified Medicare C&D Validation audit firm. The same process will be executed for Medicaid members.

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

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

Section 3 - Assurances of Compliance with Medicaid Regulations and Requirements

1. Medicaid Assurance #1 - Emergency and Urgent Care Services: Provider shall be responsible for responding to or making arrangements for emergent needs of Members with respect to Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays. In the event that Provider is unable to provide required Covered Services, Provider shall arrange for a Covering Practitioner.
2. Medicaid Assurance #2 - Continuity of Care: The Medical Services staff documents all authorizations and referrals in a software application which are then available for providers and nurse case managers to review to ensure care coordination and reduce duplication of services. The Medical Services management receives a daily report with the total number of authorizations and referrals which includes the date the request was received. This allows them to ensure requests received will be processed according to regulatory timelines and notice requirements established by the Oregon Health Authority.
3. Medicaid Assurance #3 - Medical Record Keeping: Policies and procedures are in place to ensure protected health information (PHI) maintained by PSCS is appropriately safeguarded against inappropriate uses or disclosures. The procedures describe appropriate storage and destruction of PHI. PSCS performs medical record reviews of primary care provider record keeping on an annual basis. Providers will be reviewed every 3 years in coordination with their re-credentialing cycle.
4. Medicaid Assurance #4 - Quality Improvement: PSCS has a QAPI program which was reviewed by External Quality Review Organization in 2011 and was found to have "Fully Met" the general Rules and basic elements of for Quality Assurance Performance Improvement programs.
5. Medicaid Assurance #5 - Accessibility: PSCS surveys providers annually for appointment wait times for routine, urgent and emergent appointments and reports those findings to the QAUMPT Committee. PSCS monitors the number of members who do not have a PCP assigned within 30 days. Member grievances are monitored for indications of access problems.
6. Medicaid Assurance #6 - Grievance System: PSCS has written policies and procedures available for review by OHA, which outline the process by which the plan accepts, processes, and responds to all complaints and appeals from members and their representatives. Information on these processes is shared with members as well as with PSCS providers upon entering a contract and more often as needed. PSCS's grievance system is described above in more detail.

7. Medicaid Assurance #7 - Potential Member Informational Requirements: PSCS has the ability to provide potential members with pertinent information to make a decision about enrollment. These materials would be in both printed format and available online. However, current rules prohibit PSCS from marketing to our potential members, so we do not provide this information currently.
8. Medicaid Assurance #8 - Member Education: Members receive a handbook annually or when significant changes are made. A member newsletter is sent three times per year and includes topics related to benefits, prevention, utilization and health improvement. The member website includes health care information for PSCS members. Members identified for quality improvement projects are sent materials on self-management related to the topic targeted for improvement. Materials are available in Spanish. Member Handbooks and Provider Directories noting the provider's languages will be provided to members annually and upon enrollment to ensure members can choose providers that are fluent in the member's primary language.
9. Medicaid Assurance #9 - Member Rights and Responsibilities: Member Handbooks are provided to members upon enrollment and annually to ensure members have pertinent information about their rights and responsibilities as a member of the plan. The handbook is written in 6th grade reading level and is being translated into Spanish, since we meet the thresholds in our service areas for this need.
10. Medicaid Assurance #10 - Intensive Care Coordination: Intensive care coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager. PSCS will respond to request for intensive care coordination services with an initial response by the next working day following the request. PSCS will ensure transitional care coordinators and case manager case manager's name and telephone number are available to agency staff and members or member representatives when intensive care services are provided to the member. ENCC members will have direct access available to specialists represented as an exception to the referral process.
11. Medicaid Assurance #11 - Billing and Payment Standard: PSCS will participate as a trading partner of OHA in order to timely and accurately conduct electronic transactions in accordance with HIPAA electronic transactions and security standards.
12. Medicaid Assurance #12 - Trading Partner Standard: PSCS has and will continue to execute necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards.
13. Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services: PSCS contracts with PH Tech for the processing of claims and encounters and the transmission of those encounters to OHA. PH Tech maintains policies and procedures that promote the accurate and timely submission of encounter data to OHA. PH Tech performs multiple levels of encounter validation and auditing to ensure overall quality and adherence to customer and OHA requirements.
14. Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard:
PSCS contracts with PH Tech for the processing of enrollment and disenrollment transactions received from OHA. PH Tech has built an automated system to accept and import both enrollment and disenrollment records in the HIPAA 4010 and 5010 834 format. All transmission from OHA are archived on the PH Tech file servers and imported into PH Tech's data warehouse for storage and reporting on enrollment, revenue and expense.

APPENDIX C – Accountability Questionnaire

Section 1 – Accountability Standards

C.1.1. Background information

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2 – Quality Improvement Program

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

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

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

In addition, the Columbia Gorge Region has identified several priority areas as noted in Appendix A. These areas include:

- Chronic disease support and management;
- Access to primary care;
- Preventative health care;
- Basic needs;
- Community based behavioral health;
- Access to health insurance;

- Tobacco use and reduction;
- Access to and consumption of fresh fruits and vegetables;
- Effective communication of actionable health information to Columbia Gorge residents; and
- Support of Workplace Wellness programs.

These priority areas will be addressed through community and public health programs in collaboration with PSCS community partners.

C.2.1.b. PSCS's Quality Committee is called the Quality Assurance Utilization Management Pharmacy and Therapeutics Committee (QAUMPT). This committee has a reporting responsibility to the PSCS Board that is accomplished through the PSCS Medical Director. The committee provides oversight to the quality program and provides a mechanism for stakeholder input. The committee membership includes adult and pediatric primary care providers and specialty members including a neurologist, a psychiatrist, and a neurosurgeon. The committee also includes a community pharmacist, a public member, and a behavioral health professional. Two committee members are experts in the care of elderly and/or disabled persons to meet the requirements of the Medicare Part D program. Mid Columbia Medical Center (MCMC) has an Outpatient Performance Improvement Committee (OPIC) which serves as QAC for the integrated Behavioral Medicine department in the MCOC. As behavioral health is integrated further, it is anticipated that it will continue to serve this purpose.

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

C.2.1.d. PSCS's practitioners, culturally diverse community-based organizations and members will be engaged to assist in the planning, design and implementation of the QI program. Practitioners have the opportunity to be involved through participation in the QAUMPT Committee and the QAC Committee. There is also the opportunity to provide input and receive relevant QI Program information through educational provider meetings held several times per year. As an example, community stakeholders were invited to participate in the selection and development of a project targeted toward members with Serious Persistent Mental Illness. PSCS with its community partners will identify additional opportunities to engage practitioners, community based organizations and members.

C.2.1.e. PSCS's QI program specifically addresses health care and health outcome inequities, care coordination and transitions between care settings. The QI program has elements designed to monitor access issues and identify discrepancies in care. Reports from

claims data are reviewed and compared to benchmarks or compared to rates for the general population. A process is undertaken to identify the causes of the discrepancies and create actions to mitigate the inequities. A current quality project is focused on improving low rates of diabetes indicators in members with diabetes.

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

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

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

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

has developed and implemented a process to verify with members whether services billed by providers were received. Grievances are also monitored for potential Fraud and Abuse issues.

Evidence-based guidelines are disseminated to providers as part of Quality Improvement Project interventions. Guidelines are also embedded in all medication coverage policies and disseminated to providers when prior authorizations for certain medications are requested. Medical Coverage Policies are developed after consultation with the most current evidence based medicine, State & Federal rules & regulations, and national treatment guidelines. All policies are reviewed & approved by the Quality Assurance Utilization Management Pharmacy & Therapeutics Committee (QAUMPT). In addition, consideration is being given to utilize the Gorge Connect Direct as a dissemination tool, COIPA newsletter, as well as Gorge CME meetings by the Clinical Advisory Panel. Compliance will be monitored through available billing and reporting systems that are in place in the community.

C.2.2. Clinical Advisory Panel

C.2.2.a. PSCS in collaboration with the CGHC will establish a Columbia Gorge Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. The CAP will serve as a subcommittee of the Columbia Gorge Health Council (CGHC). The role of the CAP will be to provide clinical oversight and leadership to community clinical integration efforts, clinical quality improvements projects and improvements in the local health care system and delivery. The CAP will also serve a role in coordination of the quality committees of the health plan, CGHC and the Central Oregon IPA (COIPA) as they relate to the CCO.

The CAP will consist of 15 – 17 voting members plus 2 co-chairs with voting privileges. Co-chairs will be nominated by the CAP for appointment to the positions of the Practicing Primary Care Providers and Practicing Behavioral Health Providers serving on the Governance Board. There will be a liaison between the CAP and the Community Advisory Council (CAC). Nine required representative seats will serve on the CAP. Those seats will include representatives from:

- Primary Care (3) – across the continuum from pediatrics to internal medicine, include at least one representative of RHC.
- Behavioral Health (Co-chair along with physical health provider representative).
- Federally Qualified Health Clinic.
- Public Health.
- Provider at large.
- Oral Health.
- PSCS Medical Representative.

Six to eight additional voting members will represent as many of the following disciplines as possible: Pharmacy, Long Term Care, Specialty Care, Alternative Medicine/Therapies, Hospice/End of Life, Visiting Health, Hospitalist, OT/PT/Speech, Emergency Medicine, OB/GYN, Alcohol/Drug Dependency, and Oral Health.

Members of the CAP will be involved in quality improvement planning for their representative organizations whenever possible. The co-chairs will be clinical members of the Governing Board. The CAP will include members that are representative of all county regions, as well as representative of providers of underserved populations. Duties may be split between subgroups that would gain input from others outside of the CAP.

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

C.2.3.a. PSCS has policies, processes, practices and procedures in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation. PSCS has Case Management policies and procedures to ensure early identification of members with special needs in order to allow interventions that can significantly impact the quality and cost associated with their care without sacrificing medical appropriateness or member satisfaction. Staff is dedicated for case management to members with special health care needs. The staff has been trained in motivational interviewing and is working on patient engagement and activation. Newly enrolled members with special health care needs are mailed a health risk assessment called the Wellness Survey. The survey includes some plan specific questions as well as the SF12. The SF12 is a valid and reliable survey that measures functional health and well-being from the patient's point of view. It is a widely used tool for monitoring population health, comparing and analyzing disease burden, and predicting medical expenses. Scoring is based on comparisons to national age related norms and is used to risk stratify members who may need case management or conditions support.

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

As a part of integrated care strategy, members meeting the threshold for prospective risk scores are brought to a weekly Integrated Care Management (ICM) meeting. The ICM meeting is designed as a collaborative effort to address gaps in care and bring community partners and resources together to bring the appropriate care and utilization of health services. This workgroup is comprised of behavioral health providers, ED diversion representatives, chemical dependency representatives, community health workers, the member and any other community health partners involved in the member's health care. Prior to the meeting, members or the member's representative is contacted to inform them of this meeting and to identify the member's concerns, barriers or issues they see with their own health care. This information obtained from the member is included in the discussion. After the meeting, a care plan is then initiated and the case manager, care coordinator, pharmacist and/or behavioral health specialists

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works with the PCPs office, member and community partners such as the brokerage, transportation office, disability offices, member's state case worker, specialist's office, home health provider to develop a targeted, consistent approach. Once the member or member's representative is successfully engaged, the member is transitioned from the ICM workgroup to ongoing assessment and coordination with their nurse case manager. Six months after discharge from the ICM group, the member's prospective risk score is re-assessed and brought back to the ICM group if thresholds are again met.

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

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

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

Mid-Columbia Outpatient Clinics supports a comprehensive school-based Sports Medicine Program which funds two full time and one part-time athletic trainers at The Dalles and Dufur schools. As part of this program, MCOC family physicians and pediatricians provide sideline support at home games. In addition, MCOC provide over 200 free pre-participation physical exams to middle and high school students annually. As a kickoff event, the medical group sponsors the annual Health and Safety Fair, showcasing community resources such as YOUTHINK- aimed at preventing alcohol, tobacco and substance use by youth. Additionally, MCMC sponsors the annual Kids Bike Race – a health and wellness event involving bicycle safety course, helmet and bike checks and race. All of these programs are offered free of charge to community participants.

MCMC's Water's Edge Health and Wellness Center offers programs for prevention and treatment integrating nutrition and exercise in a medical fitness model. One such program is SHAPE DOWN ~ a new cross-disciplinary pediatric obesity treatment program which is an integrative, family centered approach in the treatment of obesity in kids. The child's family, pediatricians, physical therapists and nutritionists participate in this 12-week education based, patient centered program at the Water's Edge fitness center.

The PSCS member website includes Health Coach 4 Me which includes information on Diet and Nutrition, Exercise and Activity, Medicine, Smoking Cessation, Stress Management, Vaccination, Weight Management and chronic conditions such as Asthma, Breast Cancer, COPD, Diabetes, Heart Disease, and Migraine. Members with chronic conditions are encouraged by case managers to enroll in local Living Well with Chronic Conditions programs which are offered through the Mid Columbia Council of Governments. Living Well with Chronic Conditions (the Chronic Disease Self-Management Program or CDSMP) is a six-week workshop that provides tools for living a healthy life with chronic health conditions, including diabetes, arthritis, asthma and heart disease. Through weekly sessions, the workshop provides support for continuing normal daily activities and dealing with the emotions that chronic conditions may bring about. Additionally, the Center for Mind-Body Medicine at MCMC offers Cardiac Rehabilitation, Medical Symptom Reduction, Pulmonary Health and Living Healthy With Diabetes, and integrative alternative therapies such as acupuncture, yoga, tai-chi, and massage.

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

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

In addition, PSCS has a weekly Integrated Care Management meeting (ICM). The ICM meeting is designed as a collaborative effort to address gaps in care and bring community partners and resources together to bring the appropriate care and utilization of health services. A care plan is then initiated and the case manager, care coordinator, pharmacist and/or behavioral health

specialist works with the PCPs office, member and community partners such as the brokerage, transportation office, disability offices, member's state case worker, specialist's office, home health provider to develop a targeted, consistent approach. Once the member or member's representative is successfully engaged, the member is transitioned from the ICM workgroup to ongoing assessment and coordination with their nurse case manager. Six months after discharge from the ICM group, the member's prospective risk score is re-assessed and brought back to the ICM group if thresholds are again met.

Examples of Success with ICM:

1. Member had a stroke and had to be revived. Member had severe eye damage. Member had to move into a healthcare facility due to physical limitations. At first contact, member was very depressed and was unaware of available resources and having a very difficult time navigating the system. Between the ENCC Transitional Care Coordinators and the Nurse Case Manager, working with the member, the member has been connected with several resources. Member complex issues were discussed in a weekly ICM meeting. Member was given American Blind Association information where member can order free books, other media choices and have access to other resources. PSCS worked with member and found providers in closer proximity to member. Member has been connected with a mental health (MH) provider. Member has been given information on how to obtain much needed dentures (nutrition issue) with this dental plan. Member has been given several other resources including transportation information.
2. When a member called Grievance and Appeals, staff referred the member to PSCS Care Coordinators. Upon calling the member, the Care Coordinator learned that member had been told the other pain clinic in town had a three month wait before next appointment. Knowing it was a Monday and member only had 2 more days of pain medications available, member was very frustrated and "ready to give up on insurance and doctors all together". Member was bed ridden after a failed back surgery and needed assistance with all ADL's. After Care Coordinator discussed with other staff, it was realized there was a pain clinic in town that was currently going through the credentialing process, but was not yet contracted. After calling and making arrangements, PSCS Care Coordinator was able to approve visits to the out-of-network provider to get the member the care needed. Member had an appointment that Friday morning which was four days out. Staff called and followed up that next Tuesday and member is able to move around and able to start caring for self and doing all ADL's independently.

C.2.3.f PSCS has policies and procedures to ensure a continuity of care system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations.

Care Coordination services may be requested by the member, the member's representative, physician, other medical personnel serving the member, or the member's agency case manager.

Care coordination will be identified through wellness survey scoring as well as prospective risk scores generated by our claims analysis software, Ingenix & Thomson Reuters. Interpreter Services (including sign language) are covered for doctor visits for members who do not speak English or have a hearing impairment. These services are available by phone or in person.

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

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

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

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

PSCS tracks and documents all referrals and prior authorizations. PSCS contracts with PhTech for administrative services including authorization and referral tracking and claims payment. Daily reports are sent with the total number of authorizations and referrals which includes the date the request was received. This process ensures requests will be received and processed according to regulatory timelines with completion of notice requirements established by DMAP and DCBS. Authorization criteria are based on OHP benefits and guidelines and evidence based

tools such as American College of Radiology (ACR) appropriateness criteria, Milliman, and Hayes Health Technology. Other references used in the process are Medicare criteria and guidelines and in-panel and out-of-panel physician specialty consultants and industry best practices. Clinical staff conducts medical review under the direction of the Medical Director. The Medical Services staff documents all authorizations and referrals in a software application called CIM, which is provided by PhTech. All prior authorizations and referrals are maintained in this application and available for providers and nurse case managers to review to ensure care coordination and reduce duplication of services. The Medical Services management receives a daily report with the total number of authorizations and referrals which includes the date the request was received. This allows them to ensure requests will be received and processed according to regulatory timelines and notice requirements established by the Oregon Health Authority. Timeliness for completion of prior authorization requests is reviewed monthly by Corporate Quality Assurance and periodically by Internal Audit. If internal review demonstrates prior authorization timelines are outside established guidelines, the manager of Health Services is notified and an action plan for correction is developed. This report is reviewed by the Medical Director once completed.

APPENDIX D – Medicare/Medicaid Alignment Questionnaire

Section 2 - Ability to Serve Dually Eligible Individuals

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

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

Appendix H: Transformation Scope Elements

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

For example:

- The Governance of PSCS CCO in the Columbia Gorge Region is currently being developed. As such, PSCS is specifically named as the Applicant for this application process. There is a desire by the community that more accountability be shared in the near term. PSCS and its community partners would like to have the opportunity to work with OHA to allow this evolution to be reflected in our contract as the discussion becomes more concrete and final.
- There are current rules and requirements in the system that need to be evaluated as CCOs are implemented such as the ISSRs. For example, the ISSRs as they are currently stated are not realistically applicable to current PCPCH models. As such, one area that PSCS and its community partners would like to see included in a Core Contract is some relief if possible from the ISSRs in specific parts of the system where the ISSRs may not be realistic in practice. This will have to be done in collaboration with the CCOs and OHA to ensure that both parties are able to maintain compliance with what requirements they may have.
- At the submission of this application, the CCO Rules are still temporary and PSCS and its community partners would not know what to address in terms of requests for flexibility in relation to local solutions.

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