**FamilyCare**

Incorporated

# FamilyCare Coordinated Care Organization Application
# Appendix B – Provider Participation and Operations Questionnaire

## SECTION 1 – SERVICE AREA AND CAPACITY

| Service Area Table | | | |
|---|---|---|---|
| Service Area Description | | Zip Codes | Maximum Number of Members - Capacity Level |
| Tri-County | Clackamas | All Clackamas Zip Codes plus 97032, 97071, 97362, 97375, 97002, and 97381 from Marion County | 50,500 |
| Tri-County | Multnomah | All Multnomah County Zip Codes | 120,000 |
| Tri-County | Washington | All Washington County Zip Codes | 60,000 |
| | | Tri-County Total | 230,500 |

## SECTION 2 – STANDARDS RELATED TO PROVIDER PARTICIPATION

### Standard #1 – Provision of Coordinated Care Services

FamilyCare has a comprehensive provider network that currently provides services for our FCHP, MHO and AMHI contracts. We routinely evaluate our network to assure it is meeting the needs of our Members and providers. We are in the process of reevaluating and establishing contracts necessary to ensure we have all the providers and services necessary to fully implement the CCO, including new providers such as Dental Care Organizations to provide dental services. As discussed in Appendix A, FamilyCare will use community health assessments to evaluate the adequacy of our provider network.

Table B-1 is submitted with this application as a draft to show current network adequacy. FamilyCare intends to submit an amended Table B-1 at the Readiness Review, including expanded information on providers who treat Members with special health needs and workforce development with respect to non-traditional providers, such as community health workers.

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

See Standard #1 response above.

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

| Publically Funded Health Care and Service Programs Table | | | |
|---|---|---|---|
| Name of publicly funded program | Type of public program (i.e. County Mental Health Department) | County in which program provides service | Specialty/Sub-Specialty Codes |
| Central City Concern, Inc | FQHC | Multnomah | 15 - FQHC 097 - Federal Qualified Health Cntr (FQHC) |
| Clackamas County Community Health, including School Based Health Centers | FQHC | Clackamas | 15 - FQHC 097 - Federal Qualified Health Cntr (FQHC) |
| Legacy St. Helens Clinic | RHC | Columbia | 14 - Rural Health Clinic 095 - Rural Health |

| | | | 15 - FQHC<br>084 - FQHC - Public<br>Health, State or Local<br>097 - Federal Qualified<br>Health Cntr (FQHC) |
|---|---|---|---|
| Multnomah County Health Department, including School Based Health Centers | FQHC | Multnomah | 15 - FQHC<br>084 - FQHC - Public<br>Health, State or Local<br>097 - Federal Qualified<br>Health Cntr (FQHC) |
| NARA of the Northwest | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified<br>Health Cntr (FQHC) |
| Outside In (contracting in process) | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified<br>Health Cntr (FQHC) |
| Virginia Garcia- Cornelius | FQHC | Washington | 15 - FQHC<br>097 - Federal Qualified<br>Health Cntr (FQHC) |
| Yakima Valley Farm Workers Clinic | FQHC | Multnomah, Umatilla | 15 - FQHC<br>097 - Federal Qualified<br>Health Cntr (FQHC) |

a) FamilyCare includes publicly funded providers on our panel and has identified opportunities to enhance existing services and relationships, along with areas where greater collaboration is needed. We have included publically funded providers at our CCO stakeholder meetings and have received their input to complete this application.

b) FamilyCare is in the process of negotiating agreements with counties within our service areas to establish MOUs or written agreements that satisfy ORS 414.153(4) in areas where we do not have current agreements. These agreements will be finalized to the extent possible by the Readiness Review and will describe the authorization and payment parameters necessary to maintain the mental health safety net system.

c) As mentioned above, we are currently in negotiations to obtain agreements with counties.

**Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)**
FamilyCare understands potential cultural and language barriers that Members may experience and we strive to support a Member's choice of provider based on cultural preferences by asking our Members if they want their care delivered based on their culture. FamilyCare includes providers on our panel who are aware of and sensitive to AI/AN culture and coordinates services with these providers for Members who seek culturally relevant care. We have detailed this relationship in Appendix A.

**Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities**
The referral process is the same for all FamilyCare providers. The Indian Health Services (IHS) or Tribal 638 facilities submit the prior authorization request to the Referrals and Authorizations department via FamilyCare's website or by fax. The request is reviewed based on established business rules and the provider receives a response back from FamilyCare via fax.

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

a) As a Mental Health Managed Care Organization since 1997, FamilyCare has a fully operational Integrated Service Array (ISA) Program to meet the needs of children and adolescents with severe mental or emotional disorders. FamilyCare has an extensive system of service providers who offer a range of intensive services including: inpatient psychiatric hospitalization, sub-acute care, crisis intervention/hospital diversion, psychiatric residential treatment services psychiatric day treatment services, intensive community based/in-home services and respite. An established Level of Services Intensity Process allows for quick access to the ISA from multiple points-of-entry. FamilyCare has multiple child and family Service Coordinators, who actively provide intensive care coordination to ensure that all service components are individualized, comprehensive, coordinated, culturally competent, flexible, family-focused and child-centered. Coordinated care across systems and providers is integrated to ensure that children and adolescents are served in the most natural, least restrictive environment possible to sustain connections to home, school and the community.

b) FamilyCare has established strong collaborative relationships with all of the system partners serving the needs of children and their families. On a community level, FamilyCare has partnered with community providers and other systems of care, such as through participation in the Multnomah County Children's Advisory Council, to address system issues/needs. FamilyCare's ISA Program utilizes intensive care coordination to ensure services are coordinated through regular child and family team meetings that include representatives from each of the child serving agencies involved in providing services to a child and their family.

c) FamilyCare has created an intensive care coordination and service delivery system that incorporates the System of Care Values and the collaborative principles and practices that closely resemble the ten principles of the wrap-around process in every aspect of planning, implementation and service delivery. Providers are selected based on their ability to meet the needs of our children and adolescents and deliver care that is are family-focused and child-centered, community- and team-based, culturally competent, individualized, strengths-based, flexible, collaborative and inclusive of natural supports. Intensive care coordinators work directly with families to identify individual needs and to create a coordinated plan of care that emphasizes the child and family's strengths in the least restrictive environment.

### Standard #7A – Mental Illness Services

a) FamilyCare has an established array of mental health providers who are skilled in the delivery of community-based services. We have a mental health coordinator assigned to facilitate the needs of our Members who are receiving home- and community-based services in residential care. Our mental health coordinators work closely with our Service Coordination staff to ensure the physical health concerns of our Members are also addressed.

b) FamilyCare routinely screens all Members through the use of our Health Risk Assessment. We closely monitor utilization of services and intervene with Members who are over-utilizing services. We discuss the screening process in Appendix A.

### Standard #7B – Chemical Dependency Services

a) We have engaged a comprehensive array of chemical dependency providers to provide services for our Members. As an integrated plan, we have experience in coordinating the mental health, physical health and chemical dependency needs of our Members in the community and in residential settings.

b) FamilyCare routinely screens all Members through the use of our Health Risk Assessment. We closely monitor utilization of services and intervene with members who are over-utilizing services. We discuss the screening process in Appendix A.

### Standard #8 – Pharmacy Services and Medication Management

a) FamilyCare provides a prescription drug benefit that is driven by the company's value that evidence-based information and education empower both the patient and provider to make responsible healthcare decisions. Supported by the services of our Pharmacy Benefits Manager (PBM) CVS Caremark, and overseen by the FamilyCare Pharmacy and Therapy (P&T) Committee, FamilyCare's in-house pharmacy department manages an accessible, effective and fiscally responsible pharmacy benefit through formulary development, utilization management, Prioritized List adherence, pharmacy network access, pharmacy claims adjudication and timely reimbursement and member and provider support.

b) FamilyCare uses a formulary of preferred medications, which is reviewed and approved by the FamilyCare P&T Committee. A non-preferred or non-formulary medication may be requested through a prior authorization process and an exception may be granted if it is determined the requested drug is medically necessary.

The role and responsibilities of the FamilyCare P&T Committee include, but are not limited to, developing and reviewing FamilyCare's formulary; basing its clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data and other such information as it determines appropriate; approving inclusion or exclusion of the

therapeutic classes in the formulary; reviewing policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, generic substitution, and therapeutic interchange; and reviewing and approving all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions.

In addition to the role and responsibilities of the FamilyCare P&T Committee concerning utilization management, FamilyCare's pharmacist and PBM provide concurrent and retrospective review of utilization trends to determine appropriate utilization management of prescribed medications including, but not limited to, compliance monitoring to improve adherence/persistence with appropriate medication regimens, monitoring procedures of over-utilization through multiple prescribers or multiple pharmacies, medication error identification and reduction, and screening for potential medication therapy problems due to therapeutic duplication, interactions and/or contraindications.

The FamilyCare P&T Committee, which is comprised of physicians and pharmacists practicing in Oregon and responsible for developing and approving the formulary, meets at least quarterly to review the formulary. As mentioned above, the P&T Committee bases its clinical decisions on the strength of scientific evidence and standards of practice as it determines appropriate.

c) Through our PBM CVS Caremark, FamilyCare provides a contracted national pharmacy network consisting of retail, mail order, home infusion, long-term care (LTC), specialty and I/T/U (Indian tribe, tribal organization and urban Indian organization) pharmacies sufficient to provide convenient access to Members living in urban, suburban and rural areas. The formulary choices and changes are communicated to Members, providers and pharmacy network via Member materials, postings on the FamilyCare website, Member and provider notification letters and/or point-of-sale pharmacy messaging. A form to request a prior authorization, including an exception for a non-formulary medication, is available on FamilyCare's website and may be requested from FamilyCare via phone, mail, fax or email by a Member or prescribing provider. The request will be submitted to FamilyCare who will work with a Member's provider(s) to obtain the necessary information. The Member and provider will be notified of the decision, and the Member will be provided with his/her rights and responsibilities to an appeal as applicable.

d) As FamilyCare's PBM, CVS Caremark has established integrated accumulations connectivity, communicating in real-time or in batch mode. CVS Caremark prefers real-time connection for processing integrated accumulations. CVS Caremark works with industry-leading debit card providers, CDH organizations, health plans, and third party administrators to support stand-alone pharmacy and integrated medical and pharmacy consumer-directed health plans. Its adjudication engine has the capability to process COB claims at point-of-sale real time as long as the pharmacy submits the correct "other" coverage indicator.

e) FamilyCare uses an in-house staff of pharmacy technicians, pharmacist and physicians to process pharmacy prior authorizations (PA). PAs are received 24 hours a day, seven days a week and are reviewed during the normal hours of operation of Monday through Friday, 8am to 5pm. Urgent requests are reviewed within 24 hours, including on weekends.

## F) **THIS SECTION IS CONFIDENTIAL AND EXEMPT FROM DISCLOSURE**

**Standard #9 – Hospital Services**

a) FamilyCare currently has contracts with two major hospital systems in the Tri-County area (Legacy Health System and Providence Health System) and is in the process of establishing agreements with other hospitals. All services, except highly specialized services that require out-of-state care, are available. Having multiple contracts supports providers' and Members' ability to choose where care is provided and received. Our referrals and authorizations processes require providers to treat their Medicaid populations equally in relation to access, duration and scope of services provided.

b) Our Service Coordination, Care Management and Network Services Teams play a key role in educating Members and providers on appropriate use of ambulance, emergency room and urgent care services. By working closely with Members and providers, our Service Coordinators support and influence the appropriate use of these services. Our Utilization Management Team, along with our Medical Directors, monitors and reviews utilization patterns and works closely with our Service Coordinators when concerns about inappropriate use arise. When this happens, discussion with the Member or his/her provider(s) occurs to address the concern and work together to identify ways to encourage appropriate use of these services. In many cases, FamilyCare has access to providers' EMRs to help us perform this work. Our Network Services Team handles provider relations and contracting, and they are involved in working with our hospitals and health systems to develop and support processes that encourage appropriate utilization. Providing access to Member data for use by emergency room navigators so that they can intervene, when medically appropriate, by redirecting our Members to Primary Care is one example of this collaboration.

c) Our agreements stipulate that hospitals and health systems will not be reimbursed for Adverse Events or Hospital Acquired Conditions (HACs). Our Utilization Management Team, working closely with our Medical Directors, reviews hospital care closely to identify Provider Preventable Conditions and initiates follow-up as needed.

d) Readmissions are identified and monitored by our Care Management and Utilization Management teams. Those that occur within 7 and within 30 days of the date of the first admission are reviewed by the Medical Directors to determine if the nature of the illness resulted in a readmission that was not preventable or if further investigation related to quality of care is indicated. If there was a potential preventable reason for the readmission, we address our concern collaboratively with the providers/facilities involved in the care.

e) FamilyCare will employ innovative strategies to decrease and prevent unnecessary hospital utilization, including but not limited to:
- Contracting with Ambulatory Surgical Centers (ASCs) to provide appropriate outpatient surgical care.

- Using alternative addictions/mental health facilities (residential care, transitional care) to prevent hospitalizations.
- Supporting the PCPCH through contract incentives, e.g. incent primary care access and coordination of care to monitor and control chronic conditions.
- Utilizing our Service Coordination and Care Management Programs to coordinate effective transition from inpatient setting back to PCP with the aim to reduce readmissions to the hospital, ER visits, etc.
- Assuring adult Members diagnosed with COPD, CHF and children diagnosed with asthma are managed effectively.
- Contracting with hospital diversion services to divert inpatient psychiatric stays for children and adults.
- Developing community-based in-home mental health and addiction services.
- Paying for inpatient hospital services on a capitated basis.

## SECTION 3 – ASSURANCES OF COMPLIANCE WITH MEDICAID

### Medicaid Assurance #1 - Emergency and Urgent Care Services
FamilyCare has established mechanisms to assure Members have access to emergency and urgent services 24-hour/7-days per week.  Specific service expectations of participating providers are:
- Emergency medical services - service is provided within two hours or less of presentation of symptoms to the provider/practitioner.  Immediate evaluation or triage to Emergency Department.
- Urgent care services – service is provided within 24 hours for physical health and 48 hours for mental health.
- Arrange for an answering system after office hours that Members can access through the usual office protocol.
- Response to emergency phone calls should be within thirty (30) minutes.
- Response to urgent phone calls should be within one (1) hour for physical health and thirty (30) minutes for behavioral health.
- Provide 24-hour physician coverage through another FamilyCare Participating Provider to ensure the urgent and emergency needs of members can be met 24-hours per day, 7-days per week.

Communication/Monitoring for Providers (this is for all Medicaid Assurances listed below):
FamilyCare will produce communications to providers, throughout each contract year, that are designed to communicate policies, procedures and other information required by state and federal law and rules.  The information will be communicated in writing via direct mail, email, website or web portal postings, handouts at provider office visits, provider newsletters or reference manual or workshops.  FamilyCare's auditing program is designed to identify issues and educate our providers as appropriate. The audit process is performed on a routine and scheduled basis for contracted primary care providers and high use specialists.

### Medicaid Assurance #2 - Continuity of Care
Coordination of Care
FamilyCare has established policies to ensure a system for coordination of care. The care coordination process includes identification, stratification, assessment, planning, implementation, monitoring and evaluation of options and services from multiple sources in accord with the multidisciplinary health care team. Service Coordinators perform functions, which includes but are not limited to:
- Reviewing of inpatient admissions for initial and follow-up assessments;
- Ensuring quality, cost effective care in the appropriate care setting;
- Evaluating medical histories and work with providers to ensure that a care plan with treatment goals exists;
- Providing psychological/emotional and educational support to Members;
- Facilitating and coordinate health care services for Members;
- Interpreting benefit coverage for Members and identify non-covered benefits;
- Assisting providers with innovative/alternative care options;

- Coordinating authorizations; and,
- Working with facility discharge planners to assess, plan and implement discharge needs, and ensuring health care services are arranged for day of discharge.

Referral and Authorization
FamilyCare has policies and procedures to ensure timely organization determinations regarding the benefits a Member is entitled to receive. These determinations are made using FamilyCare guidelines, nationally accepted Milliman criteria for medical necessity, and community standards of practice. Any co-morbid conditions are considered along with specific plan benefit guidelines. All information regarding determinations is maintained in the Medical Management system.

**Medicaid Assurance #3 - Medical Record Keeping**
FamilyCare has internal policies and procedures to ensure medical records will be treated as confidential to comply with all state and federal laws and the Health Insurance Portability Accountability Act (HIPAA) regarding privacy, confidentiality and disclosure of patient/Member medical records. FamilyCare requires contracted provider facilities and offices to have established procedures to:
- Safeguard the privacy of any information that identifies a patient/Member.
- Ensure information from, or copies of, medical records may be released only to authorized individuals. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.
- Maintain the medical records and information in an accurate and timely manner.
- Ensure timely access by a Member to the medical records and the information that pertain to the Member.

**Medicaid Assurance #4 - Quality Improvement**
FamilyCare has policies and procedures to ensure that Performance Improvement Projects (PIPs) and Quality Assessment and Performance Improvement projects (QAPIs) are conducted under the organization's Medical Management program to address and achieve improvement in major focal areas of clinical care and non-clinical services. FamilyCare will demonstrate that its interventions result in measurable improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each PIP or QAPI project. The Quality Management Committee with input from the Addictions and Mental Health Quality Management Committee and under the authority of the FamilyCare BOD oversees the selection, interventions and review of the PIPs and clinical QAPIs.

**Medicaid Assurance #5 – Accessibility**
FamilyCare will not discriminate between Members and non-Members subject to definition of Coordinated Care Services and identification of benefits to which they would be entitled through CCO.

**Medicaid Assurance #6 - Grievance System**
FamilyCare has policies and procedures that provide a mechanism for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives. FamilyCare's policies meet or exceed the filing and response timing guidelines in accordance with OAR 410-141-3260 through 410-141-3266, and 42 CFR 438.400 through 438.424.

**Medicaid Assurance #7 - Potential Member Informational Requirements**
FamilyCare handbooks and provider directories are available by request to potential Members. In order to best serve our Member population, FamilyCare provides informational material in Spanish, Braille, Russian, Vietnamese, Large Print and Audio. FamilyCare will also provide verbal translation of written materials.

**Medicaid Assurance #8 - Member Education**
FamilyCare will ensure that all new Members receive their Member Handbook within 14 days of the plan's notification of the enrollment. FamilyCare offers orientation to new Members through our regular distribution of a Member Handbook and supplemental health education material. Members will also receive a welcome call through our Customer Service team to proactively provide assistance with orientation questions or PCP assignments. Members may also receive an orientation call from our Health Services team using our Health Risk

Assessment tool or offering assistance with our maternity program, as applicable.

**Medicaid Assurance #9 - Member Rights and Responsibilities**
FamilyCare will inform Members of their rights and responsibilities through the Member Handbook for FamilyCare OHP Members and the Evidence of Coverage (EOC) for Medicare Members. Members receive the Handbook or EOC when they enroll in FamilyCare, or upon request. The Member Handbook and EOC are also available on our website. FamilyCare respects and abides by a Member's rights and ensures all services are provided in a culturally competent manner and are accessible to diverse ethnic backgrounds. FamilyCare does not discriminate in the provision of health care services on the basis of race, color, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin.

**Medicaid Assurance #10 - Intensive Care Coordination**
FamilyCare will provide Intensive Care Coordination services as needed to Members who are aged, blind or disabled as well as children with special health care needs and children in the Oregon Youth Authority. These services will be coordinated with, but not limited to, Members, Agency Case Managers, PCP's and community partners and will be provided to ensure that dignity, confidentiality, and specific disability issues related to Members' medical, social, and quality of life issues are respected and considered.

**Medicaid Assurance #11 - Billing and Payment Standard**
FamilyCare will process Medicaid claims consistent with the requirements set forth in the CCO contract. In addition, FamilyCare may use the following guidelines:
- FamilyCare covers all Covered Services consistent with medical management policies.
- FamilyCare pays allowable rates unless specified differently in FamilyCare Benefits or Contracts.
- Payments will not be made to any provider who does not have a DMAP identification or who has been excluded as Medicare/Medicaid providers by another state or CMS.
- When appropriate, FamilyCare will identify payers that are primary to Medicaid prior to adjudicating the claim.
- Coordination of Benefits between primary and secondary payers will be processed according to the Coordination of Benefits policy and procedure and consistent with Third Party Recovery policy and procedure.
- Claims will be processed according to the Timely Filing policy and procedure (90% of valid claims will be paid or denied within 45 calendar days of receipt).
- Ongoing monitoring is done to ensure timely payment at all times.

All of FamilyCare's provider contracts contain language regarding not holding Members responsible for provider's debt if the entity becomes insolvent.

**Medicaid Assurance #12 - Trading Partner Standard**
Trading Partner Agreement is on file and was signed on 12/14/07. Testing has been completed and appropriate monitoring systems are in place.

**Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services**
FamilyCare has established mechanisms to capture, validate and report encounter data that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. FamilyCare has monitoring systems in place and regularly reviews the operations of these systems.

**Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard**
FamilyCare currently monitors and validates enrollments and disenrollments via MMIS and 834 transactions. FamilyCare also follows the CMS Managed Care Guidelines for confirming or rejecting enrollment and disenrollment via the CMS Transaction Reply Report (TRR). Discrepancies are submitted to the state on a monthly basis.

**FamilyCare**
Incorporated

## ATTACHMENT 1 – Application
### Cover Sheet

### Applicant Information –
### RFA # 3402

ApplicantName:  FamilyCare, Inc.

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

State of domicile: Oregon

Primary Contact Person: Dayna Steringer  Title: Dir. Government Affairs

Address:                                    825    NE    Multnomah,    Suite    300

City,State,Zip:                                    Portland,          OR          97232

Telephone:    503-345-5757                                  Fax:

E-mail Address: daynas@familycareinc.org

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

Name:      Jeff Heatherington     Title:    President, CEO

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

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

7. If awarded a Contract, Applicant will be required to complete, and will be bound by, a Contract described in this RFA. Applicant agrees to the Core Contract terms and conditions in Appendix G, except to the extent Applicant has timely requested a change or clarification or filed a protest in accordance with the RFA.

8. If awarded a Contract, Applicant will meet the highest standards prevalent among Medicaid health plans in Oregon.

9. Applicant and its Affiliates complied with the Code of Conduct in Section 7.15 of the RFA in connection with the RFA.

10. Applicant accepts the terms and conditions for OHA's web portal, as posted on the web portal.

11. Applicant will negotiate in good faith regarding the statement of work for the Contract.

Signature: _____ Title: _President_ Date: _4-30-12_
(Authorized to Bind Applicant)

# ATTACHMENT 6 – ATTESTATIONS, ASSURANCES AND REPRESENTATIONS

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

| Attestation | Yes | No | Yes, Qualified | Explanation if No or Qualified |
|---|---|---|---|---|
| **Attestation A-2.** Applicant will participate in the learning collaboratives required by ORS 442.210. | X | | | |
| **Attestation A-3.** Applicant will collect, maintain and analyze race, ethnicity, and primary language data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities. | | | X | Subject to FamilyCare receiving data that identifies race, ethnicity and primary language |

## Attestations for Appendix B – Provider Participation and Operations Questionnaire

| Attestation | Yes | No | Yes, Qualified | Explanation if No or Qualified |
|---|---|---|---|---|
| **Attestation B-1.** Applicant will, as demonstrated with policies and procedures, (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse providers for dispensing a 72-hour supply of a drug that requires prior authorization in accordance with OAR 410-141-0070. | X | | | |
| **Attestation B-2.** Applicant will comply with all applicable provider requirements of Medicaid law under 42 CFR Part 438, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. | X | | | |
| **Attestation B-3.** Applicant will assure that all provider and supplier contracts or agreements contain the required contract provisions that are described in the Contract. | X | | | |
| **Attestation B-4.** Applicant will have executed provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested service area. | X | | | |
| **Attestation B-5.** Applicant will have all provider contracts or agreements available upon request. | X | | | |

| Attestation | Yes | No | Yes, Qualified | Explanation if No or Qualified |
|---|---|---|---|---|
| **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. | X | | | |
| **Attestation B-7.** Applicant's contracts for administrative and management services will contain the OHA required contract provisions. | X | | | |
| **Attestation B-8.** Applicant will establish, maintain, and monitor the performance of a comprehensive network of providers to assure sufficient access to Medicaid Covered Services as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO. Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines. | X | | | |
| **Attestation B-9.** Applicant will have executed written agreements with providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines. | X | | | |
| **Attestation B-10.** Applicant, through its contracted or deemed Participating Provider network, along with other specialists outside the network, community resources or social services within the CCO's service area, will provide ongoing primary care and specialty care as needed and guarantee the continuity of care and the integration of services through:<br>• Prompt, convenient, and appropriate access to Covered Services by enrollees 24 hours a day, 7 days a week;<br>• The coordination of the individual care needs of enrollees in accordance with policies and procedures as established by the Applicant;<br>• Enrollee involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;<br>• Effectively addressing and overcoming barriers to enrollee compliance with prescribed treatments and regimens; and<br>• Addressing diverse patient populations in a culturally competent manner. | X | | | |
| **Attestation B-11.** Applicant will establish policies, procedures, and standards that:<br>• Assure and facilitate the availability, convenient, and timely access to all | X | | | |

Attachment 6 – Attestations, Assurances and Representations

| Attestation | Yes | No | Yes, Qualified | Explanation if No or Qualified |
|---|---|---|---|---|
| Medicaid Covered Services as well as any supplemental services offered by the CCO, <br>• Ensure access to medically necessary care and the development of medically necessary individualized care plans for enrollees; <br>• Promptly and efficiently coordinate and facilitate access to clinical information by all providers involved in delivering the individualized care plan of the enrollee; <br>• Communicate and enforce compliance by providers with medical necessity determinations; and <br>• 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. | | | | |
| **Attestation B-12.** Applicant will have verified that contracted providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified providers in the future. | X | | | |
| **Attestation B-13.** Applicant will provide all services covered by Medicaid and comply with OHA coverage determinations. | X | | | |
| **Attestation B-14.** Applicant, Applicant staff and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities), and subcontractor staff will be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration. Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its affiliated companies, subsidiaries or subcontractors (first tier, downstream, and related entities). | X | | | |
| **Attestation B-15.** Neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation if applicable) or its subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. | X | | | |

## Medicaid Assurances for Appendix B – Provider Participation and Operations Questionnaire

| | | | |
|---|---|---|---|
| **Assurance B-1.** Emergency and Urgent Care Services. Applicant will have written policies and procedures and monitoring systems that provide for emergency and urgent services for all Members on a 24-hour, 7-days-a- week basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. (See 42 CFR 438.114 and OAR 410-141-3140] | X | | |
| **Assurance B-2.** Continuity of Care. Applicant will have written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all referrals and prior authorizations to other providers. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3160] | X | | |
| **Assurance B-3.** Applicant will have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIP'AA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's primary care and referral providers. Applicants will communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance. Applicants will document all monitoring and Corrective Action activities. Such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law. [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180] | X | | |
| **Assurance B-4.** Applicant will have an ongoing quality performance improvement program for the services it furnishes to its Members. The program will include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are | | X | Subject to FamilyCare receiving data that identifies race, ethnicity and primary language |

expected to have a favorable effect on health outcomes and Member satisfaction. The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.200 and 438.240; OAR 410-141-0200]

| | | | |
|---|---|---|---|
| **Assurance B-5.** Applicant will make Coordinated Care Services accessible to enrolled Members. The Applicant will not discriminate between Members and non-Members as it relates to benefits to which they are both entitled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220] | X | | Subject to definition of Coordinated Care Services and identification of benefits |
| **Assurance B-6.** Applicant will have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix G "Core Contract". The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.228, 438.400 – 438.424; and OAR 410-141-3260 to 410-141-3266] | X | | |
| **Assurance B-7.** Applicant will develop and distribute informational materials to potential Members that meet the language and alternative format requirements of potential Members. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; OAR 410-141-3280] | X | | |
| **Assurance B-8.** Applicant will have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant, Member handbook, health education, availability of intensive care coordination for Members who are aged, blind and/or disabled and appropriate use of emergency facilities and urgent care. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.10; and OAR 410-141-3300] | X | | |

| | X | |
|---|---|---|

**Assurance B-9.** Applicant will have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Attachment 4, Core Contract. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.100,

| | X | |
|---|---|---|

**Assurance B-10.** Applicants will provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.208 and OAR 410-141-3405]

| | X | |
|---|---|---|

**Assurance B-11.** Applicant will maintain an efficient and accurate billing and payment process based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant and its providers will not hold Members responsible for the Applicants or providers debt if the entity becomes insolvent. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 447.46 and OAR 410-141-0420]

| | X | |
|---|---|---|

**Assurance B-12.** Applicant will participate as a trading partner of the OHA in order to timely and accurately conduct electronic transactions in accordance with the HIPAA electronic transactions and security standards. Applicant has executed necessary trading partner agreements and conducted business-to-business testing that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 45 CFR Part 162; OAR 943-120-0100 to 943-120-0200]

| | | | |
|---|---|---|---|
| **Assurance B-13.** Applicant will maintain an efficient and accurate system for capturing encounter data, timely reporting the encounter data to OHA, and validating that encounter data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242; and the Contract] | X | | |
| **Assurance B-14.** Applicant will maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides. The Applicant will have monitoring systems in operation and review the operations of these systems on a regular basis. The Applicant will communicate these policies and procedures to providers, regularly monitor providers' compliance and take any Corrective Action necessary to ensure provider compliance. [See 42 CFR 438.242 and 438.604; and Contract] | X | | |

# Informational Representations for Appendix B – Provider Participation and Operations Questionnaire

| Informational Representation | Yes | No | Yes Qualified | Explanation |
|---|---|---|---|---|
| **Representation B-1.** Applicant will have contracts with related entities, contractors and subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract. | X | | | |
| **Representation B-2.** Applicant has an administrative or management contract with a delegated entity to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program. | | X | | |
| **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 information technology to operate the CCO program for Applicant. | | | X | Subject to definition of "systems or information technology" |
| **Representation B-4.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the claims administration, processing and/or adjudication functions. | | | X | Beginning 5/1/12 there will be a portion of the Claims Administrative functions delegated |
| **Representation B-5.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Enrollment, Disenrollment and membership functions. | | X | | |
| **Representation B-6.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the credentialing functions. | X | | | |
| **Representation B-7.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the utilization operations management. | | | X | Our PBM, CVSCaremark, provides utilization reports |
| **Representation B-8.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the Quality Improvement operations. | | X | | |
| **Representation B-9.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of its call center operations. | | | X | We have contracts with our PBM and Verity to provide after-hours/weekends call service |
| **Representation B-10.** Applicant will have an administrative or management contract with a delegated entity to perform all or a portion of the financial services. | | | X | Subject to definition |

| 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. | | | X | Subject to definition of "other services" |

(Applicant Authorized Officer)
Signature: _____          Title: Chief Operating Officer

Date: April 25th, 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** |
|---|---|---|
| X | a. | Application Cover Sheet (Attachment 1) |
| X | b. | Attestations, Assurances and Representations (Attachment 6). |
| X | c. | This Technical Application Checklist |
| X | d. | Letters of Support from Key Community Stakeholders. |
| X | e. | Résumés for Key Leadership Personnel. |
| X | f. | Organizational Chart. |
| X | g. | Services Area Request (Appendix B).(see Service Area Table) |
|   | h. | Questionnaires |
| X |  | (1) CCO Criteria Questionnaire (Appendix A). |
| X |  | (2) Provider Participation and Operations Questionnaire (Appendix B). |
| X |  | (3) Accountability Questionnaire (Appendix C) |
| X |  | • Services Area Table. |
| X |  | • Publicly Funded Health Care and Service Programs Table |
| ❏ |  | (4) Medicare/Medicaid Alignment Demonstration Questionnaire (Appendix D).[1] |

### 2. Technical Application, Optional Submission Materials

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

| ❏ | a. | Transformation Scope Elements (Appendix H). |
|---|---|---|

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

| X | b. | Applicant's Designation of Confidential Materials (Attachment 2). |

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

**APPENDIX E**

☐ a. Certified copy of the Applicant's articles of incorporation.

☐ b. Listing of ownership or sponsorship.

☐ c. Chart or listing presenting the identities of and interrelationships between the parent, 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

March 26, 2012

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

Dear Ms. Hurst,

Access Dental Plan, LLC supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care providers in Multnomah, Washington, and Clackamas counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

Since its inception, FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to provide their members with vertically and horizontally integrated health services that are built on coordination, quality and comprehensive continuous effort to monitor and improve patient safety and the performance of all care and services provided. We plan to continue to work with FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration among providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

We have worked with FamilyCare for over three years, since the inception of Access Dental Plan and our OHP contracting relationship with DMAP. We provide dental services to Oregon's vulnerable Medicaid population, and through our collaborative working relationship with FamilyCare, together we have established positive dental outcomes for our joint membership in Multnomah, Washington, and Clackamas counties.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Sincerely,

Kevin W. Boie
Chief Financial Officer

# Capitol Dental Care, Inc.

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

April 14, 2012

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

Dear Ms. Hurst,

Capitol Dental Care, Inc. supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care providers in Multnomah, Clackamas, Washington, Umatilla, Hood River, Wasco, Clatsop, Columbia, Tillamook and Yamhill Counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

Since its inception, FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to provide their members with vertically and horizontally integrated health services that are built on coordination, quality and comprehensive continuous effort to monitor and improve patient safety and the performance of all care and services provided. We plan to continue to work with FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration among providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

Capitol Dental has worked with FamilyCare for many years. Our pervious Dental Director participated in their Board and we have provided dental education materials and supplies for FamilyCare sponsored events. We have provided dental care services to the Oregon Health Plan since its inception.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Sincerely,

William Hart Laws
President

April 24, 2012

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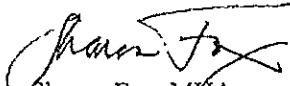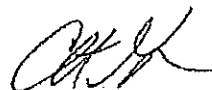Salem, Oregon 97301

Dear Ms. Hurst,

The Children's Health Alliance supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care providers in Multnomah, Clackamas, and Washington counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

Since its inception, FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. We plan to continue to work with FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration among providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

For the past two years we have been working closely with FamilyCare to improve the care of children cared for by our 125 pediatricians and nurse practitioners. We meet at least weekly with FamilyCare and have made major strides in more accurate enrollment and attribution/assignment to practices and communication with providers about their new patients, in developing population reports for each pediatrician to gain an understanding of their population, in innovative reimbursement models to compensate for non-visit based care and implementation of the patient centered primary care home, among others.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Sincerely,

Sharon Fox, MHA
Chief Executive Officer

Christina Grucella, MD
Board President

Family Dental Care, Inc.
8070 Sw Hall Blvd; Suite 200
Beaverton, Or 97008


3/26/2012

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

Dear Ms. Hurst,

Family Dental Care, Inc (FDCI) supports FamilyCare, Inc.'s application to become a
Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care
providers in Multnomah, Clackamas and Washington counties to deliver integrated and
coordinated health care for their community members' physical health, addictions and mental
health services, and oral health care.

Since its inception more than 25 years ago, FamilyCare, Inc. has placed a strong emphasis on
collaboration between health care providers and other area safety net and social service providers
in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to
provide their members with vertically and horizontally integrated health services that are built on
coordination, quality and comprehensive continuous effort to monitor and improve patient safety
and the performance of all care and services provided. We plan to continue to work with
FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration
among providers is critical to maximizing resources and efficiencies in the health care system in
underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality,
coordinated care for patients, this collaboration will become even more important.

Through the seamless CCO integration with the Oregon Health Plan, FamilyCare is going to
serve 50,000 low-income Oregonians and provide them with high quality full spectrum
community care including medical and dental coverage via a comprehensive approach.
FamilyCare was the first plan in Oregon to integrate mental and physical health coverage into
one standard plan, starting in the tri-county metro area of Portland. Taking the next step to
integrate dental treatment will be accomplished through the help of Family Dental Care
partnered with Willamette dental Group offices providing the community dental treatment on
behalf of FamilyCare plans. We have more than 55 offices located in Albany, Beaverton, Bend,
Corvalis, Eastport, Eugene, Grants Pass, Gresham, Hillsboro, Jefferson, Lincoln City, Medford,
Milwaukie, NE Portland, Roseburg, Salem, Springfield, SE Portland, Tigard, Tualatin, and
Downtown Portland to serve the dental needs of FamlyCare's CCO. This is a new partnership
but we have been providing dental care for low-income and OHP patients for more than 40
years. The dental care includes preventative care to reduce fillings and protect the children's
dentition and reducing costly procedures or extractions that would reduce their quality of life in
their later years. Fillings, root canals, extractions, tooth replacements, and 24 emergency care

will be provided. We have child specialists and anesthesiologist to provide dental therapy to our younger patients in an outpatient setting to reduce the load and costs on Oregon's hospitals.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Sincerely,

Hadi Nouredine, DMD
President
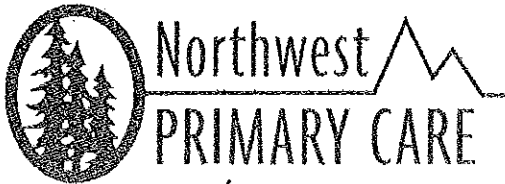
P.O. Box 22075 • Milwaukie, OR 97269 • P 503.659.4777 • F 503.652.5223 • www.nwpc.com

March 23, 2012

Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
250 Winter Street NE, 3<sup>rd</sup> Floor
Salem, Oregon 97301

Dear Ms. Hurst,

NW Primary Care PC supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care providers in Multnomah and Clackamas counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to provide their members with vertically and horizontally integrated health services that are built on coordination, quality and comprehensive continuous effort to monitor and improve patient safety and the performance of all care and services provided. We plan to continue to work with FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration among providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

We have worked successfully with FamilyCare for over a decade. Our 25 Family Practice and Internal Medicine practitioners serve Multnomah and Clackamas communities through our six clinical offices including FamilyCare members.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Respectfully,

Michael Whitbeck
Administrator

WPCS  WESTERN PSYCHOLOGICAL &
       COUNSELING SERVICES, P.C.

April 26, 2012
Tammy L. Hurst, Contract Specialist
Office of Contracts and Procurement
250 Winter Street NE, 3<sup>rd</sup> Floor
Salem, Oregon 97301

Dear Ms. Hurst,

Western Psychological and Counseling Services (Western) is a behavioral health provider writing this letter of support for FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO). We believe FamilyCare is well positioned to maximize opportunities to collaborate with health care providers in Clackamas, Multnomah, and Washington counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

Since its inception, FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid members. We look forward to the opportunity to continue to work with FamilyCare, Inc. during the CCO implementation process. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

Western has partnered with FamilyCare since mental health and addictions services were included in the health plan. It should be noted that Western administrators worked with FamilyCare even prior to that time as advocates for and partners in the process of integrating behavioral health into the physical health plan.

Western has provided behavioral health services to FamilyCare OHP members for many years. This has included the implementation of projects to integrate mental health services within a primary care setting. We have served on FamilyCare Quality Management and provider committees. It's especially important to note that FamilyCare has included behavioral health on it's overarching Quality Management Committee, with Western providing licensed psychologist representation since mental health services were fully integrated.

Due to this successful history, we are very pleased to participate in this partnership with FamilyCare going forward. We believe FamilyCare's history as a community partner and integrated health plan will serve it will in the establishment of a Coordinated Care Organization.

Sincerely,

Daryl Quick, Ph.D.
CEO
Western Psychological and Counseling Services, PC

PO Box 82819 Portland, OR 97282

# Willamette
## Dental Group

First In Proactive Dental Care

6950 NE Campus Way, Hillsboro, OR 97124
Tel 503.952.2000   Fax 503.952.2200
www.willamettedental.com

April 25, 2012

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

Dear Ms. Hurst:

Willamette Dental Group supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO). Through a process of organizational and planning meetings with a broad range of stakeholders, FamilyCare has demonstrated a strong commitment to collaborating with health care providers to deliver integrated and coordinated physical health care, addiction and mental health services, and oral health care.

Since its inception, FamilyCare has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to provide its members with integrated health services that are built on patient access, quality of care and case management.

Collaboration among providers is critical to maximizing resources and efficiencies, especially in underserved areas. Collaboration will become even more important, as CCOs focus on innovative new ways to expand access, emphasize the role of primary health care, and achieve better coordination among physical, mental and dental health care providers.

Our company has contracted successfully with FamilyCare, in the early years of the Oregon Health Plan and in a Medicare Advantage program. We plan to continue to work with FamilyCare during the CCO implementation process and thereafter as an oral health provider group. Willamette Dental Group intends to maximize opportunities to collaborate with health care providers in Clackamas, Clatsop, Columbia, Marion, Multnomah, Tillamook, Washington, and Yamhill Counties.

Improving the health of the community requires community health partnerships to embrace evidence-based methods of diagnosis and treatment of the whole person, solving health care delivery issues through innovation and teaming, thoughtfully containing cost, and preserving community assets. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the communities they serve.

Sincerely,

Matt Sinnott
Government Program Coordinator

April 25, 2012

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

Dear Ms. Hurst,

Women's Healthcare Associates, LLC supports the FamilyCare, Inc. application to become a Coordinated Care Organization (CCO) in Multnomah, Clackamas, and Washington Counties. Our support is based on the FamilyCare, Inc. demonstrated commitment to collaborate with Women's Healthcare Associates and other providers to deliver integrated health services for their members with innovative and cost effective programs and systems.

FamilyCare, Inc. has since its inception demonstrated its mission to work with the Medicaid/Medicare populations in the following key areas: health plan and provider collaboration to provide needed services; patient safety, care coordination, and integration of services; and working innovatively with providers to improve efficiency and effectiveness of services provided to members.

Women's Healthcare Associates, LLC (and its predecessor organizations) have worked with FamilyCare, Inc. since its beginning to provide obstetrical and gynecological services to FamilyCare, Inc. members. Most recently, we have worked with FamilyCare, Inc. and the Children's Health Alliance to identify means by which obstetrical and pediatric providers can work more closely to provide a continuum of gynecology, obstetric, and pediatric care that provides long term health for mothers and their children. We are very optimistic that these efforts will have significant positive impacts on the patient experience, quality, and total cost of care.

We believe that as a CCO, FamilyCare, Inc. can and will successfully collaborate with community providers, its members, and community organizations to improve the health of the community with a business model that leverages the capabilities of providers and provides cost effective solutions to many of the most ardent economic challenges which confront our health care system. We look forward to continuing our partnership with FamilyCare, Inc. as it evolves into a Coordinated Care Organization.

We would be happy to answer any questions you may have regarding our support of the FamilyCare, Inc. application to become a CCO and particularly those areas of concern you may have that are not addressed in this letter.

Sincerely,

Brian Kelly
Chief Executive Officer

# Yakima Valley
# Farm Workers Clinic

April 30, 2012

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

Dear Ms. Hurst:

Yakima Valley Farm Workers Clinic supports FamilyCare, Inc.'s application to become a Coordinated Care Organization (CCO) to maximize opportunities to collaborate with health care providers in both Multnomah (Tri-County) and Umatilla (Eastern Oregon) counties to deliver integrated and coordinated health care for their community members' physical health, addictions and mental health services, and oral health care.

Since its inception, FamilyCare, Inc. has placed a strong emphasis on collaboration between health care providers and other area safety net and social service providers in the provision of services for the Medicare/Medicaid target populations. FamilyCare seeks to provide their members with vertically and horizontally integrated health services that are built on coordination, quality, and comprehensive continuous effort to monitor and improve patient safety and the performance of all care and services provided. We plan to continue to work with FamilyCare, Inc. during the CCO implementation process and going forward. Collaboration among providers is critical to maximizing resources and efficiencies in the health care system in underserved areas. As FamilyCare, Inc. seeks new opportunities to create access to high-quality, coordinated care for patients, this collaboration will become even more important.

We have worked with FamilyCare since their inception starting in a FFS environment and then switched to a managed care arrangement about four years ago. Currently we have approximately 2850 Family Care covered lives in Multinomah County while we have another 2800 in Umatilla County. We have had a positive collaboration with them over the years through a number of services.

Success in improving the health of the community requires that members of community partnerships embrace their role as leaders and their role in using science and evidence to achieve the mission of public health. Partnerships are crucial to solving problems, preserving community assets, and building social capital in communities. Building and sustaining community partnerships that reach out to and include community-based organizations serving diverse populations will assure that partnerships are representative of the diversity of the community.

Sincerely,

Juan Carlos Olivares
Executive Director

# Jeff Heatherington
## FamilyCare Inc. President and CEO

## EMPLOYMENT EXPERIENCE:

**1984 to Present:**     Founder, President and CEO, FamilyCare Inc.and FamilyCare Health Plans, Inc.

1984 – 2008     Founder and President , FamilyCare Medical Clinics, Inc.
1978 – 2008     Executive Director, Osteopathic Physicians & Surgeons of Oregon, Inc.
1977     Director of Development and Public Relations, Goodwill Industries of Oregon, Portland, Oregon
1975 – 1976     Finance Director, Oregon Republican Party, Portland, Oregon
1970 – 1974     Business Administrator, Westminster Presbyterian Church, Portland, Oregon
1968 – 1970     Director of Admissions, Marylhurst College, Marylhurst, Oregon
1965 – 1968     Branch Director, Lower Columbia Basin Y.M.C.A., Pasco, Washington

## HONORS AND AWARDS

Doctor of Humane Letters, Honoris Causa, Western University of Health Sciences
Distinguished Service Certificate, American Osteopathic Association
Distinguished Service Chapter, Delta Tau Delta Fraternity

## COMMUNITY AND PROFESSIONAL SERVICE: (Current activities in bold)

**Visiting Professor in Health Policy Administration, McMasters University, Hamilton, Ontario, Canada, 1991 to Present**
**Western University of Health Sciences, College of Osteopathic Medicine, Board Member, 2006 to Present**
**Coalition for a Healthy Oregon, Founder, 1999 to Present**
    Chairman (1999 to 2004)
**Oregon Better Health Initiative, 2008 to Present**
**American Osteopathic Association**
    Association of Osteopathic State Executive Directors, President, 1981 – 1982
    Committee on Continuing Medical Education, 1981 – 1990
    Committee on Managed Care, 1992 – 1996
    Task Force on Graduate Medical Education, 1999 – 2000
    Task Force on Information Technology, 2004 – 2006
    Committee on Socio-Economic Affairs, 2002 – 2008
    **Task Force on the Future of Medicare Physician Payments, 2004 to Present**
    **Join Task Force on Quality and Reimbursement, 2005 to Present**
    **AOA Greatness Fund Steering Committee, 2006 to Present**
    **Bureau of Education, 2009 – 2012**

**Community and Professional Service, Con't**

**Oregon Health Forum, Board Member and Treasurer, 2002 to Present**

**Portland State University**
   **Frank Roberts Graduate Scholarship Committee, 1997 to Present**
   Walk of Heroines, Gov. Barbara Roberts Committee, 2004 – 2008
**Rotary Club of Portland, 1978 to Present**
**Oregon Osteopathic Foundation, Board Member, 2007 to Present**

Eastmoreland Hospital, Board Member, 1987 – 1997
   Committee on Medical Education, 1996 – 2004
Delta Tau Delta Fraternity
   International President, 1994 – 1996,
   Educational Foundation, Board Member, 1984 – 1996
   International Vice President, 1992 – 1994
   International Treasurer, 1984 – 1988; 1990 – 1992
   Western Division President, 1980 – 1984
Portland Symphonic Choir
   Board Member and Treasurer, 1978 – 1984; 2001 – 2004
   Board Chair 2002 – 2004
Oregon State Bar, Disciplinary Board, Lay Member, 1982 – 1988
State of Oregon
   Medical Advisory Board, Oregon Workers Compensation Division, 1979 – 1987
   Oregon Health Care Cost Containment Advisory Committee, 1985 – 1989
   Oregon Health Council, Member, 1993 – 1996
   Governor's Task force on Medical Professional Liability, 2002 – 2003
   Congresswoman Darlene Hooley, Health Care Advisory Council, 2007 – 2008

## EDUCATION:
B.A., Political Science, Willamette University, Salem, Oregon, 1965

# Jesse M. Gamez
## *FamilyCare Inc. Chief Operating Officer*

## SUMMARY

A proven health care leader with over twenty years of experience progressively responsible management and leadership roles with Kaiser Permanente Northwest and Kaiser Permanente – Northern California. Recognized for developing solutions to support integrated care models. Excellent communication skills. Demonstrated ability to work with a broad range of individuals representing Health Plan/Hospitals, Medical Group, and Labor to build high performing, successful teams. Strong budgeting, strategic planning, organization, attention to detail, and motivational skills. Dedication to the highest professional and ethical standards.

### Labor Relations/Human Resources
- Over 20 years of management experience dealing with labor issues, interpretations, and negotiations.
- Served on three bargaining teams and negotiated contracts locally, nationally, and with Human Resources.
- Over ten years experience in training managers on interest based problem solving, contract interpretation, unit based teams, and issue resolution.
- Developed hospital staffing models and agreements to add 12-hour shifts in new units, resulting in avoiding overstaffing and increasing ability to proactively recruit.
- Participated in union/management mediation with Federal Mediation.
- Took over 10-month, complex bargaining contract after unrest with the union. Turned around situation to win-win negotiation by building strong, trustworthy relationships with union leaders.
- Experience working in both a traditional union/manager organization and Kaiser's partnership relationship environment.
- Conceptualized strategies to successfully integrate Labor Management Partnership principles into medical and dental operations in a way that supported both new labor environments and on-going business needs. Turned around antagonistic relationships by developing collaborative strategies and outcomes that focused on interest and issue based problem solving.
- Developed the ability to successfully integrate staff back into the workforce from labor disputes and strikes by creating culture of open communication, diffusing tension, and building and modeling trust.
- Selected to serve on Kaiser National Bargaining Subgroup, charged with developing organizational performance and unit-based teams.
- Selected to serve on National Labor Relations Subgroup to resolve complex issues, contract interpretation, and disagreements not resolved on regional level.
- Local 250 SEIU member for 1 ½ years.

### Healthcare Administration/Leadership
- Conceptualized strategy and led operational implementation of design/construction activities for new hospital tower and remodel of existing facility, resulting in doubling capacity of the emergency department. Led $300M expansion and scaled infrastructure to support the growth.
- Developed strategy and structured business case for internalizing tertiary care services and positioning the company for growth/expansion by conserving spending and optimizing internal resources, saving $10M.
- Created strategy and led implementation of hospital wide Unit Based Teams (60 departments), resulting in developing a foundation for improving and sustaining department performance by focusing on enhancing service quality and financial targets.
- Hospital won Lawrence Patient Safety award for developing innovative simulation lab for training and development.
- Improved hospital occupancy rate from 78% to 85%, ensuring appropriate staffing and quality levels.
- Led the deployment of HeathConnect, a cutting edge inpatient electronic medical records pilot project, which became the model for rolling out this complex project nation wide.
- Sponsored Service Excellence program, which led to dramatic improved HCAHPS scores.

- Developed comprehensive safety management program and managed implementation of efforts to reduce workplace injuries by 21%.
- Identified opportunity to improve nursing cost per patient day in order to be competitive. Changed staffing plans and staffing practices to achieve future savings of $2M per year.
- Created business case for developing an Ambulatory Surgery Center, and led implementation for reducing outside care expenses by internalizing cases, realizing $4M increase in revenue.

### General Management
- Led development of strategic plan for Salem Service Area addressing clinical, marketing, facility, and financial plans.
- Developed new high-performing management team by assessing competencies and focusing on professional development.
- Served as Chairperson of KPNW Diversity Council, Medical Steering Committee, KP HealthConnect Implementation Team, and Next Generation work.

## PROFESSIONAL EXPERIENCE

**FamilyCare Health Plans ,Portland Or**                                      **2011- Current**
Chief Operating Officer
Operational accountability for overseeing day to day operations within Health Plan. Oversight of key organizational initiatives ,operational planning and execution  for 130 FTE's and 175 million dollar organization caring for 54,000 patients.

**Kaiser Permanente, Northwest Region**                                      **1992 – 9/2010**

**Salem Director of Operations  March 2007 -Current**
Took over underperforming operation, successfully improved performance, finances, quality, and service across the pillars. Operational management for three medical offices providing 300,000 annual primary and specialty care visits. Responsible for 250 FTEs and $30 million operating budget.

**Director, Regional Clinical Services and Sunnyside Medical Center Administrator/CEO, May 2004 – March 2007**
Charged with bringing Labor peace to hospital, leading clinical information system pilot program, and implementing a regional strategy to expand services of hospital and create revenue.  Overall leadership for Inpatient (205 bed hospital, expanding to 350 beds in 2007), Continuing Care (Home Health and Hospice), Expanded Care (Special Medicare Population) and Ambulatory Surgery Services (four sites in addition to the medical center).  Responsible for 1,900 FTEs and $179 million operating budget.

**Salem Primary Care Service Area Manager  January 1995 – May 2004**
Operational management for three medical offices providing 220,000 annual primary and specialty care visits. Responsible for 180 FTEs and $23 million operating budget.

**Rockwood Medical Office Administrator    January 1992 – December 1994**
Operational management of a medical office providing 121,000 annual primary and specialty care visits.  Responsible for 63 FTEs and $3.3 million operating budget.

## EDUCATION

Business Portland State  University, Portland, OR
Advanced Leadership Program, University of North Carolina, Chapel Hill, NC, June 2003

## CORPORATE AND VOLUNTEER BOARD EXPERTIENCE

Board Chair, Oregon Healthcare Workforce Institute
Corporate Board Member and Officer, NW Engineering

# GREG MARTENSON
## FamilyCare Inc. Finance Director

---

### Dynamic Business Executive
### Proven Track Record of Driving Revenue and Profits

---

High performance C-Level executive offering strong track record of success. Areas of focus include strategic planning, business development, competitive differentiation, operational efficiencies, and performance management. Development of a management system designed to link strategy, execution, and results.

---

## PROFESSIONAL EXPERIENCE

**FAMILYCARE**  Portland, OR                                                                    11/11 – Present
Finance Director

*FamilyCare is a Medicaid and Medicare Managed Care Organization (MCO) serving 55,000 members.*

Executive financial manager esponsible for all financial functions including accounting, statutory reporting, financial planning, audit & recovery, enrollment, and metric analysis.

**STRATEGI**  Portland, OR | Scottsdale, AZ                                                      09/09 – Present
Chief Executive Officer

*Strategi is a strategic advisory firm that partners with organizations to grow revenue and profits. Clients include companies in the branding, digital media, private equity, and technology industries.*

Selected Client Results:
- Created new products and offerings that moved client from a branding firm to a strategy firm.
- Created healthcare division for branding and digital media clients.
- New product and pricing model increased client recurring revenue 55% for branding client.
- Developed and executed strategic plan for digital media client, including new clients & key hires.
- Created integrated product offering through formal alliances with industry leaders for branding client.
- Created sales prospecting & lead system for branding and digital media clients.

**SCIENCE CARE**  Phoenix, AZ                                                                   12/02 – 09/09
President | Chief Operating Officer | Chief Financial Officer

*Science Care is a nine year old private for-profit whole body donor program and tissue bank based in Phoenix. Full top and bottom line responsibility - directly managed executive and management teams while reporting to company owner.*

Developed a leadership system that resulted in:
- Annual donor rate increasing from 525 to 2,500, a 31% annual growth rate.
- Revenue increasing from $2.2M to $16M, an annual growth rate of 40%.
- EBITDA increasing from $300,000 to $3.8M, an annual growth rate of 56%.
- Annual employee turnover decreasing from 42% to 15%.
- Employee satisfaction score increasing from 3.1 to 4.3, an improvement of 39%.
- Client satisfaction score increasing by 23%.
- Client credit percentage of revenue decreasing from 5.5% to 0.8%.

Other Selected Results:
- Transformed company from start up to the leading whole body donor program in the U.S.
- Twice successfully led effort to receive 3 year accreditation from AATB.
- Developed Community Relations strategy and department to grow donor rate.
- Implemented Net Promoter Score (NPS) system to improve client satisfaction.
- Developed tissue management system to match donors with client requests.
- Implemented new Quality Assurance and Process Improvement systems.

- Grew revenue by increasing donor rate, revenue per donor, and adding Medical Lab, CME, and Ancillary Tissue programs. These revenue initiatives now account for 65% of company's revenue.
- Introduced Value Added Management system that decreased expenses/unit by a total of 22%.
- Paid for explosive growth organically with no outside investment and minimal debt.
- Developed strategic sales program and managed business development team to achieve record results.
- Introduced an integrated strategy system that linked mission, vision, and values with annual strategy, quarterly re-forecasts, manager tactical plans, and individual employee goals.
- Created a culture of success, opportunity, and open communication by implementing quarterly employee meetings, weekly department meetings, and annual one on ones with all employees.

### Health Choice of Arizona   Tempe, AZ                                                                    09/00 – 10/02
### Vice President | CFO

*Health Choice was a $150 million Medicaid Health Maintenance Organization (HMO) that served members of the Arizona Healthcare Cost Containment System (AHCCS) and was owned by hospital chain Iasis Healthcare. Reported to CEO and was responsible for all finance functions including strategic and financial planning, accounting, corporate and legal relations, internal and external audits, and regulatory compliance.*

Selected Results:
- Implemented cost reduction plan that reduced expenses from 7.9% to 5.8% of revenue.
- Improved utilization management procedures and improved provider contract rates that reduced medical loss ratio from 92% to 89%, an annual savings of $4.5M.
- Designed new medical claim forecast (IBNR) model to more accurately predict expenses.
- Enhanced cash flow by improving receivables collection process.
- Improved EBITDA from 2% to 5% while exceeding budget each year.
- Developed new strategic plan, key metric and budget/forecast models.

### MatureWell Phoenix, AZ                                                                                   6/96 – 9/00
### Vice-President | CFO

*MatureWell was a five-entity $160 million Commercial and Medicare HMO. Responsible for all financial functions including accounting, planning, treasury, underwriting, investor relations, strategic planning, and regulatory compliance. Reported to CEO.*

Selected Results:
- Managed initial and secondary equity offerings of $25 million from five venture capitalists.
- Completed $5 million revolving line of credit from Silicon Valley Bank and renegotiated covenants.
- Worked with CEO to negotiate and complete an acquisition of an HMO for $11.5M and stock in 1999.
- Completed $66M Medicare quota share reinsurance arrangement. Estimated 1st year savings of $2M.
- Presented monthly forecasts including what-if and multi-scenario analyses to CEO and board of cash, equity, and compliance issues with variable drivers.

### Managed Health Network, Inc. (MHN)   Los Angeles, CA                                              10/90 – 4/96
### Director of Strategic Planning

*MHN was a $60 million commercial HMO serving clients nationwide with 14 locations. Responsible for all planning functions for this venture capital funded organization including profitability enhancement, forecasting, and strategic planning. Reported to CFO.*

Selected Results:
- Helped company grow from $16M to $60M in revenue through analysis of pricing, products, sales strategy.
- Built planning department to include a director and three analysts.
- Created economic model that analyzed profitability by product, region, pricing, and volume indicators. Model used what-if analysis to determine product, location, and pricing strategies.
- Participated in completion of three preferred financings raising $10M.
- Successfully sold the company in 1996 when Foundation Health acquired MHN.

# EDUCATION

**Master of Business Administration (Finance)**                                    California State University – Long Beach
**Bachelor of Science (Accounting)**                                                    St. Bonaventure University Olean, NY

# Douglas R. Luther, MD
## FamilyCare Inc. Medical Director

**Education**

Whitman College, Walla Walla, Washington
BA Psychology 1984

Oregon Health Sciences University
Doctor of Medicine 1989

Oregon Health Sciences University
Psychiatry Residency 1989-1993

**Work History**

Medical Director
FamilyCare Health Plans 2007-present
FamilyCare Mental Health Organization 2005-present

Private Practice Psychiatry
1993-2007

Medical Director
Providence Behavioral Health Connections 2002-2004

Inpatient Psychiatrist
Providence 1993-1996
Legacy 1996-2004

Consulting Psychiatrist
Providence Crisis Program 1996-2001
Homestreet Clinic 1998-2000

Consultant/Investigator
Summit Research 2001-2003

Chief Resident, OHSU Department of Psychiatry
1992-93

## Positions

President
Oregon Psychiatric Association
2001-02

Treasurer
Oregon Psychiatric Association
1996-2000

## Professional Organizations

Oregon Psychiatric Association
American Psychiatric Association
Oregon Medical Association

# RESUME

## William A. (Bill) Hurst

## Experience:

2011 – 2012 (Current) FamilyCareInc: Manager, Informatics and Information Technology
2006 – 2011 KPNW: Manager, KSMC Strategic Planning and Performance Improvement
2001 – 2005 KPNW: Lead Consultant, Consulting and Analytical Services/Business Consulting
1998 – 2000 KPNW: Operations Manager, Regional Call Center
1991 – 1997 KPNW: Consultant, Management Engineering/Consulting and Analytical Services
1980 – 1990 W. A. Hurst & Associates – Management Consulting, Health Care and other Industries

## Qualification Highlights:

❖ 30 Years of experience in management, data development/performance reporting, strategic/service delivery planning, and analytical positions. Deep understanding of service and care delivery processes, patient flow, ambulatory and inpatient medical operations, member/patient utilization patterns and analysis, strategic management and planning processes, capacity and capital planning, performance improvement processes performance measurement, and data infrastructure development.

❖ Focused knowledge of and interest in population based health care delivery across the care continuum. Proactive analysis of membership utilization patterns and the impact on delivery systems, leading to regional internalization efforts and access/service improvement efforts. Recent efforts include:
  o 2011 Inpatient Strategic Planning – 2 Hospital Service Delivery Plan
  o 2010 Regional Surgical Services strategic planning
  o 2009 Bridge Strategy – Business Case for internalization of surgical cases
  o 2006 – 2008 KSMC Expansion and Cardiovascular Internalization Business Case
  o 2007 Medical/Surgical internalization (KSMC 1$^{st}$)

❖ Managed development of our Hospital Data Infrastructure, leveraging KPHC EMR capabilities into cutting edge patient flow and utilization tracking systems. Initiated and chaired the Regional Clinical Services Data and Reporting Oversight Group, charged with prioritizing and resourcing all data and reporting development for Regional Clinical Services. Developed standards for documentation of Business Rules and Definitions for data development.

❖ Data Integration and Management Governor's Council – Oversight of regional data and reporting strategy.

❖ Coordination of performance measurement systems development for physicians and support staff based on service level, quality performance levels, member/staff satisfaction, and cost of care delivery. Developed Balanced Scorecards for 15 Primary and Specialty Care ambulatory care clinics and 60+ hospital and support services departments.

❖ Development of complex utilization and supply/demand modeling tools designed to translate utilization into resource requirements, used to support business cases and to enable delivery of quality care at high service levels in inpatient and ambulatory care arenas.

❖ Broad experience as a program/project manager with KPNW and other healthcare organizations, working with all levels of medical group, health plan management, and labor partners. Project Management Professional (PMP) certified.

- ❖ Supported the business case development and implementation of our regional ambulatory care and inpatient Electronic Medical Record System. Documented impact on clinical workflows, modeled training and learning curve impact on patient access, and planned the regional roll-out of the system.

- ❖ Demonstrated ability to cultivate and maintain excellent leadership and customer relationships.

- ❖ Highly developed skills in guiding leadership, management, labor and analytical staff through the process of systems understanding, strategic management/planning processes, data infrastructure development, business case development, utilization/operations analysis, performance measurement, design and implementation of improvements
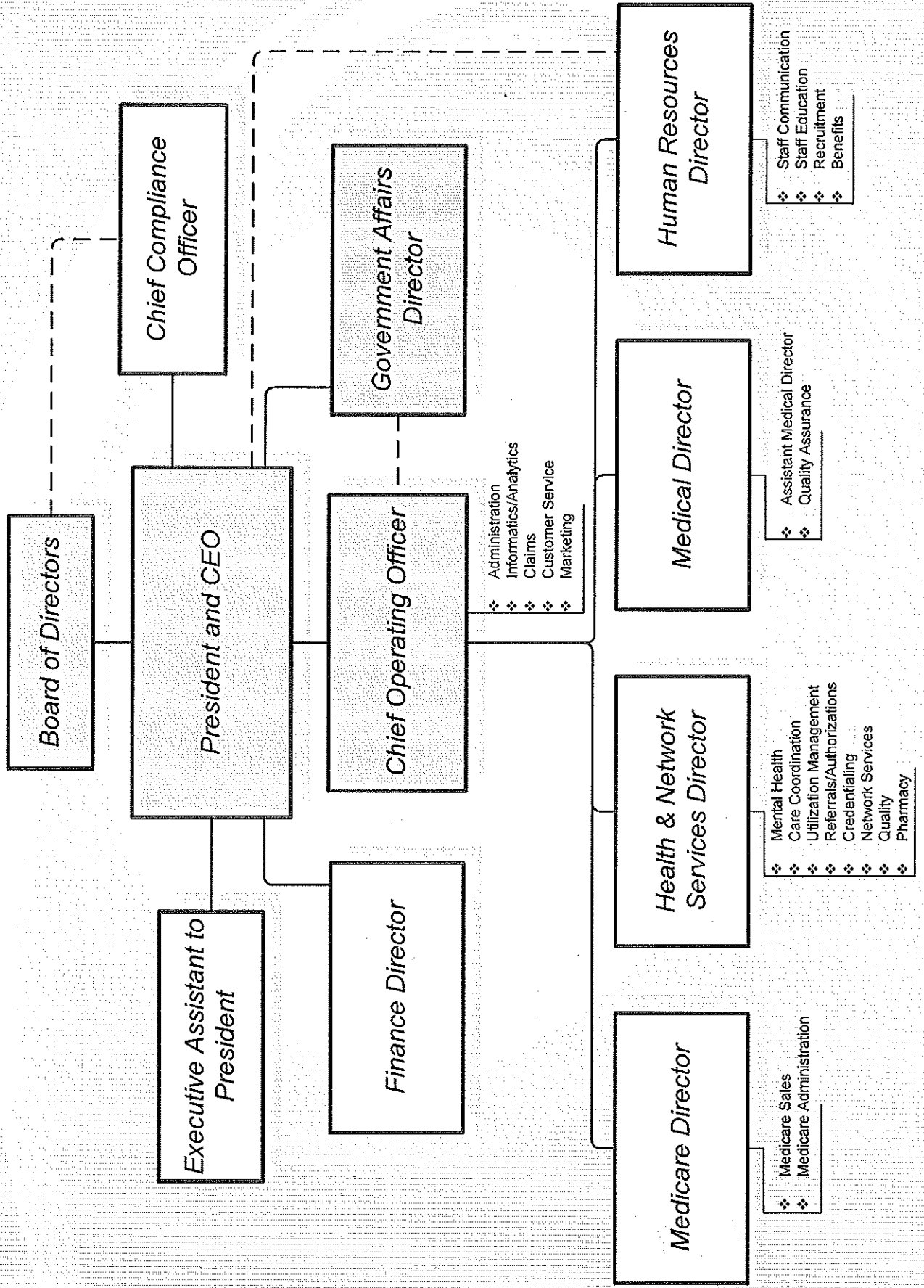
**Education:**
B.S. in Advertising & Public Relations (Marketing)
University of Utah

**Other Training:**
Strategic Management Professional (SMP) Certification (Oct 2011)
Systems Thinking Gold Mastery Certification – Haines Institute
Strategic Management Gold Mastery Certification – Haines Institute
PMP Certification – Project Management Professional – Project Management Institute
Lean/Six Sigma – Mentorship of trainees working on belt certifications
Cognos Analysis Studio, Query Studio, Report Studio, Contributor Studio
KPHC Hospital-At-A-Glance module
KPHC Reporting Workbench
Patient Flow Management – IHI Conferences/Webinars
Surgical Services Optimization – IHI Conferences/Webinars
IDEO Consulting Group process design training
Strategy Mapping and the Balanced Scorecard
Flawless Consulting – Peter Block - Seminar
Strategies and Tools for Building a Learning Organization-Ross Partners
Systems Thinking - Innovation Associates
MedModel Simulation Software - ProModel Corp.
Ithink Simulation Software - High Performance Inc.
Total Quality Management - KPNW (Juran Institute)
Call Center Management Seminars – KP Inter-Regional Call Center Conferences
TeleCenter System Software training
MicroSoft Office – Excel, Power Point, Word, Visio, MS Project

# FamilyCare Inc. and FamilyCare Health Plans

**Board of Directors**

**President and CEO**

**Chief Compliance Officer**

**Government Affairs Director**

**Executive Assistant to President**

**Finance Director**

**Chief Operating Officer**
- ❖ Administration
- ❖ Informatics/Analytics
- ❖ Claims
- ❖ Customer Service
- ❖ Marketing

**Medicare Director**
- ❖ Medicare Sales
- ❖ Medicare Administration

**Health & Network Services Director**
- ❖ Mental Health
- ❖ Care Coordination
- ❖ Utilization Management
- ❖ Referrals/Authorizations
- ❖ Credentialing
- ❖ Network Services
- ❖ Quality
- ❖ Pharmacy

**Medical Director**
- ❖ Assistant Medical Director
- ❖ Quality Assurance

**Human Resources Director**
- ❖ Staff Communication
- ❖ Staff Education
- ❖ Recruitment
- ❖ Benefits

# FamilyCare Inc. and FamilyCare Health Plans Management Team



**Chief Operating Officer**

- Manager, Network Services
- Manager, Informatics/Analytics
- Manager, Claims
- Manager, Customer Service
- Manager, Marketing

**Medical**
- Medical Director
- Assistant Medical Director
- Quality Coordinator

**Medicare**
- Medicare Director

**Finance**
- Finance Director
- Controller
- Manager, Enrollment

**Health Services**
- Health Services Director
- Manager, Care Coordination
- Manager, Utilization Management
- Manager, Mental Health
- Manager, Pharmacy

# FamilyCare Inc. and FamilyCare Health Plans

## Care/Utilization Management
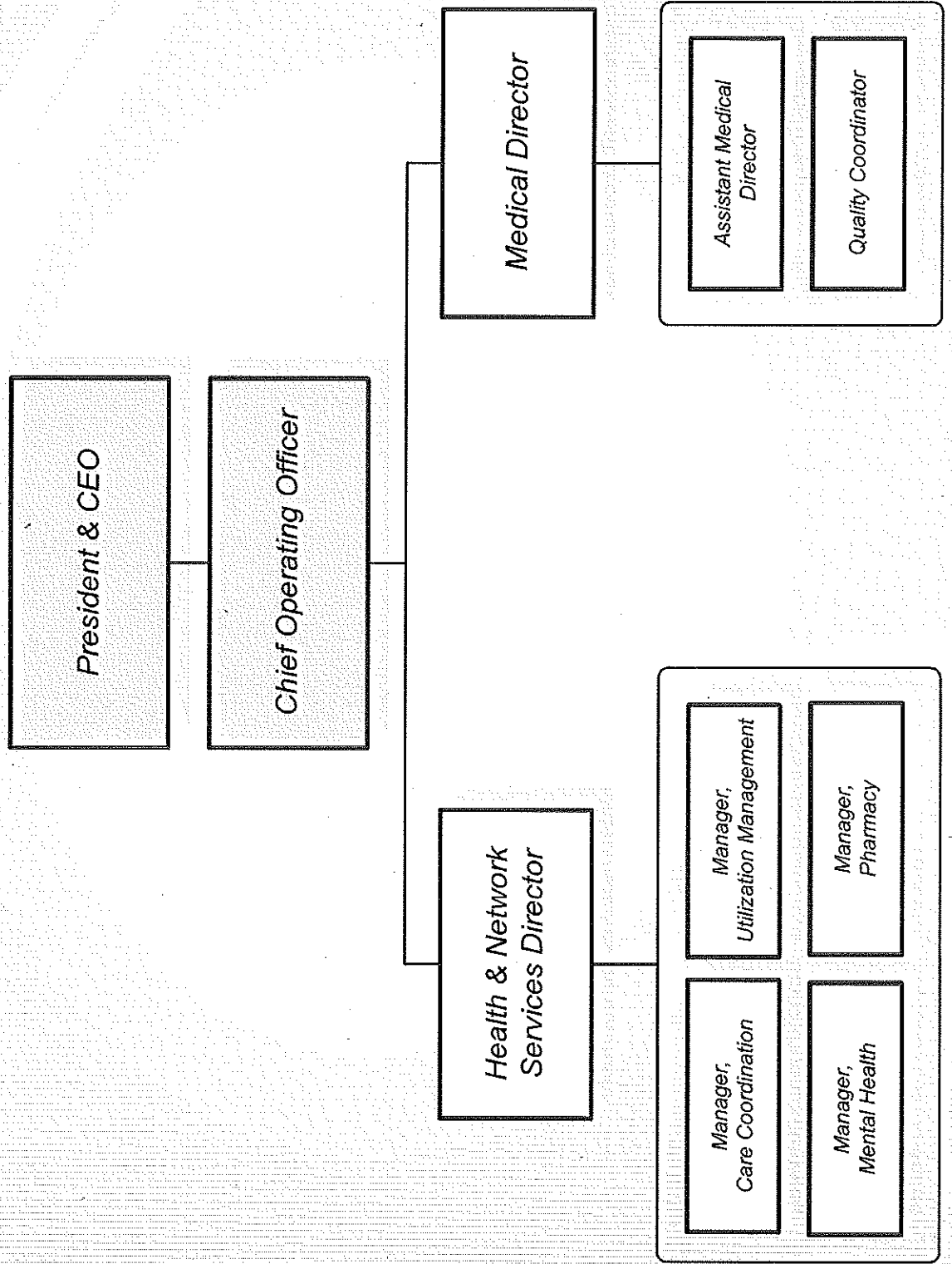
## Service Area Table

| Service Area Description | Zip Codes | Maximum Number of Members - Capacity Level |
|---|---|---|
| Tri-County Clackamas | All Clackamas Zip Codes plus 97032, 97071, 97362, 97375, 97002, 97381 from Marion County | 50,000 |
| Tri-County Multnomah | All Multnomah County Zip Codes | 120,000 |
| Tri-County Washington | All Washington County Zip Codes | 60,000 |
| | Tri-County Total | 230,000 |

## FamilyCare Coordinated Care Organization Application
## Appendix A – CCO Criteria Questionnaire

### INTRODUCTION

As a Managed Care Organization that has been serving Oregon Health Plan (OHP) Members for more than 27 years, FamilyCare already provides the coverage, services and networks essential to being a Coordinated Care Organization (CCO). FamilyCare has provided quality coordinated care in communities across the state, bringing the benefits of preventive medicine to the Medicaid population. We currently serve approximately 55,000 OHP Members and people with Medicare. FamilyCare's mission to create healthy individuals through innovative systems has brought about the development of many programs and strategies that provide the type of coordinated care that the Oregon Health Authority (OHA) seeks to achieve through health transformation.

FamilyCare is the only Managed Care Plan in the tri-county area that currently integrates physical and mental health care. FamilyCare has offered mental health care as part of its coverage since 1997. Early integration of physical and mental health has allowed our providers and staff to better coordinate patients' care in one setting. It has also enabled us to make the connections our Members need to access the right kind of care at the right time and develop operational efficiencies that maximize their benefits. Additionally, our primary care and mental health providers collaborate with our Service Coordinators (navigators) throughout our service area to help often disparate centers of care work together.

FamilyCare was one of the first organizations in the country to create and implement a Service Coordination Department. Our Service Coordination program was created to help our primary care providers manage the often complex needs of the Medicaid population. Our team of nearly 20 Service Coordinators supports providers in navigating the system so they can make patients' care their primary focus. Most of our Service Coordinators are based in clinics so they have close contact with providers, making it possible for them to reinforce care plans by promptly performing active interventions and addressing compliance issues. This results in greater satisfaction and positive outcomes for the provider and their patients, as well as higher quality health care for Members. Service Coordinators work with our Members to navigate the health care and social service system, acting as a hub of information for state agencies, family, and specialty care providers.

FamilyCare has a strong network of contracted providers throughout Oregon, many of whom are already reimbursed using alternative payment methodologies. FamilyCare works with an array of providers and private practices across the continuum of care. Our goal is to make it as easy as possible for our providers to care for our Members. By building strong relationships and establishing consistent communication, we are able to help remove access barriers and empower those we serve to make educated health care decisions. FamilyCare has long-standing relationships with local hospitals and large groups of providers who are truly committed to caring for people in this community. In the near term, we look forward to integrating with our dental partners to provide coordinated primary dental care that reduces the need for restorative care and supports the overall health of our Members. We also look forward to more closely managing the mental health drug benefit for our Members. In addition, we are acutely aware of the growing population that will require long-term care and it is our desire to develop a care management structure that coordinates and support all levels of our Members' care.

Over the past 2 years, FamilyCare has experienced tremendous growth, almost doubling our Membership overall and more than doubling our mental health plan Membership. This growth has required extensive operational shifts in staffing and infrastructure. We have addressed those challenges in several ways. Our executive team brings over 100 combined years of experience in many levels of health care delivery, including hospital administration, compliance, clinic management, finance, information technology (IT), dental plan administration and, of course, physical and mental health plan administration. Our IT systems have been enhanced by strategic vendor relationships and new software interfacing. We have re-configured our staffing and management models to accommodate our growth in staff and to better facilitate operations as a larger company. We continue to develop our infrastructure to provide better service to our Members and providers. Our recent experience in rapid change management makes us poised for growth and gives us the capacity to expand our network of providers and increase access for the Members of this community.

FamilyCare is experienced, fully operational and ready to transition to a CCO model. FamilyCare has been fully committed to serving the Medicaid population consistently for 27 years. This commitment continues as FamilyCare seeks to capitalize on our experience as an integrated health plan to develop a first class CCO.

## PART I: BACKGROUND INFORMATION ABOUT THE APPLICANT

### A.1.    Background Information about the Applicant

a. FamilyCare is an Oregon non-profit corporation, domiciled in Oregon.

b. FamilyCare's affiliates include FamilyCare Health Plans, a Medicare Advantage plan serving the tri-county area (Clackamas, Multnomah and Washington counties), Clatsop, Morrow and Umatilla counties.

c. The intended effective date of the Coordinated Care Organization (CCO) contract is August 1, 2012.

d. FamilyCare is not invoking alternative dispute resolution at this time.

e. FamilyCare requests changes to the core contract terms and conditions as describes in the attachment titled – Core Contract Changes.

f. The proposed service area is all of Clackamas, Multnomah and Washington counties, including contiguous zip codes in Marion County. See table in Appendix B for a complete list of zip codes.

g. The administration office is located at 825 NE Multnomah, Suite 300, Portland, OR 97232.

h. The proposed service area for this application is all of the zip codes in Clackamas, Multnomah and Washington counties, including contiguous zip codes in Marion County. FamilyCare currently coordinates with these counties as required by our current Fully Capitated Health Plan (FCHP) and Mental Health Organizations (MHO) contracts. FamilyCare is pursuing Memoranda of Understanding (MOU's) or other written agreements to formalize existing relationships, as required in ORS 414.153.

i. FamilyCare currently has contracts with the Oregon Health Authority (OHA) for FCHP, MHO, Physician Care Organization (PCO) and Adult Mental Health Initiative (AMHI). FamilyCare's current service areas under these contracts will change in the following way:

- FamilyCare's PCO contract covers Morrow and Umatilla counties and will continue unless and until a FamilyCare affiliated organization is awarded a Coordinated Care Organization (CCO) contract for those counties.
- FamilyCare's MHO and AMHI contracts cover Clackamas, Multnomah and Washington counties.
- FamilyCare's FCHP contract covers Clatsop, Clackamas, Jackson, Josephine, Multnomah and portions of Washington County, including contiguous zip codes in Marion County. The FCHP contract will continue in Clatsop, Jackson and Josephine counties unless and until a FamilyCare affiliate is awarded a CCO contract for those counties.

j. This is the identical organization with a current MCO contract.

k. The Applicant does not include more than one MCO.

l. This application seeks to include all of Clackamas, Multnomah and Washington counties, including contiguous zip codes in Marion County. This application seeks to include all of Washington County, which is an expansion of the current FCHP service area.

m. FamilyCare currently holds an AMHI contract.

n. FamilyCare's Medicare Advantage – Part D (MAPD) plan service area covers Clatsop, Clackamas, Morrow, Multnomah, Umatilla and Washington counties.

o. FamilyCare Health Plans, Inc. has a certificate of insurance through the Department of Consumer and Business Services (DCBS).
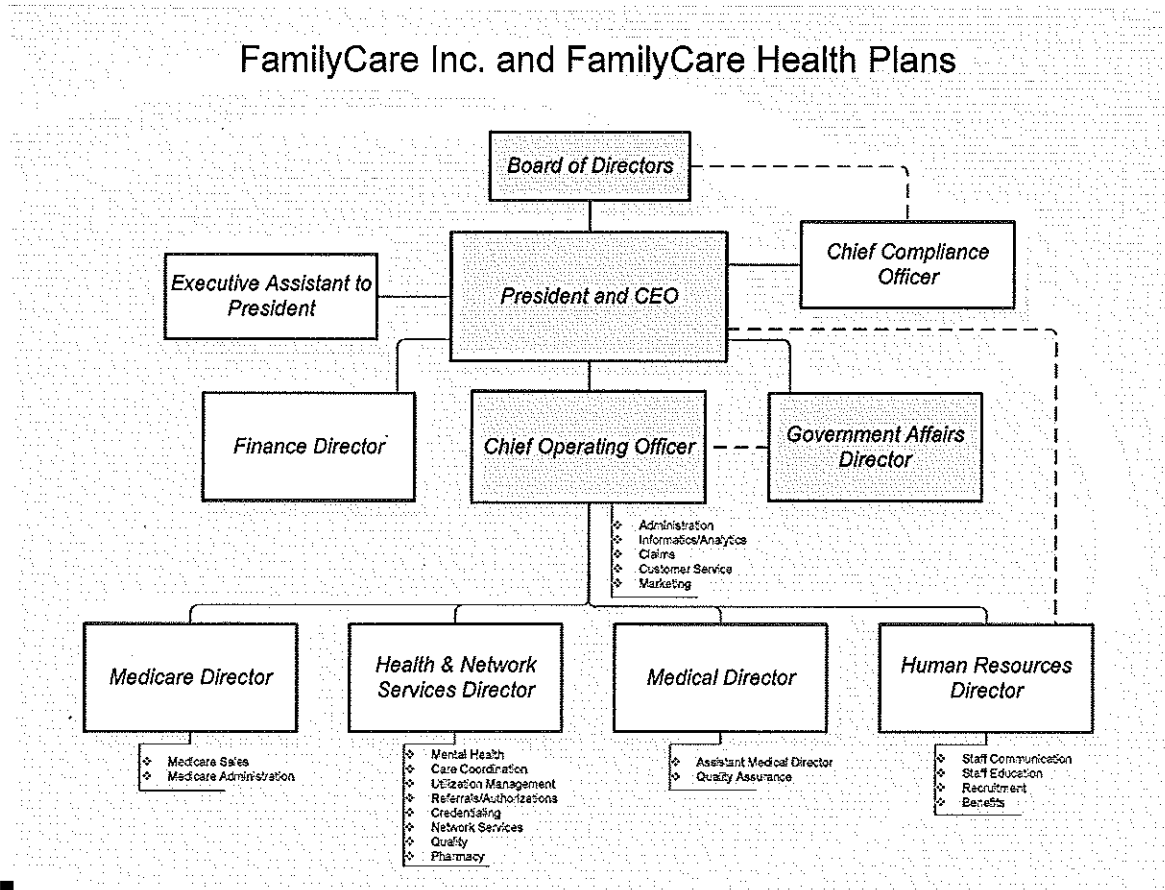
p. FamilyCare's mission is to create healthy individuals through innovative systems. We have been committed to serving the Medicaid population for our entire 27-year history and have experience managing physical, mental and dental health care for the Oregon Health Plan. We are the first osteopathic-based health plan in the nation. Our roots in osteopathic care emphasize our core focus to see each Member as a whole person, not just as a disease or condition. Our approach to managing care is person-centered, involving multiple opportunities for connection and coordination to meet Members' needs. This approach applies to our primary care providers as well. Supporting the provider-patient relationship is a core value at FamilyCare. We promote this relationship by encouraging the provider to truly manage their patients' care. By paying providers on a capitated basis, we also remove barriers to access. At the provider's discretion, the capitation payment may be supplemented by a bonus that is distributed annually to reward providers for quality outcomes and effective management of expenses.

FamilyCare is also driven by our commitment to caring for the entire community in which our Members live. We support many social service agencies, such as Cascade AIDS Project, Central City Concern and the Native American Rehabilitation Association of the Northwest (NARA) to help address disparities in health care. We sponsor provider events, staff fundraisers, and other local associations to promote and support these essential community partners.

q. Résumés have been provided for the following key leadership personnel:
- Chief Executive Officer
- Chief Financial Officer
- Chief Medical Officer
- Chief Information Officer
- Chief Administrative or Operations Officer

**r.** FamilyCare Organizational Chart

## FamilyCare Inc. and FamilyCare Health Plans

```
                              Board of Directors ─ ─ ─ ─ ─ ─ ─ ─ ─ ┐
                                                                    │
                                                        Chief Compliance
  Executive Assistant to    President and CEO               Officer
       President

  Finance Director     Chief Operating Officer ─ ─   Government Affairs
                                                         Director

                              ◦ Administration
                              ◦ Informatics/Analytics
                              ◦ Claims
                              ◦ Customer Service
                              ◦ Marketing

  Medicare Director    Health & Network    Medical Director    Human Resources
                       Services Director                          Director

  ◦ Medicare Sales     ◦ Mental Health      ◦ Assistant Medical Director   ◦ Staff Communication
  ◦ Medicare Administration  ◦ Care Coordination  ◦ Quality Assurance      ◦ Staff Education
                       ◦ Utilization Management                            ◦ Recruitment
                       ◦ Referrals/Authorizations                          ◦ Benefits
                       ◦ Credentialing
                       ◦ Network Services
                       ◦ Quality
                       ◦ Pharmacy
```

**s.** As part of its Technical submission, FamilyCare will be submitting a preliminary Table B-1 for review and feedback from OHA. A final Table B-1 will be available at the Readiness Review. Responses to Standard 1 and 2 in Appendix B, which are related to Table B-1, will also be deferred to the Readiness Review. Responses to Appendix D will be submitted by May 14, 2012.

## PART II: COMMUNITY ENGAGEMENT

### A.II.    Community Engagement in Development of Application

FamilyCare was founded with the purpose of promoting and encouraging the improvement of health care and personal health education in the community. We have offered and will continue to offer opportunities for providers, our Members and the public to learn about health care transformation, the Triple Aim and CCOs. In January 2012, we hosted an education session in Portland that explained how health care transformation would impact providers in the community. Attendees included primary and specialty care providers, county commissioners, local elected officials and state legislators. Dr. Bruce Goldberg spoke at the event and provided a vision of how CCOs will transform health care. Since then,

we have hosted meetings with multiple provider and community partners to discuss the RFA process. In addition to sharing information, we received very good input from these partners, which we are using to develop this application. We intend to continue meeting with them as we work to develop and implement the transformational changes we anticipate as a CCO.

FamilyCare posts information relevant to our Members on our website, including links to OHA's website where they can find official information on CCOs. We will post links to articles and videos related to health transformation and CCOs, including recent televised appearances by FamilyCare leaders. We are also working with the Oregon Division of Medical Assistance Programs (DMAP) to develop materials for our Members to help them during the transition to CCOs.

## SECTION 1 – GOVERNANCE AND ORGANIZATIONAL RELATIONSHIP

### A.1.1. Governance

### A.1.1.a.
FamilyCare will have a Governance Structure that meets the requirements of ORS 414.625. FamilyCare's bylaws will provide a method and criteria for selection of board members that meet the statutory requirements. FamilyCare constitutes the majority of the Governance Structure as the sole member; therefore, a majority of the board will be representative of the persons who share in the financial risk. The selection criteria will ensure that the major components of the health care delivery system are included, including at least two Primary Care providers and one Mental Health or Chemical Dependency provider in active practice. FamilyCare's board currently includes 5 community representatives and 2 physicians. The board has identified a mental health provider and a hospital representative to be included and is in the process of identifying a county elected official and a dental representative. In addition, the selection criteria will require that one member of the Community Advisory Council (CAC) be appointed to the board.

### A.1.1.b.
FamilyCare's CAC will be established and selected consistent with ORS 414.625. A selection committee consisting of an equal number of representatives from each county in the service area and the FamilyCare board of directors (BOD) will select the CAC membership. The policy guiding the selection of CAC members will require inclusion of representatives of the community and each county government; consumer representatives will constitute the majority of the CAC. In selecting the CAC, the selection committee will be directed to consider the CAC's duties, including identifying and advocating for preventive care practices, overseeing a community health assessment, adopting a community health improvement plan and publishing an annual report on progress under the plan. CAC members may include representation from the dental industry, social service agencies and educational systems.

### A.1.1.c.
The duties of the BOD/CAC representative include: attending CAC and BOD meetings, reporting on CAC activities and relaying board communications to the CAC.

### A.1.1.d.
At least one member of the board will be a provider of chemical dependency or mental health services. Additional members of the board may be representatives of the county mental health delivery system or LTC providers. In addition, the guidelines for CAC selection will emphasize the need for representation of a broad cross-section of community interests. A member of the CAC will serve on the board of directors and act as a liaison between the board and the CAC.

### A.1.2.  Clinical Advisory Panel

**A.1.2.a.**
See A.1.2.b.

**A.1.2.b.**
FamilyCare will meet the objectives and requirements of a Clinical Advisory Panel through the functions of our established Quality Management Committee (QMC), which currently exists under FamilyCare's Governance Structure.

FamilyCare's BOD, which includes several providers, oversees FamilyCare's quality measurement and reporting systems.  The BOD delegates the oversight of quality measurement and reporting to FamilyCare's QMC, who reports to the BOD Compliance and Utilization Committee.  The chair of the QMC is a member of the board.  The QMC meets bi-monthly and receives reports on quality activities, the Care Management Program, and Utilization Review activities.  The QMC evaluates and makes necessary changes to the progress and development of quality program elements, overall quality program strategy, and quality program administration.  The QMC works with FamilyCare's management team to ensure that provider and Member input is actively considered in the Compliance and Medical Management Program assessment and revisions.

The Quality Management Committee (QMC), which consists of FamilyCare's Medical Director, 2 Mental Health Providers, 3 Primary Care Providers (including 2 Pediatricians), 1 General Surgeon, and 1 OB/GYN, approves and monitors FamilyCare's quality measures and has authority to take action regarding any quality concerns.  This committee meets bi-monthly.

### A.1.3.  Type B Area Agencies on Aging

**A.1.3.a.**
FamilyCare is currently working with county representatives to develop MOUs, which describe the coordination agreements for Members receiving LTC.  FamilyCare currently works with county Area Agencies on Aging (AAA) offices and Department of Human Services (DHS) caseworkers to coordinate care.  FamilyCare's experience working with county and state agencies provides a solid framework on which the MOUs will be established.

**A.1.3.b.**
See A.1.3.a.

### A.1.4.  Mental Health Authorities

**A.1.4.a.**
FamilyCare currently has a well-established, long-standing working relationship with Local Mental Health Authorities (LMHAs) and Community Mental Health Programs (CMHPs) through our MHO contract.  For services provided outside of the Global Budget, FamilyCare will work with LMHAs and/or CMHPs to develop MOUs which describe the coordination agreements for Members receiving mental health services.

**A.1.4.b.**
FamilyCare currently holds an AMHI contract with OHA to coordinate and manage the care of Members transitioning from various stages of the long-term psychiatric care system.  We have established an array

of community based supports and services to provide for the mental and physical health needs of our Members. A mental health Service Coordinator works with our Members receiving services from extended or long-term psychiatric care programs and is responsible for ensuring that the physical and mental health needs of the Member are attended to. The Service coordinator is actively involved in developing and facilitating a timely discharge plan for each of the Members that ensures that the appropriate services are established for a successful transition to community-based care.

### A.1.4.c.
FamilyCare currently contracts with community agencies to divert, triage and manage Members who are experiencing a crisis. These agencies provide 24-hour coverage and emergent crisis services for Members at risk of inpatient care due to a mental health crisis. FamilyCare will continue our collaborative efforts with county and state agencies to engage, assess and effectively treat our Members with mental health needs.

### A.1.5. Social and support services

### A.1.5.a.
FamilyCare has been an active participant with DMAP/OHA at Regional meetings, which are held annually throughout the state. These meetings bring DHS/APD caseworkers and managed care plan staff together with DMAP/OHA to build relationships among the various plans and agencies in the area. In addition, FamilyCare staff attends the DMAP/Indian Health Services (IHS)/638 coordination meetings, which provide the opportunity to build relationships and understand each other's health care delivery models.

FamilyCare has been building relationships with social and support service agencies for our entire 27-year history. FamilyCare sponsors and supports many community-based social service organizations, such as: Cascade AIDS Project (CAP), National Alliance on Mental Illness (NAMI), Children's Relief Nursery (CRN), Skanner Foundation, Asian Health Foundation, and Central City Concern and various other Federally Qualified Health Centers (FQHCs). We will increase and expand our community presence through our CAC and Service Coordinators.

Through FamilyCare's experience as an MHO, we have established key relationships with all the school districts and the education service districts in the metropolitan area, DHS child welfare, the court system, developmental disabilities, juvenile justice and the Oregon Youth Authority. In coordinating the care for children and their families through the intensive service array, we routinely partner with all the systems, social support networks and peer support organizations providing services to our Members. FamilyCare also has similar experience in working with the adult system of care through our implementation of AMHI, also discussed in Section A.1.4.b.

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

### A.1.6.a.
FamilyCare anticipates developing a baseline community health assessment by utilizing existing community health assessments published by local hospitals, counties and other service agencies. FamilyCare, with input from the CAC, will compare data related to costs, trends, and utilization to assess potential areas of health need. The CAC will determine whether a shared community health assessment is necessary to capture data on health disparities or whether other community data are needed to create a community health improvement plan (CHIP). The CAC will develop and adopt a CHIP. This CHIP will include the scope of activities and responsibilities of the CCO, and will be assessed by the CAC and the BOD for progress, effectiveness and outcomes. The CAC, using information from the OHA Office of Equity and Inclusion, shall make recommendations based on the results of the CHIP to develop

meaningful baseline data on health disparities for modification or expansion of the CHIP activities. The BOD shall direct the CAC as to its recommendations.

Subject to the findings of the existing community health assessments, FamilyCare's historical data and BOD direction, FamilyCare will establish Provider Innovation Workgroups based around innovative health care strategies to address common health needs identified in the assessment. As an example, FamilyCare has already formed a workgroup around maternal and child health in partnership with the Children's Health Alliance and Women's Healthcare Associates. These workgroups will bring together various health care disciplines (providers and administrative staff), social service agencies, OHA, consumers and/or other partners to address specific areas of innovation in health care. Specific performance measures will be established to track effectiveness and outcomes.

Diverse populations are engaged per the membership requirements of the CAC, described in A.1.1.b.

## SECTION 2 – MEMBER AND FAMILY PARTNERSHIPS

### A.2.1. Member and Family Partnerships

**A.2.1.a.**
FamilyCare has a long history of partnering with families and teams to provide coordinated care for our Members. We are committed to the meaningful engagement of our Members, their families and caregivers and support networks with an emphasis on Member education regarding the importance of engagement and activation to ensure the most successful health outcomes. Members enrolled in the CCO will be actively engaged partners in the design and, where appropriate, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices will be reflected in the development of treatment plans and Member dignity will be respected.

All FamilyCare Members are given the choice of selecting their Primary Care Provider (PCP). This process is initiated with our new Member packet, which is available in any language or format necessary to appropriately meet Member needs. This packet is mailed within 14 days of notification of enrollment to new FamilyCare Members and includes a Provider Directory from which Members may select their PCPs. Members are encouraged to contact our multi-lingual and multi-cultural Customer Service Department if they need any assistance or have any questions in choosing a PCP. However, Members are not required to consult FamilyCare before choosing their PCP. A separate letter is also sent to new Members encouraging them to make an appointment with their PCP in order to become involved in their Primary Care Home. This letter explains the importance of not waiting until becoming sick to establish care. General information about health and wellness is also included in this letter.

FamilyCare generates a new Membership Roster report weekly and new Members are contacted with a "Welcome to FamilyCare" call. These calls are made by our Customer Service Representatives who are trained in Culturally and Linguistically Appropriate Services (CLAS), as defined by The Office of Minority Health of The U.S. Department of Health & Human Services. This call includes a brief orientation to FamilyCare, which includes physical health, mental health and oral health information. We also offer assistance in choosing a PCP and ask screening questions to determine if the Member currently has any health care needs. Upon selection of a PCP, Members are informed of their dedicated FamilyCare Service Coordinator and are provided with the Service Coordinator's contact information. Calls are documented in FamilyCare's Care Management System, where specific health care information or appropriate registries for special needs can be utilized to better assist Members in the coordination of their care. This information is then reviewed by the Member's dedicated Service Coordinator to determine appropriate follow-up.

Service Coordinators are trained to use Motivational Interviewing to assist Members in determining their desired health goals and what actions will be necessary to achieve these goals. Service Coordinators provide health, wellness and preventive information, healthy behavior coaching and, if appropriate, disease specific information and education. Self-care and self-management are encouraged and developed in every interaction with the Member. Care and treatment plans are routinely reviewed for appropriateness to determine if they are assisting the Member in achieving desired and preferred goals for health maintenance and improvement. A plan is developed for consistent follow-up with the Member to assess if goals are being met, identify gaps, and provide consistent coaching with the Member. This process ensures that Members remain active partners in their health care. In addition, Intensive Service Array (ISA) and wrap-around services are currently provided for children with special mental health needs. All children in the ISA are involved in monthly family/team meetings. FamilyCare is developing additional "wrap-around" supports using the Systems of Care model in service areas outside of places currently established.

FamilyCare's Interdisciplinary Care Team (ICT) also engages Members with specialized needs in their care and treatment planning. The ICT is a Member-centric integrated Systems of Care approach to treatment and care planning, which ensures a holistic approach to the Member's care. The ICT develops and reviews plans of care and recommends interventions and strategies to determine best practices ensuring good health outcomes for the Member. Objectives of the ICT include use of a Member-centric approach that empowers and engages the Member in the participation of his or her care plan, ensures integrated care across the health care spectrum, and improves coordination of services especially for Members with special needs and complex health issues. FamilyCare's ICT consists of internal staff including, but not limited to, a Medical Director, Manager of Care Management, Addictions and Mental Health Manager, Service Coordinator and Quality Coordinator. The ICT also includes the Member, Member's family or representative, if appropriate, the PCP and/or specialists, as appropriate. The ICT creates an individualized Member-centric care plan based on the Member's specific needs determined by the health risk assessment and is revised when there is a change in the Member's health status. The plan can be reviewed and revised at any time by ICT members, preferably with input from the member.

The Member may attend the ICT meeting or the Service Coordinator can meet with the Member at the Member's Primary Care Home location, the Member's home or via telephone to facilitate Member's interactive participation in the development of the care plan. In the event the Member is unable or chooses not to attend the ICT meeting, the Service Coordinator will act as a representative or extension of the ICT in interactively working with the Member to develop the plan of care. The Service Coordinator serves as the consistent communication link between the Member, ICT, Primary Care Provider and Specialists. The Service Coordinator ensures that all participants have agreed upon a plan of care and is responsible for the dissemination of this plan to all participants.

FamilyCare also uses Member feedback from surveys, the grievance process and representation within the Quality Committee structure to plan, design and implement the Quality Improvement Program. Information gathered from these sources assists FamilyCare with identifying areas for improvement.

**A.2.1.b.**
In addition to the comprehensive communication and engagement strategy described in the previous section, FamilyCare employs a variety of efforts to encourage all Members to be active partners in their health care and educates them on how this collaboration is imperative to achieving the best possible outcomes. Our Service Coordinators are trained to work with the PCP to look beyond the illness being treated to include the Member's family, home and community for factors that might be affecting the Member's health. The CAC will conduct periodic community assessments to identify and address underlying social determinants impacting health outcomes of our Members, such as socio-economic

status, housing, discrimination, physical environment, food security, child development, culture, social support, transportation, working conditions, etc.

FamilyCare plans to develop peer-led Learning Collaboratives for all of our Members who have common and important health concerns. Building on the model used by mental health professionals, we will create opportunities for Members to learn about health care opportunities in their community that meet their needs in a socially, culturally and linguistically appropriate manner. Peer support for people with the same chronic health problem has shown to be a highly effective way to reduce unhealthy behaviors and encourage new or better behaviors. By both receiving and providing social support, peers can help each other attain health related goals, share similar experience and provide motivation. These improvements can be achieved using fewer resources than traditional care management systems, which make peer wellness an ideal model for achieving Triple Aim goals for better care, better outcomes and lower costs.

FamilyCare has a long tradition of reaching out to our Members and the broader community in a culturally and linguistically appropriate way to encourage wellness and prevention. For instance, we organize an annual Health Fair focusing on community health needs, education and wellness with participation from a variety of local sponsors and presenters. We offer immunizations, dental treatments, bicycle safety practices, car seat safety and wellness information. We utilize and support several community-based programs, such as CRN, NAMI and CAP. These local programs offer services intended to address the specific needs of the community.

FamilyCare provides quarterly newsletters to our Members that focus on various topics related to health and wellness. We are aligning our efforts with national health and wellness awareness months to better target our Members. For example, in an effort to fight obesity and type II diabetes, we are using Diabetes Awareness Month to improve nutritional habits by incorporating newsletter topics for Members and providers, while partnering with farmers markets and education groups to promote healthy eating. We also offer an interactive health education library on our website for our Members and providers, which includes health self-assessments. We can customize these resources with local articles, links to other websites, and our own articles on relevant health and wellness topics. Tobacco cessation programs remain a high priority for the Medicaid population and we continue to develop communication strategies that reach all of our Members, especially adolescents and teens.

All written communication to the Member uses plain language, written at a sixth grade reading level and offered in the prevalent languages of the Member population. Our new Member orientation materials currently include a provider directory, general information about FamilyCare, and Member's rights and responsibilities. We will begin to include specific information on how to navigate the new system of Coordinated Care, describe the transformed health care system and encourage the Member to connect with their dedicated Service Coordinator at FamilyCare. The Service Coordinator can appropriately link the member to, and work as an extension of, the Primary Care Home and offer any clarification and assistance in navigating the new CCO landscape.

## SECTION 3 – TRANSFORMING MODELS OF CARE

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

### A.3.1.a.
FamilyCare and our providers are true partners in providing quality health care services to our Members and we are committed to a collaborative relationship that benefits our Members. We are dedicated to supporting the provider community with the information, tools, and resources needed to focus on our Members' care. FamilyCare provides a high-touch, high-tech approach that incorporates face-to-face meetings with Members and providers along with innovative programs and data management to improve

the quality of care and achieve the Triple Aim objectives, as illustrated below.

**FamilyCare – Model of Care and Success Drivers**
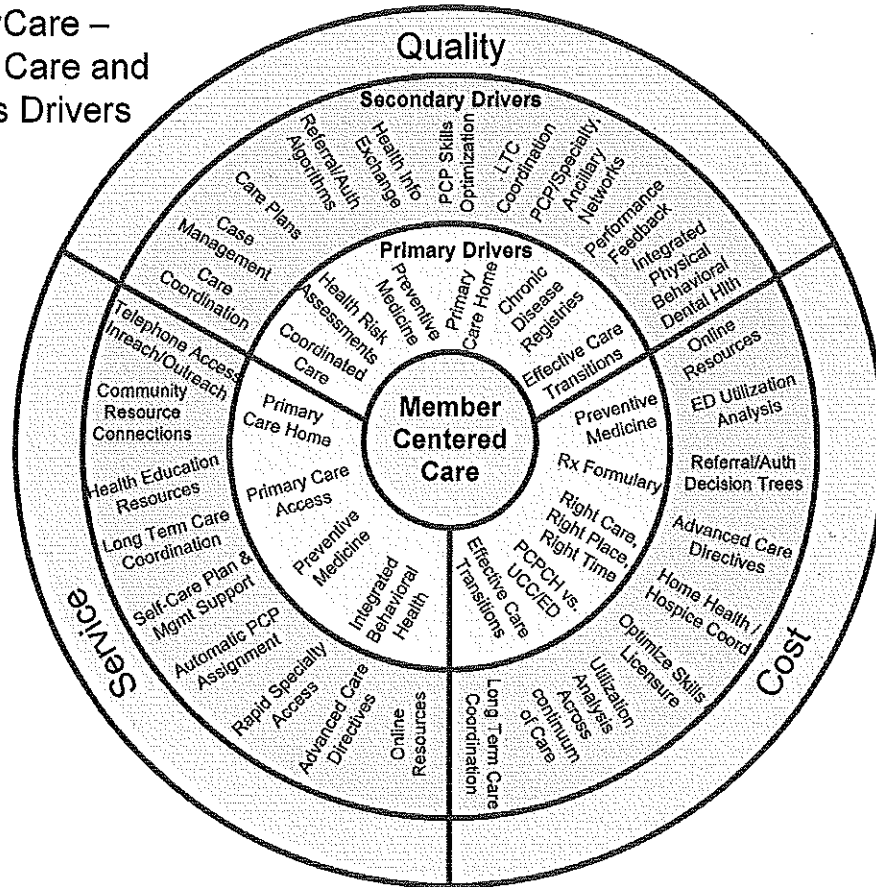


### Technical Assistance

FamilyCare provides technical assistance to our providers in a variety of ways. FamilyCare's Network Services Representatives perform orientations for new and existing network providers. We focus on helping providers understand the ins and outs of their participation in our network, what to look for when providing services for FamilyCare's Members, how to access the provider web portal and how to submit claims properly. The purpose is to make their participation in FamilyCare's network as easy as possible.

FamilyCare's Network Services Department is dedicated to building strong relationships with our health care providers by providing:
- Valuable information on our programs;
- Continuing education;
- Accessibility to our staff through face-to-face visits, telephone communication, regular mail and e-mail;
- Continuous enhancements to our various communication technologies;
- Guidance for clinic staff on policies and procedures;
- Accurate claims payment by assuring the correct information in claims payment systems; and,
- Compliance with state and federal regulatory requirements.

Because of our technical expertise and our drive to keep up with regulatory changes, legislation and trends in our industry, we also offer provider workshops and training. For example, our providers have brought to our attention a significant issue of misuse of prescription pain medication. This has been identified as a high-cost burden on the health care system and we are addressing this by providing innovative solutions for providers to use to treat patients with chronic pain. We are co-sponsoring a summit to bring industry experts and providers together to review evidence-based guidelines and assist providers in addressing this issue. We are partnering with another health plan to sponsor the event illustrating our innovative spirit and commitment to excellence. We want our providers to succeed in all their endeavors and achieve their goals. Another example of our responsiveness to our providers and Membership is the Pain Management Pilot Project discussed in Section A.3.6.d.

Tools for Coordination
FamilyCare's focus is on helping our Members achieve and maintain effective management of their condition(s) through assessment, coordination of care, education and support. We offer a variety of tools to help health care providers coordinate care. Our primary tool to help providers is our Service Coordination Program. Service Coordinators assist providers in navigating system processes and identifying resources and alternatives outside of traditional medical services to meet Members' needs. FamilyCare also provides additional tools for coordination of care, such as providing a resource list on our website and identifying community social supports in our newsletter.

FamilyCare additionally offers secure electronic access to real-time transactions and information, including: claim and authorization status, Member eligibility and benefits, PCP assignments, send and receive messages from Plan personnel, referrals, provider reference guides and administrative guidelines. This electronic access significantly eases the administrative burden for providers allowing for more time to provide direct Member care.

FamilyCare delivers provider profiles with data from our business intelligence software that offers custom and routine reporting to our providers. These profiles serve as an effective tool in maintaining a provider network that uniformly meets established practice parameters and provides opportunities for continuous quality improvement through feedback. Provider-level Member data is used to show utilization patterns, identify over- and under-utilization of services, and share information requested by the provider. Our Medical Directors meet directly with providers to review information from the provider profiles and obtain and give feedback for future development of quality measures and performance improvements.
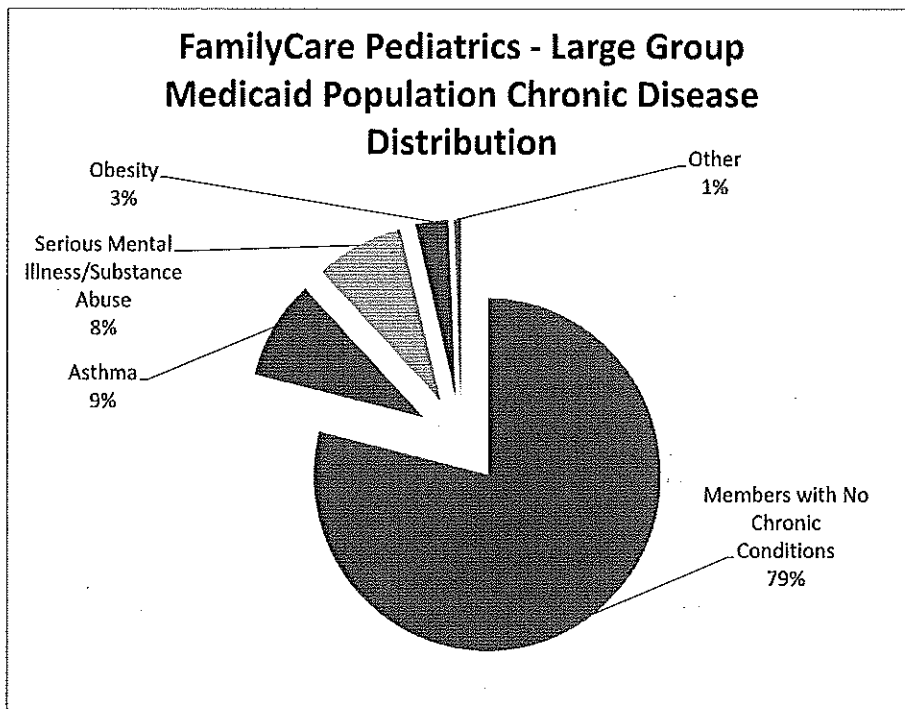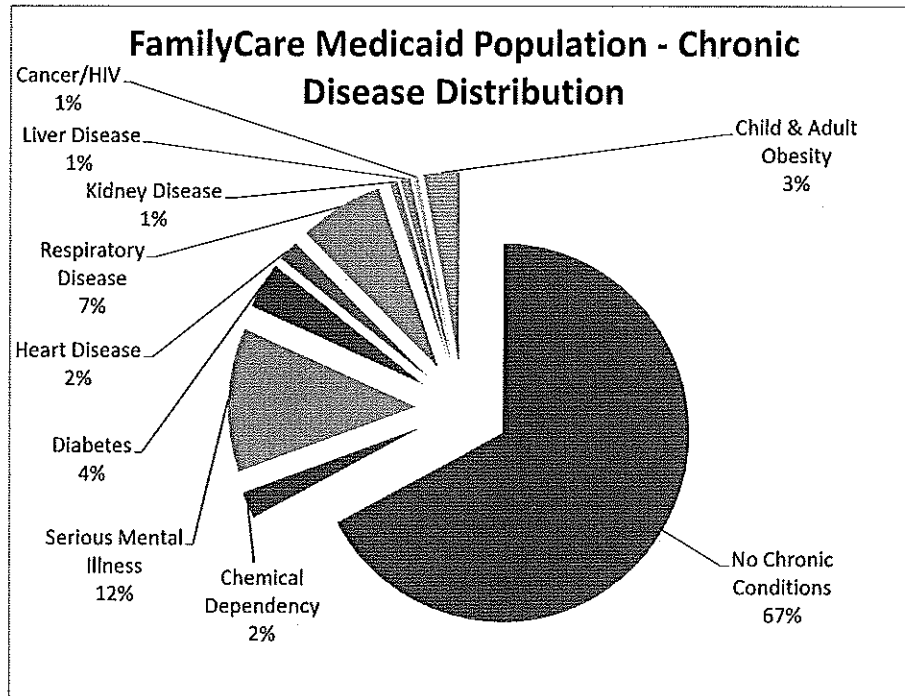
Management of Provider Concerns
FamilyCare recognizes and values the primary relationship between the provider and the patient and helps to identify and resolve barriers. We consider the providers in our network to be the leaders in the quality of care they provide. Our objective is to work with our providers to make sure our Members get regular preventive and quality medical care, as well as to reduce unnecessary medical procedures. FamilyCare conducts periodic Provider Satisfaction Surveys to measure FamilyCare's performance in meeting our providers' expectations and needs.

Relevant Member Data
Through implementation of McKesson's CareEnhance® Clinical Management Software (CCMS), FamilyCare will be able to identify high-risk Members through registries in order to collaborate with providers and ensure appropriate care planning and effective evidence-based interventions. Successful disease management relies on identifying the right Members at the right time for the right reasons. CCMS focuses on 22 common or high-cost diseases and conditions, and can be customized to include others. This relevant Member data assists providers in achieving the aims of the PCPCH. Information will be communicated in various formats. Simple diagrams are provided below as an illustration. More
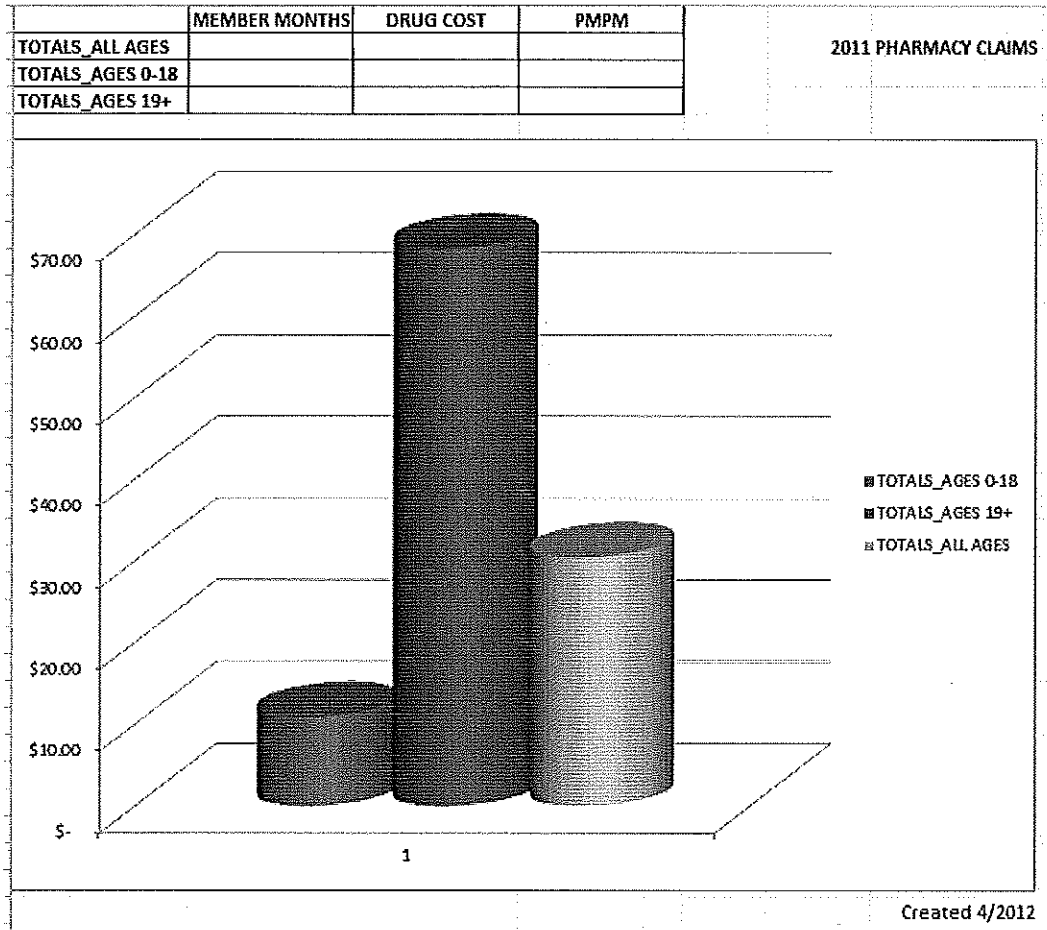
detailed information will be provided to providers including assistance to fully understand their patient population.

**FamilyCare Medicaid Population - Chronic Disease Distribution**

- Cancer/HIV 1%
- Liver Disease 1%
- Kidney Disease 1%
- Respiratory Disease 7%
- Heart Disease 2%
- Diabetes 4%
- Serious Mental Illness 12%
- Chemical Dependency 2%
- Child & Adult Obesity 3%
- No Chronic Conditions 67%

**FamilyCare Pediatrics - Large Group Medicaid Population Chronic Disease Distribution**

- Obesity 3%
- Serious Mental Illness/Substance Abuse 8%
- Asthma 9%
- Other 1%
- Members with No Chronic Conditions 79%

The analysis provided by FamilyCare is supported by our MicroStrategies software that allows us to identify key activities designed to help the provider focus on their patients with chronic conditions. This key data, along with analysis and consultation with FamilyCare's Medical Director, allow providers to better manage their patients' care and promote provider and Member engagement.  The chart below is an example of the type of information provided to our providers and details the number of Members within a practice that have certain chronic conditions and how many of those Members have been seen within the past 2 years for an appointment.  This information will assist PCPCHs with outreach to their chronic disease populations.

| ACA-Qualified Chronic Condition Category | ACA-Qualified Chronic Condition | Number of Members with condition | Number of Members rendered services at contracted PC-PCHs |
|---|---|---|---|
| Serious Mental Illness | Depression | 39 | 1 |
| | Schizophrenia | 3 | 3 |
| | Attention Deficit Disorder | 833 | 74 |
| | Post-Traumatic Stress Disorder | 150 | 3 |
| | Dementia | 13 | 0 |
| | Alzheimer's | 12 | 0 |
| | Autism | 159 | 13 |
| | Bipolar Disorder | 37 | 3 |
| | Anorexia Nervosa | 2 | 0 |
| Substance Abuse | Chemical Dependency | 46 | 2 |
| Diabetes | Diabetes | 55 | 4 |
| Heart Disease | Congestive Heart Failure | 7 | 1 |
| | Chronic Ischemic Heart Disease | 0 | 0 |
| Asthma | Asthma | 1439 | 226 |
| Chronic Respiratory disease | Emphysema | 6 | 0 |
| | Chronic Bronchitis | 6 | 0 |
| | Chronic Obstructive Pulmonary Disease | 16 | 0 |
| Chronic Kidney Disease | End-Stage Renal disease | 4 | 0 |
| Chronic Liver Disease | Hepatitis C | 9 | 0 |
| HIV/AIDS | HIV_AIDS | 1 | 0 |
| Cancer | Ovarian Cancer | 0 | 0 |
| | Lung Cancer | 0 | 0 |
| | Breast Cancer | 0 | 0 |
| | Prostate Cancer | 0 | 0 |
| | Colorectal Cancer | 2 | 0 |
| Obesity | Adult Obesity | 0 | 0 |
| | Child Obesity | 480 | 81 |

We will also provide information to our providers to help identify the cost of providing care to our Members and collaborate to develop strategies to reduce the cost of care. We currently provide information to our providers on drug costs per Member, as shown in the chart below with confidential information removed.

|  | MEMBER MONTHS | DRUG COST | PMPM |
|---|---|---|---|
| TOTALS_ALL AGES |  |  |  |
| TOTALS_AGES 0-18 |  |  |  |
| TOTALS_AGES 19+ |  |  |  |

2011 PHARMACY CLAIMS



Created 4/2012

Training and Tools to Communicate in a Linguistically and Culturally Appropriate Fashion
Through trainings, newsletters and our website, providers have access to the tools necessary to communicate with Members and their families in a linguistically and culturally appropriate fashion. We contract with interpreters, who are committed to providing high-quality on-site and telephonic interpretation in any language as a means of bridging the language barrier between our providers and all Members for whom English is not their primary language.

**A.3.1.b.**
Social determinants, such as cultural needs and socio-economic factors, are often barriers to Members' engagement in their health care. FamilyCare partners with culturally appropriate community services and PCPCHs to help overcome these barriers to better engage Members in their care. FamilyCare recognizes that the PCPCH model is an effective tool to engage Members in health care transformation. FamilyCare uses techniques, such as Motivational Interviewing, to connect Members to their primary care home. As part of a person-centered approach, Members are active participants in their care planning. Examples of this engagement were outlined in Section A.2.1. Our foundation in osteopathic medicine drives our desire

to work in partnership with Members to help them achieve a high level of wellness by focusing on health education and disease prevention.

We will invite Members to participate in a high-touch, team-centered approach as they enroll, both in the new Member packet and on the welcome calls. We inform Members about PCPCH clinics and educate them on the services offered with a strong focus on effective wellness and prevention, coordination of care, active management and support of individuals with special health care needs. We emphasize a patient- and family-centered approach to all aspects of care that focus on the whole-person in order to address a Member's physical and behavioral health care needs. We anticipate increased demand for assignment to PCPCHs and have specific goals outlined for the achievement of the highest-level certification for our primary care clinics, as discussed in A.3.1.c.

### A.3.1.c.

Our goal is to create an integrated strategy to support PCPCHs in achieving a patient-centered medical home, improve health outcomes and position PCPCHs for ongoing participation in primary care delivery under health reform. We will achieve this goal through these four approaches:

1. Engaging Members in accessing a patient-centered medical home.
2. Developing state and national level partnerships that provide coordinated training, technical assistance and support for clinic transformation to PCPCHs.
3. Continuing the strategic relationship with the State regarding reimbursement reform that supports the PCPCH model.
4. Exploring opportunities for measuring statewide health outcome improvements and cost effectiveness of the PCPCH model.

The Service Coordinator will serve as the communication hub for the PCPCH and other health and services providers to ensure timely communication for comprehensive care management. FamilyCare has always valued the relationship between the Member and PCP. FamilyCare is experienced in actively collaborating, exchanging information and facilitating and participating in care reviews with PCPs and specialists including mental, behavioral, and dental providers. FamilyCare will use the ICT as described in Section A.2.1.a. to enable communication from all disciplines and service providers to develop and review plans of care and recommend interventions and strategies to ensure the care the Member receives is comprehensive. The graph below illustrates this coordination.

FamilyCare – Member Centric Care Coordination and Provider Support
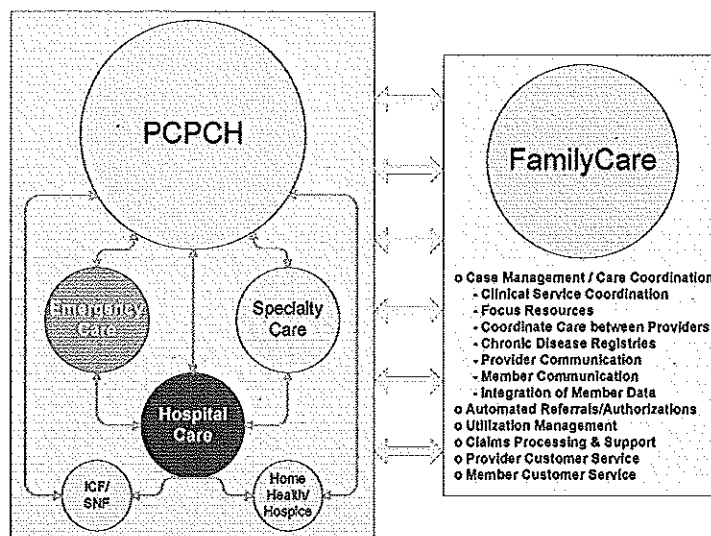
Our Service Coordinators are well versed in the benefits of having primary care clinics that are certified as PCPCHs and will assist providers with certification, if needed. We have created a PCPCH policy and have included information in our provider manual and on our website. Specifically, we plan to provide:
- Monthly meetings for quality and utilization,
- Payment incentives,
- Data profiles,
- Identification of gaps,
- Service coordinators embedded within clinics, and,
- Registry information from our Care Management system on chronic conditions of our Members.

We anticipate the demand for Member enrollment into PCPCHs to be high and therefore plan to assist clinics to become PCPCHs. FamilyCare provides technical and operational support for PCPCHs by conducting baseline assessments for Members with chronic conditions assigned to PCPCHs, and identifies chronic condition prevalence by clinic, as illustrated in graphs and charts provided in Section A.3.1.a. We will support redesigning workflow processes and provide technical assistance to participating practices to achieve higher tiered status.

FamilyCare is currently offering differential payments to PCPCH clinic providers for Members with chronic conditions. We are developing payment models that incentivize PCPCHs to provide a higher level of care and to help defray the cost of additional staff necessary to help coordinate that care. We use health information technology to monitor our Members' health as well as our providers' total population health. We will compensate high-performing primary care providers for providing excellent, patient-centered care based on national and statewide standard quality measures.

We will continue to educate our providers on the immediate need to maximize their participation in the PCPCH program as soon as possible. Currently we are contracted with 11 PCPCHs. As identified in the graph below, this represents 19% of our Membership is currently assigned to a PCPCH, which is high given our largely private provider panel and a good indicator of support for this program considering that the state just began to certify clinics earlier this year. Our target is to have 75% of our contracted primary care clinics certified by the end of 2012 with a stretch goal of 90% certified by the end of 2013.



**FamilyCare - Current Membership Attached to PCPCH**

PCPCH 30%

Non-PCPCH 70%
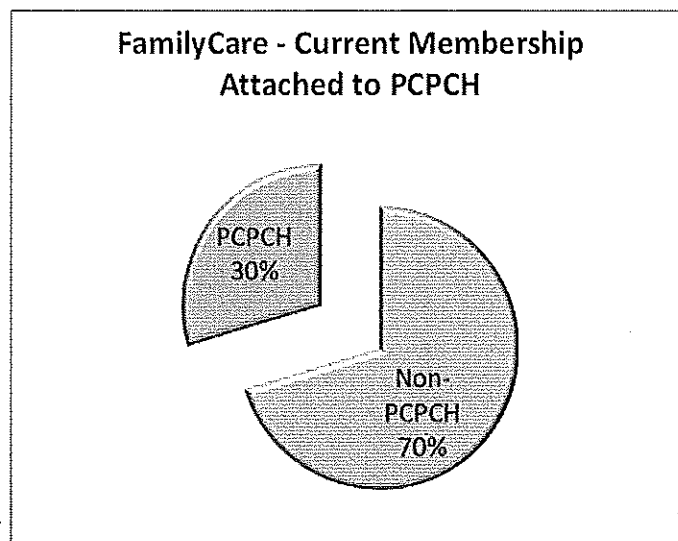
**A.3.1.d.**
As noted in the previous section the Service Coordinator will serve as the communication hub for the PCPCH and other health and services providers across the continuum of care including DHS Medicaid-funded LTC providers and services. FamilyCare is contracted as a PCO in Eastern Oregon and has been working to improve communication and coordination with the AAA/APD offices to better coordinate care and management of transitions. We attend the AAA /APD Transition and Diversion Team meetings and will expand on this relationship. FamilyCare may utilize the ICT to ensure LTC providers and services and the PCPCH are communicating and providing appropriate and well-coordinated care. We will explore and build upon existing Systems of Care approaches to enhance the participation of all members of the care team.

**A.3.1.e.**
FamilyCare values the services provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), migrant health clinics and School-Based Health Clinics (SBHCs). We are committed to ensuring the continued viability of these providers. FamilyCare has a strong and well-established relationship with SBHCs already operating in Umatilla, Multnomah and Clackamas counties. The graph below illustrates our existing relationships with these providers including PCPCHs.
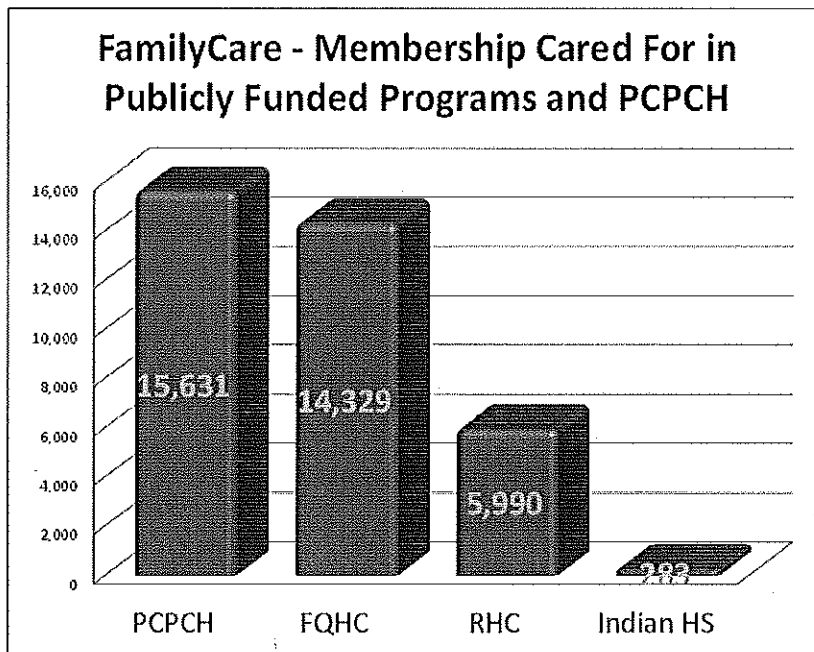


Currently our contracted FQHCs, RHCs and SBHCs are actively applying to become PCPCHs. We will continue to support and encourage their efforts.

**A.3.2.   Other Models of Patient-Centered Primary Health Care**

**A.3.2.a.**
FamilyCare's mission is to create healthy individuals through innovative systems. Family physicians are the foundation in building a caring, efficient health care system in cooperation with specialists and other providers. We believe that medical decisions are best made between the patient and provider and that osteopathic medicine creates opportunities for innovation in health care.

As mentioned in A.1.6.a., we are currently developing a new program called Provider Innovation Workgroups, which will be formed by providers from multiple and often disparate systems of care. The workgroups will each focus on one of four innovative health care initiatives in one of the following four focus areas – dental, mental health, maternal and child and service coordination/navigation. In the future, we may develop other models of patient-centered primary health care. At this time, we are fully supporting the PCPCH initiative and encouraging all of our providers to take advantage of this program.

**A.3.2.b.**
See Section A.3.1.

**A.3.2.c.**
See Section A.3.1.

**A.3.2.d.**
See Section A.3.1.

**A.3.3. Access**

**A.3.3.a.**
FamilyCare assures that services are geographically located in settings that are as close as possible to where Members reside by contracting or having strong relationships with providers throughout the community from primary care providers to SBHCs yielding a robust provider network. Our network of partners provides an array of services for all of our Members including those under-served and diverse populations. FamilyCare continually monitors its provider capacity and referral patterns to identify needs within a community with consideration for Member's cultural and linguistic needs. Utilization reports are discussed, reviewed and implementation strategies determined through the Utilization Management Committee, Quality Management Committee and the Board of Directors.

Our Service Coordinators understand our Members' needs because they are hired from and live in the areas where they work. Service coordinators are embedded in the community and co-located at providers' offices to facilitate outreach, engagement and re-engagement of diverse communities and under-served populations. For example, we understand that care coordination can be challenging for rural communities with many small, independent providers, scarce resources and health care services that must cover vast geographical areas. We realized the importance of having administrative services close to our Members as well and opened an office in Pendleton to better accommodate the needs of our Members in Umatilla and Morrow counties. In addition, our Service Coordinators have access to providers Electronic Medical Records (EMRs) to help facilitate access to services for our Members. FamilyCare also encourages the use of telehealth services for any Member in need of a specialized service that is not available locally.

FamilyCare offers services in a variety of non-traditional settings including in Members' homes, SBHCs, and Tribal clinics, as examples. We also collaborate with providers to outreach to Members with severe and persistent mental illness (SPMI) and we have care coordination services already in place to address these Members' specialized needs. FamilyCare also financially incentivizes providers to conduct post-hospital follow-up within 7 days of discharge for Members with SPMI who have been hospitalized on an inpatient psychiatric unit (many of whom have SPMI). More information on community-based services for SPMI Members is outlined in Section A.3.5.a. Additional outreach services include identifying barriers to accessing services, such as transportation issues. We plan to use more non-traditional health care workers to support individuals to become active partners in improving their own health. Examples include going into Members' homes, if needed, to help with activities for daily living, check medications, check safety of home, ensure adequate food, water and electricity is available, and determine

social/emotional/behavioral health care needs. FamilyCare also partners with organizations, such as the Native American Rehabilitation Association of the Northwest (NARA), to ensure the needs of specific populations are being met. We will continue to pursue other areas and programs specific to the needs of all our Member populations.

FamilyCare also contracts with a pharmacy network and mail-order pharmacy service to allow easy access to prescription medication for all of our Members.

### A.3.3.b.
We anticipate higher levels of Member interaction needed for Members new to Managed Care, i.e., Members joining from the Fee-for-Service (FFS) population. We anticipate enhancing our communication efforts with all Members to educate and provide assistance on new processes and procedures in place as a result of CCO transformation. We have a vast amount of outreach experience to new populations, such as the Phase II implementation with the Oregon Health Plan (OHP).

We foresee challenges with identifying new Members who have chronic conditions. Our staffing model will address the anticipated increase in new Member calls, health assessment intake, care coordination outreach and help to identify new Members who have chronic conditions. Staffing levels will be adjusted to ensure we are meeting the needs of our new Members within acceptable community standards.

We also understand that our current and new providers in our network will require additional attention to support them in understanding the new CCO process. Our strategy is to meet with them well in advance of the contract start date to effectively establish the new coordination of care process and answer any questions or concerns they may have.

### A.3.3.c.
As detailed in Section A.2.1.a, FamilyCare strives to engage all Members in establishing health care. We include education in our Member handbook that encourages Member involvement. Members are encouraged to take a lead in and follow their treatment and/or recovery plans. As outlined in this application, FamilyCare will use a variety of resources to engage our Members to become fully informed partners in transitioning to this new model of care. In addition, we are working in concert with OHA to develop specific mailers to appropriately engage our Members in this new process.

Member engagement will continue to be a major focus of our attention. The Care Management Team is implementing a new care management system and is trained in Motivational Interviewing to improve Member commitment. For example, our urban population tends to be more transient which makes it more difficult to establish relationships. We will attempt to reach this population in more creative ways such as obtaining multiple contact information, texting, secure e-mail and other internet and social media outlets.

### A.3.4. Provider Network Development and Contracts

### A.3.4.a.
FamilyCare's Network Services team handles provider relations and contracting. Our Network Services team works closely with our Care Management and Utilization Management Teams to identify opportunities to build on our existing network of primary care and specialty providers. For primary care, our goal is to maintain access at a level of at least 120% of our needs to ensure capacity and Member choice of provider. We are strong advocates of primary care providers and recognize the important role they play in coordinating and overseeing the full spectrum of care. We work closely with our primary care providers to support them in their efforts to qualify for PCPCH tiers and to manage chronic conditions effectively. As an existing MCO and MHO plan, we have the experience to coordinate the physical, behavioral and mental health needs of our Members.

FamilyCare takes the lead in arranging services and ensuring that Members' needs are met in situations where services from providers external to our service area are required. For instance, we are contracted with providers and facilities in Washington State and have a national network of pharmacies. We can provide a number of examples of Members requiring out-of-state care. In one case, a second opinion was arranged on the East Coast for a Member to determine if surgery was an appropriate course of treatment. We worked with providers locally to ensure the out-of-state specialist had all the information about the Member's medical history, assisted with the arrangement of travel and enabled providers to be in contact throughout the process. The diagram below demonstrates this example with the shaded boxes representing FamilyCare's coordination touch points.

FamilyCare - Example of a Complex Case - Out of State Consult – Care Coordination/Case Management
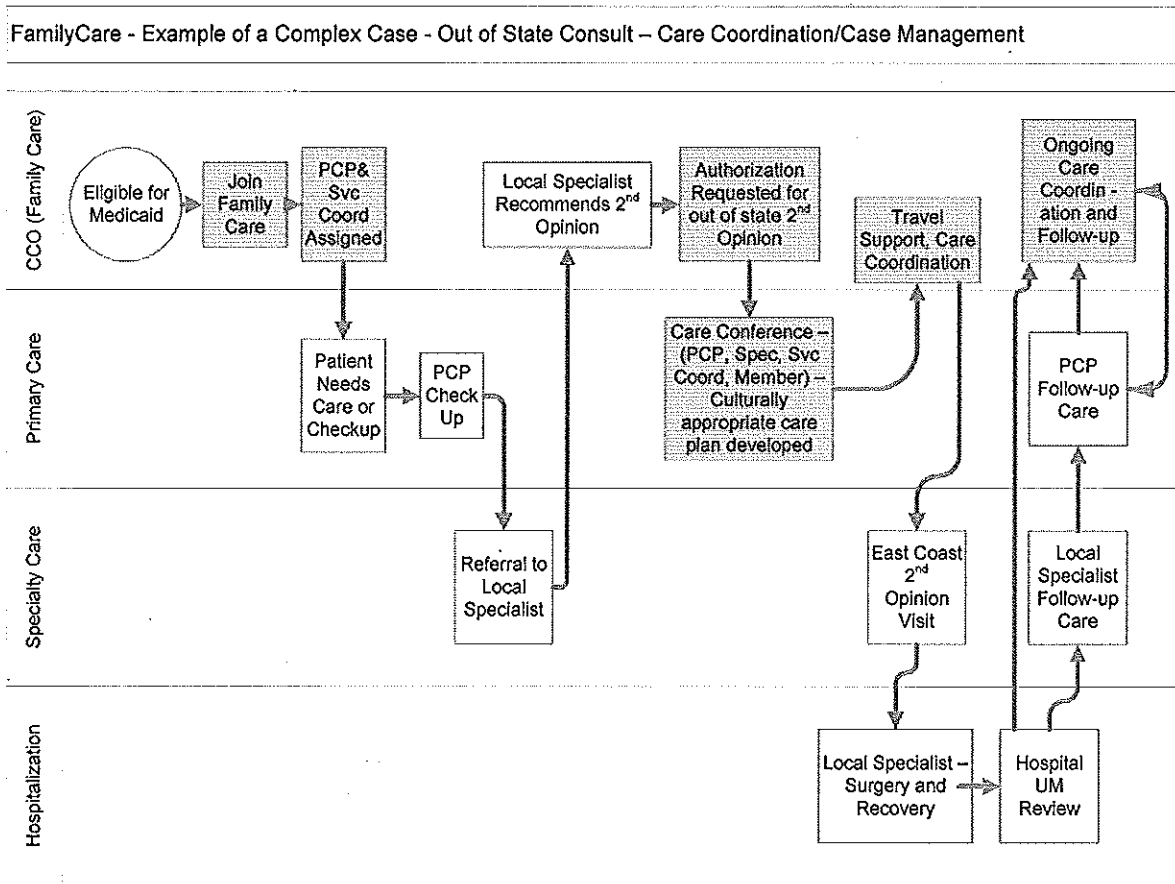


**A.3.4.b.**
FamilyCare has established mental health and chemical dependency services in place to intervene when appropriate to prevent unnecessary inpatient psychiatric admissions. A previous Performance Improvement Plan (PIP) for FamilyCare was the use of a community agency to reduce psychiatric admissions for children by providing intensive crisis services in the home. Crisis diversion services are available for both children and adults to provide community-based services that allow the Member to avoid hospitalization. If a mental health or chemically dependent Member is hospitalized, specialized Service Coordinators work with the Member and the hospital staff to get the appropriate outpatient services in place and decrease the inpatient length of stay. We provide follow-up with each Member who has been hospitalized to ensure that the appropriate services are established to prevent readmission.

Hospital Diversion
FamilyCare believes that diverting individuals from unnecessary hospitalization is extremely beneficial for a person experiencing a mental health crisis and provides significant cost savings. FamilyCare contracts with the Hospital Assessment and Diversion Service program to appropriately assess and divert Members from hospitalization and to provide safe and appropriate community-based stabilization services. Intensive Case Management staff are available on-call to respond when a FamilyCare Member is experiencing a psychiatric crisis and has been taken to a hospital in the tri-county area. Staff conduct a mental health assessment to determine what the clinical and safety needs of the Member are and determine whether they can be treated in a less intensive level of care as an alternative to hospitalization. If it is determined that diversion is appropriate, the Member will receive support to access community-based care such as a crisis resolution and/or respite center, outpatient therapy, psychiatric care and temporary housing.

Community-Based Crisis Stabilization Services
Community-based crisis stabilization is a short-term (up to 90 days) community-based alternative to psychiatric hospitalization. Families with a child in acute crisis can receive an array of traditional mental health services, such as therapy, psychiatry, and crisis respite. They can also receive non-traditional, strengths-based and individualized services. The intended outcomes are to increase safety, stabilization and community integration. Most families are transitioned to ongoing mental health services such as Intensive Community Treatment Services (ICTS). Catholic Community Services is a contracted agency that provides this type of a hospital diversion program.

Medical Detoxification
FamilyCare provides medical detoxification and stabilization for Members when clinically appropriate to address drug/alcohol abuse and dependence. Members may receive 4-7 days of medical treatment for early withdrawal symptoms. Members may self-refer to a local detoxification facility for assessment and treatment. A team of clinical staff and technicians provide around-the-clock medical care, and the facility's Medical Director sees patients several times a week. Each patient also engages in ongoing professional counseling. Upon completing the program, patients receive support from program staff to identify safe housing and ongoing resources to support recovery.

**A.3.4.c.**
FamilyCare's MHO has managed OHP benefits for Members living in Clackamas, Multnomah and Washington counties since 1997. Mental health and addiction services for adults, children and families are provided through an extensive system of care that includes outpatient, intensive outpatient, intensive home-based services, intensive case management, community-based crisis stabilization, respite, supported housing, transitional housing, psychiatric day treatment, psychiatric residential treatment, sub-acute and inpatient psychiatric care. Medical detoxification and medication-assisted treatment for Members struggling with addiction are also available. The vast array of services available for our Members allows them to receive services in a setting that is most conducive to meeting their needs. Our network is also designed to meet the unique cultural and linguistic needs of our Members. Our partnerships with providers have allowed us the flexibility to gear our services to the unique needs of each Member rather than expecting the Member to adapt to the system of established services. FamilyCare has also developed a payment methodology that compensates providers for offering services in non-traditional settings such as the home, school, a shelter, etc.

### A.3.5. Care Coordination

Care Coordination:

FamilyCare has almost 20 Service Coordinators involved in the coordination and facilitation of interventions.

Service Coordinators functions include:
- Providing intensive care coordination and case management for all Phase II (aged, blind, disabled with special health needs) Members and Medicare enrollees.
- Providing early identification of Members in need of care coordination (through reports, claims review, Health Risk Assessment, etc.).
- Creating individualized care plans to identify objectives and goals to assist in the care management of the Member.
- Ensuring that care coordination activities are focused on meeting the objectives and goals established by FamilyCare and/or external entities (CMS, AHRQ, DMAP, etc.).
- Developing relationships with community partners and resources to assist Members in managing their healthcare needs.
- Outreach to Members regarding health and wellness education as well as preventative care.

### A.3.5.a.

FamilyCare assists with the flow of relevant information between all members of the care team to support coordinated care integration. Our Service Coordinators are co-located with some of our primary care providers and are able to convey timely dental, mental and physical health information necessary to coordinate care. We use a variety of health information technology (HIT) resources, from direct access to providers' EMRs to claims management, to link services and care providers across the entire continuum of care. Supporting the free exchange of information between providers will avoid duplication of services, medication errors, and missed opportunities to provide effective preventive and primary care.

FamilyCare is experienced in actively collaborating, exchanging information, and providing care reviews and planning with DHS LTC providers. Communication is coordinated and exchanged by Service Coordinators regular participation in care team meetings with LTC transitions teams. FamilyCare has long-standing collaborative relationships with DHS providers to assist and coordinate care for Members such as those in LTC, those with special needs receiving services for developmental disabilities and mental health concerns, and those in the custody of the Oregon Youth Authority or foster care. We are building on these existing relationships to standardize and more effectively manage the flow of information for all of these Members.

FamilyCare has intensive care coordination services in place for Members with SPMI to effectively support the flow of information between providers. Our Care Management Team includes licensed physical and mental health professionals with years of experience managing care for individuals with SPMI. We ensure that the comprehensive needs of the Members are addressed and that services are not duplicated. The care of SPMI Members is routinely addressed through interdisciplinary care team meetings. A care plan is developed that clearly defines the needs of the Member, how his or her needs will be addressed and by whom. The care plan is shared with all members of the care team.

Additionally, drug utilization reviews are conducted at point-of-service to check for medication errors and/or duplication with necessary notification to providers. We look at prior authorizations and exception requests for appropriateness of treatment. People with SPMI are often enrolled in a Medication Therapy Management (MTM) program. For example, a Member on Medicare who has schizophrenia, taking

multiple Part D medications and is spending more than $750 a quarter on prescription medications would be enrolled in our Medicare MTM program. This Member receives a comprehensive medication review ·from a pharmacist. We will apply our experience in the Medicare program for handling these issues for this population to our Medicaid population. This program would be dependent on the state defining the criteria of the MTM program within the context of the PCPCH.

**A.3.5.b.**
FamilyCare continually assesses our existing provider network and develops additional partnerships necessary to allow maximum access and coordination with social and support services. Consequently, we have established key relationships with a broad network of government and non-profit support services and a seasoned provider network including crisis management, community prevention, and self-management programs to effectively meet our Members' needs. These foundational relationships include the DHS child welfare, self-sufficiency and developmental disabilities staff, the schools, court systems, and a variety of peer support and self-management services. Behavioral health crisis management services are available for all Members 24 hours a day.

FamilyCare will build upon these existing relationships and will continue to coordinate with other non-traditional and alternative services as necessary based on Member need. We will develop a resource directory of social and community partners for our providers and Members to easily access. We will continue to coordinate and assist Members to access community and social services while identifying additional ways to maximize community services. Working in partnership with our providers, we will maximize access to community support services for our Members.

**A.3.5.c.**
FamilyCare will create culturally and linguistically appropriate materials to serve as tools to assist providers in educating Members about our Service Coordination program components and the role of our Service Coordinators. We will include contact information for the Member's designated FamilyCare Service Coordinator, philosophy of the Service Coordination program and Member's rights and responsibilities to assure effective communication in all language and formats necessary for our Members to understand. Designated Service Coordinators are an additional resource for educating Members and providers about Service Coordination.

**A.3.5.d.**
FamilyCare will develop a standardized screening tool to identify Members who have multiple diagnoses and complex care needs. We will work with providers to implement this tool to employ uniform methods for identifying this population. This tool will also be used during new Member enrollment to assist in the identification of these Members. Members identified as having multiple diagnoses and/or complex care needs will be referred to their assigned Service Coordinator for further evaluation of the Member's care coordination needs.

FamilyCare's Health Risk Assessment is another tool that assesses the acuity of Members' needs and provides the stratification necessary to determine the appropriate level of care coordination. Information gleaned from these tools will be entered into CCMS and shared with all providers. The Interdisciplinary Care Team (ICT), as described in section A.2.1.a, will use these tools to develop a plan of intensive care coordination for Members with complex health care needs and will collaborate with all members of the care team, including Developmental Disabilities Programs, if necessary. The ICT will expand its function to more closely model existing wrap-around programs and other Member-centric Systems of Care.

**A.3.5.e.**
As a mental health managed care plan for Oregon Health Plan Members, FamilyCare has the expertise, experience and services in place to effectively coordinate care for Members with SPMI. As participants

in AMHI, FamilyCare has demonstrated the ability to ensure that Members receive the appropriate type of services at the right time. We have worked effectively with long-term mental health residential services to coordinate Members' needs allowing many to move to less restrictive levels of care.

Timely communication between FamilyCare and AAA/APD is critical to the successful coordination of care for Members receiving DHS Medicaid-funded LTC services. FamilyCare will develop strategic agreements and execute MOUs with AAA/APD offices in order to most effectively coordinate care and manage transitions of these Members.

In order to meet the state's expectations and goals for coordination of care for these Members, FamilyCare will deliver Member-centered care in the most appropriate setting that supports the highest level of functioning and independence. Doing so will support our goal of improving the Member's quality of life and reducing avoidable ER use or inpatient hospitalizations.

FamilyCare will enhance our Service Coordination program to possibly include co-location with LTC staff in medical settings or the LTC office. In addition, FamilyCare will work with AAA/APD Transition and Diversion teams to coordinate services in settings to support appropriate care.

### A.3.5.f.

FamilyCare will build upon our foundation of evidence-based practices by exploring innovative ways to move beyond the clinic setting in order to expand the use of non-traditional methods to engage Members to be active participants in their health care and health outcomes. FamilyCare has experience in exploring and implementing innovative ways to coordinate care. Our Service Coordination Program was implemented six years ago to coordinate care and services by co-locating Service Coordinators in providers' offices to assist Members with navigating through the health care system. Service Coordinators become part of the care team and encourage the primary relationship between Members and their primary care home. FamilyCare's Service Coordination program is a Member-centric approach for all mental, physical, social, environmental, and behavioral health care needs that are coordinated across the spectrum of care, including preventive, acute, chronic, and end-of-life care.

Service Coordinators facilitate communication across diverse providers and settings, assemble and manage meetings among interdisciplinary teams of practitioners and develop a comprehensive health management plan. Service Coordinators often are the bridge to multiple social service agencies to provide appropriate care for our Members. We have invested in flexible information reporting systems that allow us to stratify Members into high, medium, or low resource users. This helps the Care Management Team to allocate the caseload equitably across the coordination teams. Our programs also identify formal quality improvement projects and monitor progress toward meeting quality improvement goals.

FamilyCare intends to expand on our Service Coordination Program by using non-traditional health care workers, such as Community Health Workers, Advocates, and Health Coaches. We are also interested in creating opportunities for utilizing peers for physical health support. We recognize that many Members are disenfranchised and do not have access to traditional modes of health care. Providing innovative care and services to Members in our community will help reduce health disparities and achieve healthier outcomes for our Members. FamilyCare will develop or use existing measurements, such as Member surveys, to establish baseline Member satisfaction and engagement rates. Tools, such as the surveys provided by ACORN (A Collaborative Outcomes Resource Network), allow Members and providers to find the most effective and meaningful ways to interact. ACORN engages Members by monitoring and providing feedback from providers on their progress and has been shown to improve care outcomes.

As stated in the following section, A.3.5.g, the first priority for FamilyCare is to ensure that Members have a primary care home and a primary care team. The assigned Service Coordinator serves as the navigator for the primary care home and is responsible for coordination of care and managing transitions.

Assignment of Responsibility and Accountability:

**A.3.5.g.**
All of our Members are assigned a PCP and a Service Coordinator within 14 days of enrollment. A Service Coordinator can also assist Members with selection of a PCP, if needed. Welcome calls and other outreach, occurs as stated in Section A.2.1., ensure that Members receive needed care no later than 30 days after enrollment. FamilyCare's PCP assignment process affords each Member an automatic assignment to a dedicated Service Coordinator who assists the member in navigating the care delivery system to ensure appropriate levels of care and service are received. In addition to new Member outreach, the Service Coordination team runs a report weekly to identify new Members. New Members are contacted by letter and phone to engage them in participation with their PCP and Primary Care Home. Any barriers to care are assessed and addressed to allow seamless access to needed services.

We encourage our providers to reach out to our Members by sending providers a new Member roster. Many of our PCP network providers call new Members to arrange a new patient wellness exam.

**A.3.5.h.**
Access to primary care is assured as stated in A.3.5g. A PCP's culture and language skills are considered in Member assignment. The Member's PCP will conduct an initial health evaluation in a culturally and linguistically appropriate manner using interpreter services during the visit, if needed. The Service Coordination Team conducts a Health Risk Assessment (HRA) using interpreter services, TTY line or braille when needed to ensure the accurate exchange of Health Information. We provide a multi-lingual customer service line. Screening calls, Primary Care evaluations, and HRAs are used to assess appropriate levels of care and to determine if a higher level of care is needed. FamilyCare's comprehensive Transitions policy is discussed in the following sections.

Comprehensive Transitional Care:

**A.3.5.i.**
Since FamilyCare has been an integrated health plan with both physical and mental health plans, we have years of experience providing a range of coordination intervention. Service Coordinators attempt contact with all Members transitioning care within 1-3 days per FamilyCare's Post Discharge policy (see flow sheet below that outlines this process). The Service Coordinator works with the Member to identify any knowledge deficits, lack of understanding or barriers to successfully carrying out the discharge instructions. The Service Coordinator ensures the Member has the ability to follow-up as prescribed, including understanding when and with whom to follow-up and transportation needs. If a Member is not reached by phone the Service Coordinator follows up with a letter encouraging the Member to contact the Service Coordinator. If necessary, we also contact community partners to find alternative ways of reaching the Member. Partnering with hospital discharge coordinators is key for identifying Members at high-risk for readmission or poor outcomes post discharge. Service Coordinators ensure that appropriate services are in place to assist the Member in making a successful transition.
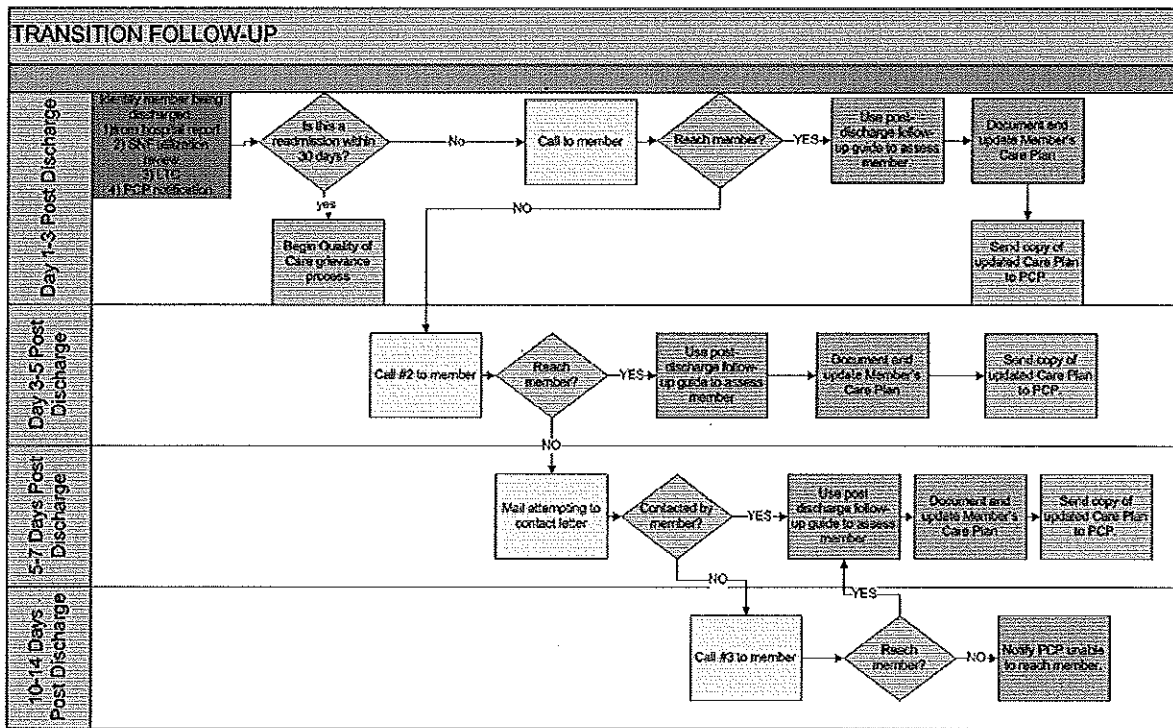
All youth and adults with serious mental health issues who are being admitted or discharged from a residential treatment center or the state hospital have an assigned mental health Service Coordinator who is responsible for ensuring that the care they receive meets his or her needs and that an appropriate plan for transitional care is in place. The Service Coordinator continues to follow the care of the Member to ensure a successful transition into the community.

**A.3.5.j.**
FamilyCare ensures comprehensive transitional care by partnering with AAA and APD to promote and monitor improved transitions for Members receiving DHS Medicaid-Funded LTC services and supports. FamilyCare, AAA and APD are integral parts of the Members' care team and will routinely meet to identify ways to improve transitional care and supports for Members by proactively addressing barriers or gaps in services, as described in Section A.3.4.

FamilyCare will notify AAA/APD within 3 days of post-acute placement when post-acute care is expected to last 30 days or less. We will notify AAA/APD no later than the 15th day of post-acute placement, if post-acute care is expected to last more than 30 days. FamilyCare will also notify AAA/APD within 3 days of post-acute placement for any individuals currently served by AAA/APD in Medicaid-funded LTC. We will work to ensure placement in the least restrictive care setting while ensuring health outcomes consistent with the individual's desires and goals.

**A.3.5.k.**
FamilyCare will continue to work with all facilities and service providers to improve the management and tracking of Member transitions from one care setting to another. FamilyCare recognizes that engagement of the Member and family members in care management and treatment planning is essential to the success of a comprehensive transition plan. Our Care Management software will be used to document activities related to Member transitions.

FamilyCare has a Medicare Advantage Plan and has experience in managing transitions in alignment with CMS requirements and guidelines. FamilyCare will obtain service agreements with hospitals and specialty facilities for effective monitoring of Member's transitions. Coordination of care and timely communication is key to successful transitions of care. Consequently, FamilyCare will work with providers, facilities, Members and other responsible parties to manage and support Members through transitions.

The Service Coordinator will serve as the communication hub for Members, Member's family, PCP and other specialty and service providers regarding changes in health status, transitions and care plans. FamilyCare will use available data, such as admission reports, claims data, emergency room reports, and communication with AAA/APD offices, specialty providers, hospitals and PCPs to assist Members and coordinate care to improve transitions and maintain the Member in the least restrictive setting. These efforts include, but are not limited to, the identification of planned transitions, unplanned transitions and Members at risk for transition.

For planned transitions, the Service Coordinator will contact the Member prior to the scheduled transition to ensure that the Member is supported prior to the planned transition. The purpose of this call is to address Member questions regarding the planned transition and educate the Member of potential transition needs which may include: home with Family, home with outpatient follow-up, home with Home Health, Skilled Nursing Facility, Inpatient Rehab or LTC services.

FamilyCare will support the Member and the Member's family during the planned transition by providing the Service Coordinator's contact information to the facility discharge planner where the Member's planned transition is occurring. The Service Coordinator will be available to assist the Member, family, provider and facility discharge staff to meet transition needs which may include care planning, goal setting, identification of caregiver, equipment needs, physical and social barriers, and ambulatory follow-up appointment(s).

Transition to Skilled Nursing Facilities, Acute Inpatient Rehab and Long-Term Acute Care (LTAC) are coordinated and authorized by the Service Coordinator. Prior to authorizing, the Service Coordinator will confirm the care plan has been received by the destination facility. The Service Coordinator will document confirmation in the care management system. The Service Coordinator will contact the Member within 48 hours of his or her transition. For planned transitions the Member's primary or treating provider will receive fax notification at the time the planned transition is authorized.

Service Coordinators will identify unplanned transitions by reviewing the Inpatient Hospital Authorization Report on a daily basis. FamilyCare will provide the same support to the Member during unplanned transitions as with the planned transitions noted above. The Service Coordinator will contact the member within 48 hours of transition home. For unplanned transitions the Member's primary or treating provider will receive fax notification within 72 hours of transition.

FamilyCare will continually monitor for Members at risk for transition in order to ensure the delivery of Member-centered care in the most appropriate setting, reduce avoidable ER or inpatient hospitalizations, and improve the quality of our Member's lives by supporting the highest level of functioning and independence. FamilyCare will identify those at risk for transition by reviewing ER reports, Inpatient/SNF admission report, Inpatient High Cost Report, Utilization Reporting via claims, Trigger Diagnosis Early Notification for Stop Loss, Readmissions within 30 days, Disease specific reports, Member outreach, coordination with LTC teams and Health Risk Assessments. Members identified as at risk for transition receive case management by the Service Coordinator to reduce unplanned transitions. The Service Coordinator collaborates with the provider, community resources, caregivers, the Member and Member's family to reduce transitions while maintaining the Member in the least restrictive setting.

Managing transitions is key to ensuring the most successful outcomes in a high quality and cost-effective manner. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting. We will provide a support structure that holds hospitals and specialty services accountable for achieving successful transitions of care and establish service agreements that include the role of patient-centered primary care homes.

Individual Care Plans:

**A.3.5.1.**
FamilyCare strives to see beyond the chronic condition and uses a holistic view of the Member. Through Motivational Interviewing, Service Coordinators assist the Member to identify areas of his or her life (health, wellness or environment) where the Member wants to make changes. Individualized goals are the cornerstone for successful care plans. Working collaboratively with the Member on the individualized goals ensures Member engagement and maintains the Member-centered focus.

The QMC has established criteria to prioritize the selection of Members for enrollment into the Care Management Program that includes:
1. Members identified with a repetitious admission history.
2. Members who do not meet the utilization review criteria for continued stay, but require alternative placement for care in an effort to prevent further deterioration of their medical and/or psychological condition and/or readmission.
3. Members for whom alternative placement for care has become a deterrent for discharge.
4. Members who are at risk for extensive utilization of medical and/or behavioral care and services, as identified by diagnosis and/or condition.
5. Members who meet criteria for the disease management program.
6. Members with accumulated claims of a specified dollar amount or greater within a specific time period.
7. Members with inappropriate utilization of services as identified by deviation from expected treatment for the presenting diagnosis. (Example: Several emergency room visits for a non-emergent diagnosis.)
8. Member referral by participating providers, Member and/or Member family.
9. Members with SPMI receiving home and community-based services covered under the State's 1915(i) SPA.

For those Members who meet these criteria, the Service Coordinator uses the HRA to develop an individualized plan of care with the Member to address the following:

- Knowledge and understanding of their disease(s)/condition(s),
- Intervention options and goals,
- Availability of community resources to support care plan, and,
- Target education to support care plan.

The Service Coordinator encourages the Member to actively participate in developing the plan of care by using outreach efforts aimed at providing health and wellness information, healthy behavior coaching, disease specific information/education and encouragement to actively participate in their health management and consistent follow-up with the Member. Evidence-based Care Guidelines are used to encourage and educate Members regarding the importance of active participation in their self-care.

**A.3.5.m.**

FamilyCare's process for screening Members includes various methods to engage Members in ways most meaningful to them. High-needs Members are identified through a variety of sources such as claims data, trigger diagnoses, special needs populations, community partner referrals, DHS LTC referrals, authorization requests, our Care Management software and/or Health Risk Assessments. FamilyCare's Care Management software enables successful disease management programs by profiling and identifying Members for intensive care coordination ensuring improved compliance through consistently administered case management and improving disease management program efficiency. Combining case, disease, and utilization management into a seamless process improves communication among all members of the care team for better outcomes. Members not referred directly to case management continue to be monitored to ensure they are receiving optimal management and treatment.

High-needs Members are contacted by a Service Coordinator or other member of the care team to assess needs and develop a care plan. One example is FamilyCare screens for depression through our Primary Care partners. In the project, all FamilyCare Members are screened for depression to identify Members who may want services but have been unable or unwilling to ask for help or those Members who do not recognize they may need care for depression. We believe this program provides opportunity for the PCP to discuss mental illness in a non-threatening way and identify Members at risk before the situation is life altering.

**A.3.5.n.**

FamilyCare will continue to partner with the AAA, APD and DHS Medicaid-funded LTC providers in the communities we serve. Information obtained by our partners will be used as an extension of FamilyCare's information and used to improve the coordination of care for our Members receiving services from these partners. FamilyCare is working with counties to develop MOUs that will address how FamilyCare and AAA, APD and DHS will work together, including information sharing and communication processes.

**A.3.5.o.**

Members with high needs will be reassessed at least semi-annually and when there is an occurrence of a significant health status change. This reassessment will be conducted in a collaborative manner with a Member-centered and Member-directed examination of the care plan to see if it continues to meet the Member's needs.

As discussed in Section A.3.5.d, FamilyCare conducts a thorough HRA for Members who have been identified as high risk or who may be at risk. This information is used to assess the acuity of the Member's needs and provides stratification for the Member's level of care coordination. Upon completion of the initial HRA and Care Plan, a quarterly or semi-annual reassessment is planned. Utilization trends, PCP communications, specialist communications, LTC updates, referrals and Member contact will identify significant changes in the Members health status. When this occurs a reassessment will be conducted in order to ensure the Member's care plan and health needs are being adequately addressed.

**A.3.5.p.**

FamilyCare believes care plans should be shared freely, within the provision of state and federal laws and regulations, among all members of the care team. FamilyCare participates in developing care plans as a member of the care team and will facilitate the distribution and coordination to all members of the care team, including AAA and APD. FamilyCare is working with counties to develop MOUs, which will establish clear guidelines and expectations around information sharing and communication processes. We will continue our robust process and expand processes in a coordinated manner.

## A.3.6. Care Integration

**Mental Health and Chemical Dependency Service and Supports**

### A.3.6.a.

FamilyCare has developed a comprehensive, coordinated, community-based service delivery system that offers effective services that are matched to the individualized needs of the Member or family. The service array reflects the cultural, linguistic and social diversity of the Members we serve. The providers selected for our network must align with the values of FamilyCare that emphasize holistic person-centered, individualized, strengths-based recovery oriented, culturally competent care that is accessible, collaborative, cost efficient care and community-based. Many of our contracted providers offer culturally appropriate peer support in addition to relevant treatment modalities.

One of our network chemical dependency providers offers cultural and linguistically appropriate care to our Native American Membership. The Member can elect to receive treatment that is specific to their culture. For example, they offer recovery programs such as the Red Road to Recovery and the White Buffalo Society, which incorporate ancient spiritual traditions with modern medical approaches to substance abuse recovery. They offer to connect the Member with tribal elders for sweat lodges, beading, and other ceremonial practices as a part of their chemical dependency treatment.

Another provider offers chemical dependency treatment with a focus on Hispanic traditions, which offer greater family involvement. They also recognize that connection to specific religious institutions is important for some of our Hispanic Membership seeking chemical dependency treatment.

FamilyCare will continue to develop and build upon our existing provider networks as we expand our Membership and better understand their cultural and linguistic needs. FamilyCare is committed to continuous learning, exploration, and education of the provider network and all care teams to ensure the diverse needs of our Membership are met.

### A.3.6.b.

As an experienced integrated physical and mental health managed care organization, FamilyCare already has the staffing expertise, systems and services in place to address the needs of Members with serious mental health and chemical dependency conditions. The addictions and mental health department at FamilyCare coordinates the services for Members with these specific needs. We have an established network of behavioral health and addictions providers skilled in caring for the unique needs of these Members. FamilyCare contracts with several agencies that provide medication-assisted therapies, community-based behavioral health services and social supports for the Members they serve. We utilize intensive case management and hospital diversion and support services to assist Members in transitioning from residential and hospital stays as well as allowing Members to avoid more restrictive levels of care completely. As an integrated health plan, we coordinate the care very effectively.

Assertive Community Treatment
Assertive Community Treatment (ACT) is a highly effective team-based model of care providing comprehensive and flexible treatment and support to individuals who live with serious mental illness. ACT is identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice that consistently demonstrates positive outcomes and is considered by experts as an essential treatment option. ACT uses a multidisciplinary team approach to provide intensive services where and when consumers need them—in their homes, at work and in other community settings—24 hours a day, seven days a week. ACT teams include peer support specialists and practitioners with expertise in psychiatry, nursing, social work, substance abuse treatment and employment, who work

closely together to provide integrated and outreach oriented-services. Team members stay in close contact with Members to help them recover and to respond quickly with more services and supports if circumstances change.

Intensive Case Management Services
FamilyCare provides intensive case management services to our Members within the tri-county area. Intensive Case Management Services (ICMS) are designed to be a flexible, community-based package of care that includes assessment and strengths-based treatment planning and recovery oriented case management that helps identify the Member's service needs, and establishes and maintains support systems and service coordination. The ICMS team delivers high quality, evidenced-based services in the Member's home or other community setting in order to avoid hospitalization by maintaining the Member safely in the community.

Intensive Home-Based Stabilization Services
Intensive home-based stabilization services are rigorous services provided in the home and community for youth between the ages of 5-17 years old and their families. An agency team will provide multiple services during the week to stabilize the youth and their family. The precipitating factors for referral to this intervention include a deterioration of functioning within the family, school environment, peer relationships or community. These youth are at risk for an out-of-home placement or are currently transitioning back into the community. The therapeutic team works closely with the family to support and maintain the youth in the community. Generally, this will include individual and family therapy, skills training, 24/7 crisis phone support to be provided multiple times a week and ongoing psychiatric medication management if needed. A clinical review (ISA Referral) completed by the FamilyCare Care Management Team determines whether this level of care would appropriately address the child and family's needs. The goal of this level of care is to prevent more acute treatment programs, such as psychiatric residential treatment. Length of stay generally varies from three months to one year depending on medical necessity. There are several contracted agencies that provide this service including: Albertina Kerr, LifeWorks NW, Morrison Child and Family Services, Options Counseling, Trillium Family Services, Youth Villages-Oregon Intercept, and Catholic Community Services. This level of care requires pre-authorization.

Medication-Assisted Treatment (Suboxone)
FamilyCare is currently in the process of developing an alternative treatment approach for Members seeking treatment for their addiction to opiates. The CRC/Allied Health Group experiences a large number of calls from potential patients seeking Suboxone treatment. Suboxone treatment offers an alternative to the traditional methadone treatment program, including the potential for office/pharmacy-based dispensing, while avoiding much of the stigma still associated with methadone treatment.

Members identified for Suboxone treatment can present with different characteristics than 'traditional' methadone clients. The "preferred" candidate for Suboxone treatment is young, (under 35), has a relatively short addiction history, is not using intravenously (or has very recent, limited IV use), is often employed or employable, has intact family and community connections, is not very interested in counseling or coming to an 'addictions agency' every day and may or may not see themselves as an 'addict'. The expected course of care is one year of Suboxone/counseling, (stabilization + three months taper off medication) followed by referral to continuing outpatient care for those Members not establishing a strong connection with a recovery community.

The other situation appropriate for Suboxone treatment is a Member who has been prescribed opiates by his or her PCP for pain, is having them discontinued, is failing or has failed titration from opiates and is being referred by their PCP. This Member may not see him or herself as an 'addict' and may not have

had prior addiction treatment. The expected course of care is approximately six months to one year of Suboxone/counseling followed by referral.

<u>The RENEW Program at Central City Concern</u>
Another innovative service designed to assist Members in reducing or eliminating their use of opiates is the RENEW program. The RENEW program is an activity-based approach to addressing chronic health conditions and managing chronic pain. The program focuses on five areas to promote wellness: nutrition, exercise, enjoyment, relaxation and connection to community. Providing a structured group model, the program's focus is on active engagement, education and peer support, providing participants the opportunity to learn individualized tools they can carry with them in their day-to-day lives.

The content and format of each group is tailored to support the goals of each individual, while also continuing to follow the principles of the RENEW program. Below are the program initiatives with content examples:
- Move (exercise) – Tai Chi, Yoga, resistance and aerobic exercise
- Eat (nutrition) – Healthy snacks, cooking classes, grocery shopping outings
- Relax – Meditation, biofeedback, audio-visual entrainment, aromatherapy
- Enjoy – Crafts, gardening, games, leisure-based activities
- Connect (community) – Volunteering, peer networking, exploring nature. Clients may also participate in the Living Room activities at the Old Town Recovery Center (OTRC)

FamilyCare currently holds an AMHI contract with OHA to coordinate and manage the care of Members transitioning from various stages of the long-term psychiatric care system. We have established an array of community based supports and services to provide for the mental and physical health needs of our Members. A mental health Service Coordinator works with our Members receiving services from extended or long-term psychiatric care programs and is responsible for ensuring that the physical and mental health needs of the Member are attended to. The Service coordinator is actively involved in developing and facilitating a timely discharge plan for each of the Members that ensures that the appropriate services are established for a successful transition to community-based care.

**A.3.6.c.**
FamilyCare enjoys the benefit of having operated as an integrated plan since 1997. An attempt is made to complete an HRA for FamilyCare Members when they enroll on our plan with a priority for Members identified as Special Needs. We are able to identify Members at risk for mental health and chemical dependency issues and provide outreach to assist them in proactively addressing potential health concerns. Addictions and mental health and physical health care coordinators regularly collaborate to assist in identifying Members who are at risk and developing an integrated plan of care. Our network of mental health and chemical dependency providers allows us to connect Members with resources they need.

**A.3.6.d.**
FamilyCare is committed to the integration of prevention and primary care services at the clinic and community level. An example of our responsiveness to our providers and Membership is the Pain Management Pilot Project.

The FamilyCare Integration Team developed a Pain Management Pilot Project to address the growing concern among providers about dealing with Members with the diagnosis of chronic pain. This project was developed in cooperation with one of our FQHCs who is the Primary Care Home for a significant number of our Membership. This pilot project was developed by our Integration Team and spearheaded

by a FamilyCare Service Coordinator with assistance from our Medical Director and a nurse with the FQHC.

The pilot project was developed in response to concerns from our providers about unacceptable narcotics use, chronic pain as a non-funded diagnosis, and the scarcity of resources and difficulty in managing these complex Members. The provider frustration also coincided with an increase in Member dissatisfaction regarding their care. The clinic provided a spreadsheet of over 1400 FamilyCare Members who had been seen in clinic for chronic pain. We applied an algorithm and reduced this list to around 100 Members.

In consultation with several providers who specialize in pain management, we chose an evidence-based curriculum with a Cognitive Behavioral Therapy Approach and a Dialectical Behavioral Therapy based emphasis on Mindfulness Skills development and exercises. Group topics include mindful eating, breathing and relaxation techniques, the importance of nutrition and exercise, guided imagery, distress tolerance, and the importance of community and connecting with others.

The Service Coordinator who spearheads the pilot project did outreach to the Members identified as most likely to engage in a pain management group. The group is to run for 11 weeks and has completed its fourth week. The group has room for 15 participants and the project has successfully engaged 12 members each week.

A Member/participant pre-survey was conducted and a post-survey will be conducted in addition to a provider pre- and post-survey. The pilot project will be evaluated and refined for possible future use in other clinics. In addition to satisfaction surveys, other utilization metrics will be applied to measure the effectiveness of the pain management pilot project.

Through the efforts of our Service Coordination staff and our established network of physical and behavioral health providers, FamilyCare is able to provide a holistic approach to care and prevention. Our orientation and ongoing communication with Members focuses on their physical as well as mental well-being. As previously indicated, FamilyCare also routinely screens all Members through the use of our HRA. Each Member is assigned to a Service Coordinator, who is responsible for assisting the Member in connecting with a primary care provider and other appropriate resources to meet their needs.

As previously indicated, FamilyCare has an extensive network of physical and behavioral health providers that must demonstrate a holistic approach to care that is strength-based, family-focused, community-based and culturally competent. FamilyCare contracts with the Multnomah County crisis line to provide after-hours emergency mental health services for our Members. We also contract with several different providers for mental health crisis and hospital diversion services for children and adults.

The mental health and addiction providers with whom FamilyCare contracts must comply with Senate bill 267, which mandates that 75% of all mental health and addiction services be evidence-based by the 2009-2011 biennium.

**Oral Health**

**A.3.6.e.**
FamilyCare intends to include the dental service component in its global budget and to initiate dental service operations contemporaneously with physical and mental health service operations. FamilyCare has conducted meetings with Dental Care Organizations (DCOs) serving Members in the tri-county area and created a standing dental subcommittee for operational planning and implementation.

FamilyCare intends to contract with every DCO with Members in the service area that is ready, willing and able to contract. Our target date to begin contractual negotiations with the DCOs is May 1, 2012. We intend to conclude the contracting process by July 15, 2012.

DCO contracting will be based on the full-risk capitation model currently in place with DMAP. DCOs will be paid an actuarially derived per Member per month fee based on historical, pooled encounter data and applicable dental service plan designs. Contracts will include provisions for necessary data reporting, auditing, quality improvement, coordination of care and reduction of hospital emergency department encounters (including triage, navigation and referrals from emergency departments to individual and/or pooled DCO emergency care providers when health acuity factors permit hospital discharge), as well as provisions required under applicable state and federal requirements.

DCO performance will be managed intensively to ensure appropriate Member access to services and high quality care. Performance benchmarks will be established based on a variety of factors including encounter data analysis, audits, quality improvement projects, coordination of care with primary health care providers and hospitals and Member surveys.

**A.3.6.f.**
FamilyCare intends to utilize intensive case management and navigation to coordinate care for Member's oral health needs, prevention and wellness as well as facilitating appropriate referrals to dental providers. Case management responsibilities of FamilyCare and DCO will be addressed contractually and through performance management metrics and evaluations. DCOs are in various stages of planning for electronic medical record systems. Goals will be established for integrating DCO, health provider, and health system electronic medical records. Consultation and referral guidelines will be mandated contractually among service providers. Key oral health and systemic health communication protocols will be established contractually among service providers, addressing, among other things, care during pregnancy, diabetes and periodontal disease/risk factors, oral health and heart health, tobacco cessation, early childhood caries and dental emergency care (pain, swelling and bleeding). FamilyCare will assist hospital emergency departments to coordinate care with DCOs, including facilitating hospital privileges for qualified DCO providers, real time triage and navigation for dental emergency interceptive care by DCOs whenever Members present to emergency departments with tooth-related emergency and without systemic health acuity factors requiring hospitalization. FamilyCare will assist PCPs who suspect necessary, urgent or emergent dental care needs to triage and navigate for DCO interceptive care or referrals for less urgent needs. FamilyCare will assist DCOs that suspect necessary, urgent or emergent physical or mental health care needs to triage and navigate those services for the Member.

**Hospital and Specialty Services**

**A.3.6.g.**
FamilyCare has performance/quality expectations written into contracts with many providers, including hospitals. Current discussions include strategies to improve transitions and reduce readmissions. Effective communication will be imperative to meet these goals. FamilyCare has well-established processes for providers to request specialty and hospital care, and we intend to continue those processes.

FamilyCare has, or is working to obtain, agreements with its contracted hospital and specialty care providers to coordinate care with a Member's PCPCH or primary care provider. All contracted providers have access to a web portal, which indicates the Member's PCP and Primary Care Home. Hospitals and specialty providers are informed of this when entering into provider agreements with FamilyCare. This enables these providers to have ready access to information regarding the Member's Primary Care Home. This has been particularly helpful in emergency room interventions and diversion.

FamilyCare has partnered with at least one hospital in their Emergency Room navigation program. In this program a Member presents to the Emergency Room and is assessed for an emergent condition. If their condition is not emergent, the ER Navigator will counsel and educate the Member about the importance of primary care. The ER Navigator is able to access FamilyCare's website to see who the member is assigned to for Primary Care. They discuss with the Member the importance of establishing care and to see if there are any barriers to establishing care. The ER Navigator has 24-hour access to FamilyCare's Care Management Phone Queue and can call and leave relevant information so the Service Coordinator can follow-up with the Member.

FamilyCare will build on this access and exchange of information to improve communication between hospitals, specialty providers, PCPs and PCPCHs with the intent of improving communication and the coordination of care. Another essential area of partnering is communication with hospital discharge coordinators for identifying Members at high-risk for readmission or poor outcomes post-discharge. This communication allows the Service Coordinator to most effectively communicate with the Member and with the PCPCH to ensure that appropriate services are in place to assist the Member in making a successful transition.

FamilyCare has written agreements that include information about the exchange of information and how to access services and referrals for the Members. FamilyCare ensures PCPs and PCPCHs are aware of the referral process through provider newsletters, our website with provider web portal, provider education and regular correspondence regarding process changes. Contracted providers have agreed to notify FamilyCare of all planned and unplanned transitions. This occurs with the daily exchange of census information, utilization review, and referrals and authorizations. FamilyCare has access to specific hospital EMR admission and discharge information for many hospitals with whom we work. We will work toward refinement of all agreements and processes to exchange discharge information so that accurate and timely follow-up with the Member is performed. This will assist in reducing readmission rates.

As previously discussed, FamilyCare's Comprehensive Transitional Care policy is the foundation for building even more robust and successful transitions with the PCPCH and/or PCP and the Member in the central treatment planning role. FamilyCare's integrated approach to transitional care ensures the Member's care plan follows the Member through their transitions and is updated as needed.

FamilyCare will continue to work with the PCP and PCPCH and all facilities and service providers to improve the management and tracking of Member transitions from one care setting to another. FamilyCare recognizes that engagement of the Member and family members in care management and treatment planning is essential to the success of a comprehensive transition plan. Our Care Management software will be used to document activities related to Member transitions and changes to the Member's Care Plan. Our ICT and hands on coordination approach will ensure the PCPCH and Member are central to the development and maintenance of the Member's plan of care.

### A.3.7.  DHS Medicaid-Funded Long Term Care Services

### A.3.7.a.
As a Managed Care Organization administering both physical and mental health benefits for Oregon Health Plan Members, FamilyCare has the demonstrated expertise, experience and services in place to effectively coordinate care for Members receiving DHS Medicaid funded LTC Services. We ensure that Members receive the appropriate type of services at the right time. We have worked effectively with long-term mental health and physical health residential services to coordinate Members' needs allowing many to move to less restrictive levels of care.

Accepted best practices will be used in coordinating care and transitions with DHS funded LTC services and providers. Timely communication between FamilyCare and AAA/APD is critical to the successful coordination of care for Members receiving DHS Medicaid-funded LTC services. Where strategic agreements are not in place, FamilyCare will develop and execute MOUs with AAA/APD offices in order to most effectively coordinate care and manage transitions of these Members.

In order to meet the state's expectations and goals for coordination of care for these Members, FamilyCare will deliver Member-centered care in the most appropriate setting that supports the highest level of functioning and independence. Doing so will support our goal of improving the Member's quality of life and reducing avoidable ER use or inpatient hospitalizations.

FamilyCare will enhance our Service Coordination program to possibly include co-location with LTC staff in medical settings or the LTC office. In addition, FamilyCare will work with AAA/APD Transition and Diversion teams to coordinate services in settings to support appropriate care. FamilyCare has contracts with some PCPs and PCPCHs who have co-located behavioral health specialists in some Primary Care settings. FamilyCare will explore additional co-location strategies to provide care coordination in congregate settings. FamilyCare will build upon relationships where we do have processes in place to ensure that the CCO care team has representation on the AAA/APD teams and vice versa. We will expand on the Systems of Care wrap-around approach in place for children to include as many special needs Members as possible. This approach will ensure an integrated team-based approach to coordination of care where Members, PCPCHs, AAA/APD, and all other stakeholders participate in a unified plan of care.

As indicated in our Care Integration response, FamilyCare already contracts with several agencies that provide medication-assisted therapies, community-based behavioral health services and social supports for the Members they serve. We utilize intensive case management and hospital diversion and support services to assist Members in transitioning from residential and hospital stays as well as allowing Members to avoid more restrictive levels of care completely. FamilyCare has demonstrated our commitment to using innovative, community-based approaches through Assertive Community Treatment, Intensive Case Management Services, Intensive Home-Based Stabilization Services, and Medication-Assisted Treatment.

FamilyCare contracts with groups which will provide in-home primary care to our Members. Where possible we will expand our use of in-home services so that clinicians may perform assessments, plan treatments, and provide interventions to the person in their home, community based or nursing facility setting. We recently had great success in a pilot program for our Medicare Advantage population where clinicians went in to the home to obtain an in-depth health history, check for environmental and safety concerns, medication reconciliations, and assess for other health and safety needs.

## A.3.8. Utilization Management

### A.3.8.a.

FamilyCare's Utilization Management (UM) activities are the same for all Members including Members receiving Medicaid-funded LTC services, Members with special health care needs, Members with intellectual disability and developmental disabilities, adults who have SPMI and children who have serious emotional disturbance. The authorization process is the same regardless of level of care in that services requiring authorization are required to come from the PCP or the PCP's authorized specialist. For acute inpatient hospital stays FamilyCare requires notification within 24 hours of admission. FamilyCare identifies over-and under-utilization through utilization patterns including ER, preventable admissions, readmissions and pharmacy data and referral patterns pulled from referrals, pre-service

requests and claims data. Utilization Review will be conducted on Member's receiving LTC through participation with the AAA/APD offices for the purposes of ongoing coordination of care.

## SECTION 4 - HEALTH EQUITY AND ELIMINATING HEALTH DISPARITIES

### A.4.1.
To address disparities in a cultural community, knowing something about that community's health care beliefs and behaviors is essential. In other words, one of the best ways to help people be healthier is to speak to them in ways that are culturally acceptable and relevant to them. It helps, for example, to know how the group generally prefers to receive information; whether they trust information given to them by a physician or other health care provider, or if they are more likely to believe something passed on by a community elder.

FamilyCare uses three key steps to do this outreach. First we gather background information about the community that we plan to work with and assess our own organization. Second, we use existing and new contacts to develop relationships with community members and organizations. Finally, we plan and implement an outreach program that includes the following:

- Innovative and practical strategies to address documented gaps in care;
- Strengthening and standardizing efforts to collect information on the race and ethnicity of enrollees, either directly or indirectly;
- Incorporating disparities reduction goals and objectives into health plan and provider contracts;
- Linking monetary incentives to initiatives to reduce disparities in health care;
- Analyzing utilization and performance data by race and ethnicity to identify disparities and target patient and provider interventions;
- Increasing access to culturally and linguistically appropriate care; and,
- Developing community-based strategies and working with community partners to reach out to minority Members.
- Reviewing outreach efforts by FamilyCare's Diversity Council on a consistent and regular basis.

A comprehensive, multi-stakeholder strategy is needed to reduce racial and ethnic disparities in health care delivery. Progress in this area requires the full engagement of the health care stakeholder community. FamilyCare values diversity at every level of the organization, diversity with our provider community partners and diversity of resources to help Members in a culturally competent way. FamilyCare has multi-lingual and multi-cultural staff with immediate access to interpreters. FamilyCare's Diversity Council looks at ways that FamilyCare internally and externally practices cultural competency to improve the health of our Members and the community.

### A.4.2.
We receive from DMAP race, ethnicity and primary language information for our Members. Our claims data includes information on mental health and substance abuse disorder data. The Members' information, including race, ethnicity, primary language, mental health and substance abuse disorder data, will be tracked in our new claims processing system and CCMS system and we will be able to report necessary quality information from these fields. We will analyze data based on these demographic factors to determine whether disparities exist and with whom, ultimately to ensure all Members are receiving appropriate care.

## SECTION 5 – PAYMENT METHODOLOGIES THAT SUPPORT THE TRIPLE AIM

**A.5.1.**
FamilyCare has developed payment methodologies and approaches that promote the Triple Aim by allowing providers the time to effectively manage their patients. The foundation of our reimbursement strategy is to provide the best compensation possible for our providers and facilities where care to our Members is delivered. Given our strong belief that Primary Care plays the most important role in our Members' care, we offer PCPs enhanced base rates and bonuses for providing services in a cost-effective manner. We also provide opportunities for providers to participate in a full range of applicable and innovative quality incentives. Examples of these incentives include setting targets for immunization rates, primary care access and health screening such as mammograms and A1c testing for diabetics.

Future payment strategies may include allowing payment for patient management in a non-traditional setting, such as by e-mail or telephone.

We are also exploring through our developing Provider Innovation Workgroups ways to incentivize providers to work together and manage their shared patients. For instance, connecting dentists and hospitals in a program that works with Members who misuse the Emergency Room for non-emergent dental conditions. By ensuring access to primary dental services and redirecting appropriately, better outcomes for the Member are achieved, as well as significant savings.

As discussed throughout section A.3.1., payments for PCPCH clinics are differential based on tier achieved, which incentivizes clinics to be certified at the highest level. Using outcome based measurements to determine provider payments will also allow providers to benefit from a healthier patient population, which is the essence of transformation.

## 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.**
Current Capacity:
- Distributing provider profile utilization data to our provider partners to encourage and support efforts to influence and improve Member utilization.
- Identifying and providing data and analysis on chronic care populations to encourage and support efforts to monitor and improve care and outcomes.
- Demonstrating active case management and care coordination and communication with providers in support of chronic care and direct communication with Members to monitor chronic conditions and preventive care.
- Providing performance feedback to providers on quality and service performance indicators, such as Balanced Scorecards, including the costs of providing care in order to meet the Triple Aim objectives.

Improvement Plans:
- FamilyCare is currently implementing a new Case Management/Care Coordination software system which will enable us to best determine where to focus resources, better coordinate care, improve communication and integrate data at key points in the workflow:
  - Improved identification and management of Members with chronic conditions.
  - Proactive case management/care coordination protocols and via automated provider

notification of care needs.
- o Automated email/postal service mailings to Members to ensure/encourage preventive care.
- o New Member Health Care Assessment documentation and maintenance of current Health Care Assessments on all Members.
- FamilyCare is currently implementing an automated Authorization and Referral request system to enable providers to initiate requests and receive immediate authorization determination via auto-authorization protocols/auto-approval criteria built into the system to help achieve the goals of the Triple Aim.
- FamilyCare will provide tools to have conversations using technology to mentor provider leadership to create a storyline describing their care for Members. We will provide an online Health Risk Assessment and plan to use Facebook, Twitter, texting and secure email to communicate with our Members and providers.
- We plan to provide a Member portal on our Website allowing access to our Health Information Library and Member's personal health records.

### A.6.1.b.
We are actively encouraging adoption of EHR "Meaningful Use" by our provider partners to improve quality, safety and effectiveness of care. We are currently in the process of surveying our provider network to ascertain:
- EHR adoption rate;
- Achievement of "Meaningful Use," i.e. use of advanced EHR components, which include computerized physician order entry (CPOE), physician documentation and closed-loop administration; and,
- Receptivity to a partnership with FamilyCare in development of cooperative efforts to support our networks' linkage to regional Health Information Exchange, Health Information Organizations, and Health Information Service Providers.

### A.6.1.c.
Our goal is to act as liaison for our provider network and to provide leadership and coordination in creating a culture for adoption of the vision of sharing health information among providers to improve care and outcomes. To achieve this goal, a strong emphasis on change management and provider network engagement will be essential to ensure that providers support the effort and understand the benefits of using the advanced EHR components.

# FamilyCare Coordinated Care Organization Application
## Appendix B – Provider Participation and Operations Questionnaire
### SECTION 1 – SERVICE AREA AND CAPACITY

| Service Area Table | | | |
|---|---|---|---|
| Service Area Description | | Zip Codes | Maximum Number of Members - Capacity Level |
| Tri-County | Clackamas | All Clackamas Zip Codes plus 97032, 97071, 97362, 97375, 97002, and 97381 from Marion County | 50,500 |
| Tri-County | Multnomah | All Multnomah County Zip Codes | 120,000 |
| Tri-County | Washington | All Washington County Zip Codes | 60,000 |
| | | Tri-County Total | 230,500 |

### SECTION 2 – STANDARDS RELATED TO PROVIDER PARTICIPATION

**Standard #1 – Provision of Coordinated Care Services**

FamilyCare has a comprehensive provider network that currently provides services for our FCHP, MHO and AMHI contracts. We routinely evaluate our network to assure it is meeting the needs of our Members and providers. We are in the process of reevaluating and establishing contracts necessary to ensure we have all the providers and services necessary to fully implement the CCO, including new providers such as Dental Care Organizations to provide dental services. As discussed in Appendix A, FamilyCare will use community health assessments to evaluate the adequacy of our provider network.

Table B-1 is submitted with this application as a draft to show current network adequacy. FamilyCare intends to submit an amended Table B-1 at the Readiness Review, including expanded information on providers who treat Members with special health needs and workforce development with respect to non-traditional providers, such as community health workers.

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

See Standard #1 response above.

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

| Publically Funded Health Care and Service Programs Table | | | |
|---|---|---|---|
| Name of publicly funded program | Type of public program (i.e.County Mental Health Department) | County in which program provides service | Specialty/Sub-Specialty Codes |
| Central City Concern, Inc | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Clackamas County Community Health, including School Based Health Centers | FQHC | Clackamas | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Legacy St. Helens Clinic | RHC | Columbia | 14 - Rural Health Clinic<br>095 - Rural Health |

| Multnomah County Health Department, including School Based Health Centers | FQHC | Multnomah | 15 - FQHC<br>084 - FQHC - Public Health, State or Local<br>097 - Federal Qualified Health Cntr (FQHC) |
|---|---|---|---|
| NARA of the Northwest | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Outside In (contracting in process) | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Virginia Garcia- Cornelius | FQHC | Washington | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Yakima Valley Farm Workers Clinic | FQHC | Multnomah, Umatilla | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |

a) FamilyCare includes publicly funded providers on our panel and has identified opportunities to enhance existing services and relationships, along with areas where greater collaboration is needed. We have included publically funded providers at our CCO stakeholder meetings and have received their input to complete this application.

b) FamilyCare is in the process of negotiating agreements with counties within our service areas to establish MOUs or written agreements that satisfy ORS 414.153(4) in areas where we do not have current agreements. These agreements will be finalized to the extent possible by the Readiness Review and will describe the authorization and payment parameters necessary to maintain the mental health safety net system.

c) As mentioned above, we are currently in negotiations to obtain agreements with counties.

### Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN)
FamilyCare understands potential cultural and language barriers that Members may experience and we strive to support a Member's choice of provider based on cultural preferences by asking our Members if they want their care delivered based on their culture. FamilyCare includes providers on our panel who are aware of and sensitive to AI/AN culture and coordinates services with these providers for Members who seek culturally relevant care. We have detailed this relationship in Appendix A.

### Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities
The referral process is the same for all FamilyCare providers. The Indian Health Services (IHS) or Tribal 638 facilities submit the prior authorization request to the Referrals and Authorizations department via FamilyCare's website or by fax. The request is reviewed based on established business rules and the provider receives a response back from FamilyCare via fax.

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

a) As a Mental Health Managed Care Organization since 1997, FamilyCare has a fully operational Integrated Service Array (ISA) Program to meet the needs of children and adolescents with severe mental or emotional disorders. FamilyCare has an extensive system of service providers who offer a range of intensive services including: inpatient psychiatric hospitalization, sub-acute care, crisis intervention/hospital diversion, psychiatric residential treatment services psychiatric day treatment services, intensive community based/in-home services and respite. An established Level of Services Intensity Process allows for quick access to the ISA from multiple points-of-entry. FamilyCare has multiple child and family Service Coordinators, who actively provide intensive care coordination to ensure that all service components are individualized, comprehensive, coordinated, culturally competent, flexible, family-focused and child-centered. Coordinated care across systems and providers is integrated to ensure that children and adolescents are served in the most natural, least restrictive environment possible to sustain connections to home, school and the community.

b) FamilyCare has established strong collaborative relationships with all of the system partners serving the needs of children and their families. On a community level, FamilyCare has partnered with community providers and other systems of care, such as through participation in the Multnomah County Children's Advisory Council, to address system issues/needs. FamilyCare's ISA Program utilizes intensive care coordination to ensure services are coordinated through regular child and family team meetings that include representatives from each of the child serving agencies involved in providing services to a child and their family.

c) FamilyCare has created an intensive care coordination and service delivery system that incorporates the System of Care Values and the collaborative principles and practices that closely resemble the ten principles of the wrap-around process in every aspect of planning, implementation and service delivery. Providers are selected based on their ability to meet the needs of our children and adolescents and deliver care that is are family-focused and child-centered, community- and team-based, culturally competent, individualized, strengths-based, flexible, collaborative and inclusive of natural supports. Intensive care coordinators work directly with families to identify individual needs and to create a coordinated plan of care that emphasizes the child and family's strengths in the least restrictive environment.

### Standard #7A – Mental Illness Services

a) FamilyCare has an established array of mental health providers who are skilled in the delivery of community-based services. We have a mental health coordinator assigned to facilitate the needs of our Members who are receiving home- and community-based services in residential care. Our mental health coordinators work closely with our Service Coordination staff to ensure the physical health concerns of our Members are also addressed.

b) FamilyCare routinely screens all Members through the use of our Health Risk Assessment. We closely monitor utilization of services and intervene with Members who are over-utilizing services. We discuss the screening process in Appendix A.

### Standard #7B – Chemical Dependency Services

a) We have engaged a comprehensive array of chemical dependency providers to provide services for our Members. As an integrated plan, we have experience in coordinating the mental health, physical health and chemical dependency needs of our Members in the community and in residential settings.

b) FamilyCare routinely screens all Members through the use of our Health Risk Assessment. We closely monitor utilization of services and intervene with members who are over-utilizing services. We discuss the screening process in Appendix A.

### Standard #8 – Pharmacy Services and Medication Management

a) FamilyCare provides a prescription drug benefit that is driven by the company's value that evidence-based information and education empower both the patient and provider to make responsible healthcare decisions. Supported by the services of our Pharmacy Benefits Manager (PBM) CVS Caremark, and overseen by the FamilyCare Pharmacy and Therapy (P&T) Committee, FamilyCare's in-house pharmacy department manages an accessible, effective and fiscally responsible pharmacy benefit through formulary development, utilization management, Prioritized List adherence, pharmacy network access, pharmacy claims adjudication and timely reimbursement and member and provider support.

b) FamilyCare uses a formulary of preferred medications, which is reviewed and approved by the FamilyCare P&T Committee. A non-preferred or non-formulary medication may be requested through a prior authorization process and an exception may be granted if it is determined the requested drug is medically necessary.

The role and responsibilities of the FamilyCare P&T Committee include, but are not limited to, developing and reviewing FamilyCare's formulary; basing its clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data and other such information as it determines appropriate; approving inclusion or exclusion of the

therapeutic classes in the formulary; reviewing policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, generic substitution, and therapeutic interchange; and reviewing and approving all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions.

In addition to the role and responsibilities of the FamilyCare P&T Committee concerning utilization management, FamilyCare's pharmacist and PBM provide concurrent and retrospective review of utilization trends to determine appropriate utilization management of prescribed medications including, but not limited to, compliance monitoring to improve adherence/persistence with appropriate medication regimens, monitoring procedures of over-utilization through multiple prescribers or multiple pharmacies, medication error identification and reduction, and screening for potential medication therapy problems due to therapeutic duplication, interactions and/or contraindications.

The FamilyCare P&T Committee, which is comprised of physicians and pharmacists practicing in Oregon and responsible for developing and approving the formulary, meets at least quarterly to review the formulary. As mentioned above, the P&T Committee bases its clinical decisions on the strength of scientific evidence and standards of practice as it determines appropriate.

c) Through our PBM CVS Caremark, FamilyCare provides a contracted national pharmacy network consisting of retail, mail order, home infusion, long-term care (LTC), specialty and I/T/U (Indian tribe, tribal organization and urban Indian organization) pharmacies sufficient to provide convenient access to Members living in urban, suburban and rural areas. The formulary choices and changes are communicated to Members, providers and pharmacy network via Member materials, postings on the FamilyCare website, Member and provider notification letters and/or point-of-sale pharmacy messaging. A form to request a prior authorization, including an exception for a non-formulary medication, is available on FamilyCare's website and may be requested from FamilyCare via phone, mail, fax or email by a Member or prescribing provider. The request will be submitted to FamilyCare who will work with a Member's provider(s) to obtain the necessary information. The Member and provider will be notified of the decision, and the Member will be provided with his/her rights and responsibilities to an appeal as applicable.

d) As FamilyCare's PBM, CVS Caremark has established integrated accumulations connectivity, communicating in real-time or in batch mode. CVS Caremark prefers real-time connection for processing integrated accumulations. CVS Caremark works with industry-leading debit card providers, CDH organizations, health plans, and third party administrators to support stand-alone pharmacy and integrated medical and pharmacy consumer-directed health plans. Its adjudication engine has the capability to process COB claims at point-of-sale real time as long as the pharmacy submits the correct "other" coverage indicator.

e) FamilyCare uses an in-house staff of pharmacy technicians, pharmacist and physicians to process pharmacy prior authorizations (PA). PAs are received 24 hours a day, seven days a week and are reviewed during the normal hours of operation of Monday through Friday, 8am to 5pm. Urgent requests are reviewed within 24 hours, including on weekends.

F) **THIS SECTION IS CONFIDENTIAL AND EXEMPT FROM DISCLOSURE**

## Standard #9 – Hospital Services

a) FamilyCare currently has contracts with two major hospital systems in the Tri-County area (Legacy Health System and Providence Health System) and is in the process of establishing agreements with other hospitals. All services, except highly specialized services that require out-of-state care, are available. Having multiple contracts supports providers' and Members' ability to choose where care is provided and received. Our referrals and authorizations processes require providers to treat their Medicaid populations equally in relation to access, duration and scope of services provided.

b) Our Service Coordination, Care Management and Network Services Teams play a key role in educating Members and providers on appropriate use of ambulance, emergency room and urgent care services. By working closely with Members and providers, our Service Coordinators support and influence the appropriate use of these services. Our Utilization Management Team, along with our Medical Directors, monitors and reviews utilization patterns and works closely with our Service Coordinators when concerns about inappropriate use arise. When this happens, discussion with the Member or his/her provider(s) occurs to address the concern and work together to identify ways to encourage appropriate use of these services. In many cases, FamilyCare has access to providers' EMRs to help us perform this work. Our Network Services Team handles provider relations and contracting, and they are involved in working with our hospitals and health systems to develop and support processes that encourage appropriate utilization. Providing access to Member data for use by emergency room navigators so that they can intervene, when medically appropriate, by redirecting our Members to Primary Care is one example of this collaboration.

c) Our agreements stipulate that hospitals and health systems will not be reimbursed for Adverse Events or Hospital Acquired Conditions (HACs). Our Utilization Management Team, working closely with our Medical Directors, reviews hospital care closely to identify Provider Preventable Conditions and initiates follow-up as needed.

d) Readmissions are identified and monitored by our Care Management and Utilization Management teams. Those that occur within 7 and within 30 days of the date of the first admission are reviewed by the Medical Directors to determine if the nature of the illness resulted in a readmission that was not preventable or if further investigation related to quality of care is indicated. If there was a potential preventable reason for the readmission, we address our concern collaboratively with the providers/facilities involved in the care.

e) FamilyCare will employ innovative strategies to decrease and prevent unnecessary hospital utilization, including but not limited to:
   • Contracting with Ambulatory Surgical Centers (ASCs) to provide appropriate outpatient surgical care.

- Using alternative addictions/mental health facilities (residential care, transitional care) to prevent hospitalizations.
- Supporting the PCPCH through contract incentives, e.g. incent primary care access and coordination of care to monitor and control chronic conditions.
- Utilizing our Service Coordination and Care Management Programs to coordinate effective transition from inpatient setting back to PCP with the aim to reduce readmissions to the hospital, ER visits, etc.
- Assuring adult Members diagnosed with COPD, CHF and children diagnosed with asthma are managed effectively.
- Contracting with hospital diversion services to divert inpatient psychiatric stays for children and adults.
- Developing community-based in-home mental health and addiction services.
- Paying for inpatient hospital services on a capitated basis.

## SECTION 3 – ASSURANCES OF COMPLIANCE WITH MEDICAID

**Medicaid Assurance #1 - Emergency and Urgent Care Services**
FamilyCare has established mechanisms to assure Members have access to emergency and urgent services 24-hour/7-days per week. Specific service expectations of participating providers are:
- Emergency medical services - service is provided within two hours or less of presentation of symptoms to the provider/practitioner. Immediate evaluation or triage to Emergency Department.
- Urgent care services – service is provided within 24 hours for physical health and 48 hours for mental health.
- Arrange for an answering system after office hours that Members can access through the usual office protocol.
- Response to emergency phone calls should be within thirty (30) minutes.
- Response to urgent phone calls should be within one (1) hour for physical health and thirty (30) minutes for behavioral health.
- Provide 24-hour physician coverage through another FamilyCare Participating Provider to ensure the urgent and emergency needs of members can be met 24-hours per day, 7-days per week.

Communication/Monitoring for Providers (this is for all Medicaid Assurances listed below):
FamilyCare will produce communications to providers, throughout each contract year, that are designed to communicate policies, procedures and other information required by state and federal law and rules. The information will be communicated in writing via direct mail, email, website or web portal postings, handouts at provider office visits, provider newsletters or reference manual or workshops. FamilyCare's auditing program is designed to identify issues and educate our providers as appropriate. The audit process is performed on a routine and scheduled basis for contracted primary care providers and high use specialists.

**Medicaid Assurance #2 - Continuity of Care**
Coordination of Care
FamilyCare has established policies to ensure a system for coordination of care. The care coordination process includes identification, stratification, assessment, planning, implementation, monitoring and evaluation of options and services from multiple sources in accord with the multidisciplinary health care team. Service Coordinators perform functions, which includes but are not limited to:
- Reviewing of inpatient admissions for initial and follow-up assessments;
- Ensuring quality, cost effective care in the appropriate care setting;
- Evaluating medical histories and work with providers to ensure that a care plan with treatment goals exists;
- Providing psychological/emotional and educational support to Members;
- Facilitating and coordinate health care services for Members;
- Interpreting benefit coverage for Members and identify non-covered benefits;
- Assisting providers with innovative/alternative care options;

- Coordinating authorizations; and,
- Working with facility discharge planners to assess, plan and implement discharge needs, and ensuring health care services are arranged for day of discharge.

<u>Referral and Authorization</u>
FamilyCare has policies and procedures to ensure timely organization determinations regarding the benefits a Member is entitled to receive. These determinations are made using FamilyCare guidelines, nationally accepted Milliman criteria for medical necessity, and community standards of practice. Any co-morbid conditions are considered along with specific plan benefit guidelines. All information regarding determinations is maintained in the Medical Management system.

## Medicaid Assurance #3 - Medical Record Keeping
FamilyCare has internal policies and procedures to ensure medical records will be treated as confidential to comply with all state and federal laws and the Health Insurance Portability Accountability Act (HIPAA) regarding privacy, confidentiality and disclosure of patient/Member medical records. FamilyCare requires contracted provider facilities and offices to have established procedures to:
- Safeguard the privacy of any information that identifies a patient/Member.
- Ensure information from, or copies of, medical records may be released only to authorized individuals. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.
- Maintain the medical records and information in an accurate and timely manner.
- Ensure timely access by a Member to the medical records and the information that pertain to the Member.

## Medicaid Assurance #4 - Quality Improvement
FamilyCare has policies and procedures to ensure that Performance Improvement Projects (PIPs) and Quality Assessment and Performance Improvement projects (QAPIs) are conducted under the organization's Medical Management program to address and achieve improvement in major focal areas of clinical care and non-clinical services. FamilyCare will demonstrate that its interventions result in measurable improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each PIP or QAPI project. The Quality Management Committee with input from the Addictions and Mental Health Quality Management Committee and under the authority of the FamilyCare BOD oversees the selection, interventions and review of the PIPs and clinical QAPIs.

## Medicaid Assurance #5 – Accessibility
FamilyCare will not discriminate between Members and non-Members subject to definition of Coordinated Care Services and identification of benefits to which they would be entitled through CCO.

## Medicaid Assurance #6 - Grievance System
FamilyCare has policies and procedures that provide a mechanism for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives. FamilyCare's policies meet or exceed the filing and response timing guidelines in accordance with OAR 410-141-3260 through 410-141-3266, and 42 CFR 438.400 through 438.424.

## Medicaid Assurance #7 - Potential Member Informational Requirements
FamilyCare handbooks and provider directories are available by request to potential Members. In order to best serve our Member population, FamilyCare provides informational material in Spanish, Braille, Russian, Vietnamese, Large Print and Audio. FamilyCare will also provide verbal translation of written materials.

## Medicaid Assurance #8 - Member Education
FamilyCare will ensure that all new Members receive their Member Handbook within 14 days of the plan's notification of the enrollment. FamilyCare offers orientation to new Members through our regular distribution of a Member Handbook and supplemental health education material. Members will also receive a welcome call through our Customer Service team to proactively provide assistance with orientation questions or PCP assignments. Members may also receive an orientation call from our Health Services team using our Health Risk

Assessment tool or offering assistance with our maternity program, as applicable.

## Medicaid Assurance #9 - Member Rights and Responsibilities

FamilyCare will inform Members of their rights and responsibilities through the Member Handbook for FamilyCare OHP Members and the Evidence of Coverage (EOC) for Medicare Members. Members receive the Handbook or EOC when they enroll in FamilyCare, or upon request. The Member Handbook and EOC are also available on our website. FamilyCare respects and abides by a Member's rights and ensures all services are provided in a culturally competent manner and are accessible to diverse ethnic backgrounds. FamilyCare does not discriminate in the provision of health care services on the basis of race, color, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national-origin.

## Medicaid Assurance #10 - Intensive Care Coordination

FamilyCare will provide Intensive Care Coordination services as needed to Members who are aged, blind or disabled as well as children with special health care needs and children in the Oregon Youth Authority. These services will be coordinated with, but not limited to, Members, Agency Case Managers, PCP's and community partners and will be provided to ensure that dignity, confidentiality, and specific disability issues related to Members' medical, social, and quality of life issues are respected and considered.

## Medicaid Assurance #11 - Billing and Payment Standard

FamilyCare will process Medicaid claims consistent with the requirements set forth in the CCO contract. In addition, FamilyCare may use the following guidelines:

- FamilyCare covers all Covered Services consistent with medical management policies.
- FamilyCare pays allowable rates unless specified differently in FamilyCare Benefits or Contracts.
- Payments will not be made to any provider who does not have a DMAP identification or who has been excluded as Medicare/Medicaid providers by another state or CMS.
- When appropriate, FamilyCare will identify payers that are primary to Medicaid prior to adjudicating the claim.
- Coordination of Benefits between primary and secondary payers will be processed according to the Coordination of Benefits policy and procedure and consistent with Third Party Recovery policy and procedure.
- Claims will be processed according to the Timely Filing policy and procedure (90% of valid claims will be paid or denied within 45 calendar days of receipt).
- Ongoing monitoring is done to ensure timely payment at all times.

All of FamilyCare's provider contracts contain language regarding not holding Members responsible for provider's debt if the entity becomes insolvent.

## Medicaid Assurance #12 - Trading Partner Standard

Trading Partner Agreement is on file and was signed on 12/14/07. Testing has been completed and appropriate monitoring systems are in place.

## Medicaid Assurance #13 - Encounter Data Submission and Validation Standard – Health Services and Pharmacy Services

FamilyCare has established mechanisms to capture, validate and report encounter data that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides. FamilyCare has monitoring systems in place and regularly reviews the operations of these systems.

## Medicaid Assurance #14 - Enrollment and Disenrollment Data Validation Standard

FamilyCare currently monitors and validates enrollments and disenrollments via MMIS and 834 transactions. FamilyCare also follows the CMS Managed Care Guidelines for confirming or rejecting enrollment and disenrollment via the CMS Transaction Reply Report (TRR). Discrepancies are submitted to the state on a monthly basis.

## FamilyCare Coordinated Care Organization Application
## Appendix C – Accountability Questionnaire

### SECTION 1 – ACCOUNTABILITY STANDARDS

### C.1.1. Background Information

**C.1.1.a.**

FamilyCare uses a broad set of software tools and products to facilitate the use of health care cost and utilization data. We use this data to enrich a collaborative partnership with our providers aimed at improving cost and outcomes. FamilyCare imports our paid claims data into our MicroStrategy tool to create utilization and health care cost reports. We generate specific provider profiles that track a wide variety of usage and utilization reports such as, member RX per assigned PCP, costs per visit, inpatient and outpatient outliers, ER usage, medical expense ratio, specialty claim costs and other member usage driven reports. By providing our providers specific and general data for their practices, we create a collaborative partnership aimed at improving costs and outcomes.

As discussed previously, FamilyCare's significant growth over the past two (2) years has necessitated changes to internal staffing, information technology and operation structure. Many of these changes have related specifically to FamilyCare's ability to provide data on cost, utilization and outcomes.

By October 1, 2012, we will have fully implemented a software program provided by PH Tech that focuses exclusively on helping health care organizations make claims management easier and more flexible. PH Tech uses web-based technology and offers software products and services that put providers in control and give them the means for up-to-the-moment monitoring of authorizations, referrals and claims. Providers will be able to directly pull reports for their Members. This claims data will feed into our new Care Management system that will help identify specific and chronic conditions or procedures that may put Members at high risk. Our new system will be set up in a way that allows for certain codes to trigger certain actions by our Service Coordinators. For instance, if a Member has a claim for an inpatient stay, it will alert the assigned Service Coordinator to follow-up with this Member to assist in transitional care aimed at preventing possible readmissions.

**C.1.1.b.**

FamilyCare participates and will continue to participate in Healthcare Effectiveness Data and Information Set (HEDIS) reporting for Medicare Advantage and Special Needs Plans (SNP) lines of business. FamilyCare also reports data to Quality Corp for public reporting measures. This initiative has produced three rounds of private data reports for adult primary care providers on measures of chronic disease care and women's preventive services. In November 2010, adult primary care providers and pediatricians began receiving private reports on 20 measures, which also included pediatric care and utilization. Quality scores on nine of these measures have been publicly reported for clinics with four or more providers since February 2010.

FamilyCare reports quarterly on appeals and grievances received by Members as well as maintains two Performance Improvement Projects (PIPs). One PIP is related to improving metabolic testing for

Members with schizophrenia. The other PIP is integrated with both physical and mental health working to improve physical health access for Members with chemical dependency and mental health services. Both PIPs demonstrate FamilyCare's emphasis on the Member's complete care, focusing on both physical and mental health needs.

**C.1.1.c.**
FamilyCare's Board of Directors (BOD) has delegated the authority to the Quality Management Committee (QMC) to review and approve providers that meet FamilyCare's standards for panel participation. The QMC ensures that an effective Credentialing Program is established, supported and maintained. FamilyCare adheres to comprehensive credentialing and re-credentialing processes in accordance with state and federal regulations and the National Committee on Quality Assurance (NCQA) standards and guidelines for all applicants prior to participation in FamilyCare's provider network. Credentialing policies and procedures are reviewed by the QMC on an annual basis. As directed by the BOD, the Medical Directors have the authority and responsibility of day-to-day oversight of the Credentialing Program including the review and approval of providers who meet FamilyCare's definition of Category I applicants, who are subject to final approval by the QMC. Providers not meeting the Category I criteria, and/or any applicant whom the Medical Director has outstanding concerns or questions will be referred to the QMC for final review and credentialing decision.

All providers must complete the credentialing process, even when joining from a contracted practice. A provider will not be appointed or reappointed to FamilyCare's panel if the provider meets any of the following criteria: a) Is subject to Medicare/Medicaid sanctions or exclusions; b) Is subject to license restriction which affects or may affect the ability of the provider to provide contracted services to FamilyCare Members; or c) Has failed to demonstrate sufficient training, experience, competence, ethics, qualifications, insurance and/or the ability to work in a professional manner. Provider performance data reviewed during the process includes, but is not limited to, quality review and improvement findings, access surveys, utilization review, Member complaints and other Member satisfaction measures.

**C.1.1.d.**
FamilyCare shares performance information with providers as part of quality improvement projects. As stated in C.1.1.b, FamilyCare participates in a public reporting program with Quality Corp that is shared with providers for quality improvement purposes. Additionally, FamilyCare collaborates with providers in areas of immunization rates, access, and drug safety. FamilyCare's Quality Coordinator collects the necessary data from a FamilyCare Business Analyst. The Quality Coordinator analyses the data, reviews the data with the Integrated Quality Committee (IQC) and reports the results of the data analysis to the QMC. More information on reporting was detailed in Section C.1.1.a.

**C.1.1.e.**
All performance information that FamilyCare shares with Members reflect FamilyCare's dedication to meeting Members' cultural and linguistic needs. As stated throughout Appendix A, FamilyCare provides all Member materials in formats that meet Members cultural and linguistic needs. Performance information is currently shared with Medicare Members when requested per Medicare guidelines. We plan to report Providers' PCPCH status in our Member Handbook to identify providers involved with quality programs, as discussed in Appendix A. Additionally, FamilyCare currently has consumers participate on the Addictions and Mental Health Quality Management Committee (AMHQMC). We will also have consumers on our Community Advisory Councils whose role will be to assist us in providing appropriate information to our Members.

For our Dual-Eligible population, Members can view our Five-Star Quality Rating for our Medicare Advantage Plan on the CMS website. We will provide our rating on our website for Members to see our dedication to quality outcomes.

**C.1.1.f.**

FamilyCare has expanded the use of quality measures/reporting in connection with provider incentives. For 2010, FamilyCare's MHO providers received an incentive bonus for post-hospital follow-up care provided to Members following an acute hospitalization. FamilyCare renewed the program for 2012. Two large provider groups in the tri-county area participate in an incentive program to improve immunization rates for children 2-10 years of age. Another incentive program is for access to primary care providers for children 0-10 years of age. FamilyCare is working with additional provider groups to establish quality incentive programs focused on health screening and outcome measures. FamilyCare is continuously developing quality incentives in partnership with our providers to improve outcomes for our Members.

**C.1.1.g.**

FamilyCare collects and reports data to OHA for the quality measures listed in Table C-1 using many methods including: claims data, pharmacy data, enrollment data, Health Risk Assessments (HRA) and Member surveys. FamilyCare uses these data sources to report both state and federal quality measures, including HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS). FamilyCare abstracts data from medical records to obtain data not likely to be captured in encounter claims data, such as the end-of-life measures.

To demonstrate our capacity to collect and report required quality measures, we have provided information below on Chronic Care Improvement Programs (CCIPs) that are required by Medicare and Performance Improvement Projects (PIPs) that are required by Medicaid.

As of January 2006, Medicare required Medicare Advantage Organizations (MAOs) to initiate one self-selected Chronic Care Improvement Program (CCIP) per year and to submit reports on these projects in advance of the MAO's routine CMS audit. FamilyCare has implemented three CCIPs since becoming a MAO for the following conditions: Congestive Heart Failure (CHF), diabetes and Chronic Obstructive Pulmonary Disease. Using CHF as the primary example, FamilyCare targets Medicare Advantage (MA) Members, age 18 and older, with CHF. We identified 140 unique Members with a diagnosis of CHF. 71% of eligible Members are Dual-Eligible.

FamilyCare's process that is currently in place to inform MA Members of their eligibility in the CCIP includes:
1.  On a monthly basis, Health Services updates a list of eligible enrollees with CHF diagnosis for case management.
2.  The Service Coordinators contact the Members by telephone and/or letter to:
    a.  Complete a Health Risk Assessment (HRA);
    b.  Discuss participation in the CCIP (out in/opt out); and,
    c.  Develop a CHF care plan.
3.  On a semi-annual basis, a letter is mailed to the enrollees participating in the CCIP with the opportunity to opt out of the program. The letter also includes a self-addressed stamped envelope to be returned to the Service Coordinator.
4.  Using an Excel spreadsheet, the Service Coordinator tracks the number of Members the 'opt out' letters was mailed to and the number of Members who opted out.
5.  The Service Coordinator tracks, scans and saves the Members opt out letter.
6.  The Service Coordinator contacts the Members to verify that the Members understand the content of the letter.
7.  The Service Coordinator then scans and saves the letters into the Members electronic files.

8. If a Member chooses to opt back into the program, the Service Coordinator will document in the Medical Management System under the case management module and note the change on the CHF opt out list spreadsheet.
9. The process is initiated semi-annually.

Medicare Members meeting the inclusion criteria are included in a list provided to the Care Management Department for Service Coordination and are automatically enrolled in the CCIP. 24% of Members in the eligible population had at least one inpatient acute hospital stay during 2011, 39% of the eligible population had at least one Emergency Department visit during 2011. FamilyCare will be able to reduce these rates by providing disease management. Reducing the rates will demonstrate improved health status and access to primary care.

As of February 2012, all eligible Members were mailed Optional Opt-out letters. This will be an on-going process as new Members become eligible to the plan and meet eligible criteria.
- Letters will be mailed via certified mail.
- Return receipts will be forwarded to Quality Coordinator to track portion of members receiving letter and response rate.

By April 1, 2012, interventions to be implemented for all Members who did not opt out of CCIP, on an on-going basis include:
- Assess the Member's compliance with CHF care via the Health Risk Assessment (HRA).
  - Barriers: knowledge of medications/treatments/condition; barriers to medications/follow-up appointments. When barriers are identified through HRA, the Service Coordinator can problem-solve with the Member to overcome the barriers.
- Develop CHF care plan.
  - Barriers: Difficult to gauge Member's engagement level, intervention will improve engagement by involving Member in developing a care plan and setting short- and long-term attainable goals.
- Provide education based on Member's current knowledge of CHF.
  - Barriers: Health literacy, cultural/language barriers. The Service Coordinator Team received training in health literacy. There are four members of the Service Coordinator Team who speak Spanish, one American Sign Language, and one Tagalog. All Service Coordinators know how to access interpreter services.
- Follow-up based on Member's compliance with plan of care and educational needs.

The interventions/strategies described above seek to:

- Engage Member in self-management;
- Increase the Member's knowledge and treatment related to CHF;
- Improve the Member's health status, quality of life and compliance with medications and diet;
- Delay progression of CHF; and,
- Reduce incidence of hospitalization and ER services.

The Member's progress is measured through care plan compliance and specific utilization reports including, Pharmacy, ER and Inpatient. Monthly monitoring of the Members includes:
- Medication utilization appropriate to the diagnosis to assess Member compliance with medication plan of care.
  - On a quarterly basis, the Member's list of medications is reviewed for compliance.
- Inpatient/ER utilization to assess Member compliance with overall plan of care.
  - For the ER and inpatient utilization, CHF must be the primary diagnosis code.

- Service Coordinators assess the Member's level of need based on reports on frequency of medications filled by the enrollees to focus education and intervention.
    - o Quarterly updates of the CCIP participants' performance is discussed at the Service Coordination meetings. Any improvement opportunities will be discussed and approved by the Integrated Quality Committee (IQC) and Quality Management Committee (QMC).

In addition to CCIPs, FamilyCare has demonstrated capacity to collect and report on any required quality measures as previously required by OHA for the Performance Improvement Projects (PIPs). In 2011, FamilyCare chose to focus on 2 PIPs with a focus on integration of physical and mental health. One PIP focused on chemical dependency for Members with mental health issues and the other PIP focused on connecting Members with schizophrenia to their PCP and ensuring appropriate metabolic testing.

FamilyCare is developing an internal set of code identifiers to track flexible services and supports that are not included in the traditional CPT/HCPC code set. This will allow accurate recording and following of these items and/or services aimed at coordinating and achieving better health outcomes.

More information is included in Section C.2.3.b.

## SECTION 2 – QUALITY IMPROVEMENT PROGRAM

### C.2.1. Quality Assurance and Performance Improvement (QAPI)

**C.2.1.a.**
FamilyCare's Quality Management (QM) Program maintains quality improvement projects. The QM's goal and purpose is aligned with FamilyCare's mission to create healthy individuals through innovative systems through the ongoing monitoring of utilization management, financial management, quality assessment and improvement, compliance and education activities that link together to ensure efficient and effective utilization of resources and compliance with applicable federal and state laws, regulations and contracts.

**C.2.1.b.**
FamilyCare's BOD, which includes several providers, oversees FamilyCare's quality measurement and reporting systems. The BOD delegates the oversight of quality measurement and reporting to FamilyCare's QMC, who reports to the BOD Compliance and Utilization Committee. The QMC meets bi-monthly and receives reports on quality activities, the Care Management Program, and Utilization Review activities. The QMC evaluates and makes necessary changes to the progress and development of quality program elements, overall quality program strategy, and quality program administration. The QMC works with FamilyCare's management team to ensure that provider and Member input is actively considered in the Compliance and Medical Management Program assessment and revisions.

FamilyCare's BOD Compliance and Utilization Committee oversee FamilyCare's QM Program. FamilyCare's QM Program consists of the following groups:
- The Quality Management Committee (QMC), which consists of FamilyCare's Medical Director, 2 Mental Health Providers, 3 Primary Care Providers (including 2 Pediatricians), 1 General Surgeon, and 1 OB/GYN, approves and monitors FamilyCare's quality measures and has authority to take action regarding any quality concerns. This committee meets bi-monthly.
- The Addictions and Mental Health Quality Management Committee (AMHQMC) consists of Addictions and Mental Health (AMH) providers, FamilyCare staff (including Medical Director, Addictions and Mental Health Manager and Quality Coordinator) and Consumer representation. This committee makes recommendations regarding the AMH quality program to the QMC. This committee meets bi-monthly.

- The Integrated Quality Committee (IQC) consists of FamilyCare personnel (Medical Director, Quality Coordinator and Managers of Care Management, Utilization Management, AMH, Information Technology, Pharmacy, Member Services and Compliance). This committee meets bi-monthly to discuss and monitor FamilyCare's QM Program and makes recommendations to the QMC.

**C.2.1.c.**
FamilyCare maintains multiple quality improvement projects. Each project is selected based on: 1) identified need from internal data (utilization data, claims data, etc.); 2) identified need based on external data/reporting (e.g., HEDIS, CAHPS, or from Member grievances); or 3) regulatory requirements, e.g., 2012 Chronic Care Improvement Program focus is to be based on cardiovascular disease per CMS. Recent and on-going projects include projects focused on diabetes mellitus (DM), breast cancer screening (BCS), congestive heart failure (CHF) and other projects aimed to improve the outcomes and satisfaction of our Members.

Once potential projects are identified, the projects are reviewed in detail by the IQC, described in C.2.1.b. This interdisciplinary team works together to identify significant problems that have resulted in poor Member outcomes, Member dissatisfaction, or barriers to success. The QMC further narrows the focus of the project based on solutions to these problems. Upon approval from the IQC, projects are presented to the QMC.

All performance measures are measured using national standards and methodologies. Improvement is determined based on a baseline threshold, unless specified otherwise. Quality improvement projects are measured using consistent methodology to insure accurate results and trending.

**C.2.1.d.**
FamilyCare uses Member feedback from surveys, the grievance process, and representation within the QM Program structure to plan, design and implement the Quality Improvement Program. Information gathered from these sources assist FamilyCare to identify areas for improvement. Providers also have many opportunities for involvement including provider orientations, quality committees and provider profile meetings with FamilyCare's Medical Directors.

**C.2.1.e.**
Health Outcome Inequities
FamilyCare works to eliminate inequities by providing culturally competent care. FamilyCare uses quality measures focusing on vulnerable populations within our Membership. One example is the PIP discussed in Section C.1.1.b. that focuses on health outcome inequities for our Members with Schizophrenia. FamilyCare works with Members' care teams, both physical and mental health, to improve the rate of screening for these Members to improve their health outcomes.

Care Coordination
Care Management activities are a collaborative process that promote quality care and cost-effective outcomes that enhance the physical, psychosocial and vocational health of Members. The Care Management process uses a continuous cycle of identification, stratification, assessment, planning, implementation, monitoring and evaluation of options and services from multiple sources in collaboration with the interdisciplinary health care team to promote and coordinate quality and cost-effective care for our Members.

Transitions
FamilyCare ensures comprehensive transitional care by partnering with community providers for early identification of FamilyCare Members, who will be transitioning to other settings. For example,

FamilyCare has a current quality improvement project focusing on transitions of care from inpatient settings to home. We work with Members to identify education, treatment and/or other post-discharge needs. FamilyCare believes unnecessary hospital readmissions can be prevented, which is always in the best interest of our Members. More information can be found in Appendix A, Sections A.3.5.i. and A. 3.6.g.

## C.2.1.f.

FamilyCare has an established plan and thorough process for appointing, reappointing and ongoing monitoring of providers. The QMC and Medical Director oversee FamilyCare's Credentialing Program and regularly monitor providers by ensuring credentialing standards and criteria outlined in provider contracts are met. Quality of care inquiries and investigations are reviewed, and findings are included in the applicable provider's credentialing process. Providers are re-credentialed at least every three years unless the QMC determines that a provider's credentialing period is for less than three years. The QMC generates quarterly reports to the BOD regarding the Credentialing Program and activities ensuring that credentialing activities are completed, including recommendations, action and follow-up. FamilyCare maintains the confidentiality of Member and/or provider information and the privacy of medical records and other information. The BOD provides recommendations that may require follow-up by the QMC and the Credentialing Program. FamilyCare follows the Fair Hearing policy and procedure for receiving and processing appeals relating to credentialing practices.

## C.2.1.g.

Customer Satisfaction

It is a core value of FamilyCare that quality relationships among Members, providers and employees are based on commitment, trust, respect and communication. FamilyCare adheres to meaningful procedures for timely hearing, tracking and resolving of grievances between our Members and FamilyCare or another entity or individual through which FamilyCare provides health care services. The Quality Coordinator analyzes all Member grievances and dissatisfaction to identify trends and ensure that clinical, facility and cultural appropriateness is at the forefront of the resolution. Analysis results and grievance data are reported to the QMC, which may recommend additional action be taken by FamilyCare depending on findings.

Fraud and Abuse/Member Protections

FamilyCare has internal activities, controls and criteria in place to promote prevention and detection of potential fraud, waste and abuse. Internal and external audits are performed to monitor and test processes, identify possible trends and patterns and develop appropriate action plans for remediation. Examples of audit criteria include: DMAP services verification, provider coding consistent with encounter, services consistent with the level billed, persons/entities reviewed against exclusion lists, etc.

Treatment Planning Protocol and Use of Evidence-Based Guidelines

FamilyCare's Interdisciplinary Care Team, discussed in Appendix A, Section A.2.1.a., creates an individualized Member-centric care plan based on the Member's specific needs. Care plans are consistent with FamilyCare's adopted Clinical Guidelines (CGs), which are communicated to the providers through FamilyCare's website. Providers can access additional guidelines through the Agency for Healthcare Research and Quality (AHRQ) and a link to these guidelines is available on FamilyCare's website. In addition, all contracted entities are required to comply with FamilyCare's policies and guidelines, per provider agreement. FamilyCare's ICT reviews care plans for appropriateness and effectiveness.

FamilyCare's Medical Directors review and approve CGs for both physical and mental health, and report to the QMC and AMHQMC for final review and approval. Approved CGs are uploaded to the provider portal. All guidelines are reviewed and updated every two years.

**C.2.2. Clinical Advisory Panel**

**C.2.2.a.**
Please see below.

**C.2.2.b.**
Through our Mission and core values, FamilyCare is structured to practice evidence-based best practices and education that empower both the Member and provider to make responsible health care decisions. FamilyCare's BOD governs the QMC, AMHQMC, and IQC, who implement and monitor best clinical practices. These committees include community provider representatives or industry expert consultants, who review and approve best clinical practices, which in turn are incorporated into the plan benefit.

As discussed in Appendix A, FamilyCare's QMC will act as the CAP and provide accountability to the BOD.

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

**C.2.3.a.**
FamilyCare ensures that PIPs and Quality Assessment and Performance Improvement (QAPI) projects are conducted under the organization's QM program to address and achieve improvement in major focal areas of clinical care and non-clinical services. FamilyCare's quality activities aim to improve Member outcomes using evidenced-based best practices, emerging best practices and innovative strategies. Interventions are consistent with CGs and evidence-based practice. More information was previously provided in Section C.1.1.g.

**C.2.3.b.**
FamilyCare is currently working on quality measures that include, but not limited to, follow-up after hospitalization for mental illness (HEDIS), breast cancer screening for women 42-69 years of age (HEDIS) and immunization rates for children 2 years of age (Oregon Immunization Alert). FamilyCare participates with DMAP on annual ambulatory care measures and with CMS for annual HEDIS submissions. More information was previously provided in Section C.1.1.g.

FamilyCare has multiple projects and/or incentives that are currently in place or are in various stages of negotiation. These include formal arrangements with subsets of providers that provide financial payment for meeting quality standards, or more general projects/activities that are designed to improve the quality of care our Members receive, with subsequent improvements in outcomes and cost-effectiveness.

We have language in selected contracts that financially incentivize providers to improve performance (or maintain at a high level) in such areas as immunizations for children, and reduction in ED visits. We have tentative contractual agreements for such measures as depression screening in adults, laboratory monitoring for diabetic Members, cervical cancer screening, and breast cancer screening. We are in the process of finalizing several inpatient measures for several facilities, measures that come from Medicare's Hospital Compare site. These include incentives for improving quality of care related to measures of inpatients receiving Pneumovax and influenza vaccination, and measures related to specific care of cardiac patients.

Recognizing the importance of timely follow-up for Members who have been hospitalized on inpatient psychiatric units, FamilyCare has an incentive program for our contracted outpatient mental health providers that increases compensation when they provide follow-up to members within a week of their discharge from inpatient care. Additionally, our Medical Director performs a psychiatric review of all mental health admissions that occur within 30 days of a previous admit/discharge.

We are in early the stages of working with a mental health provider in Eastern Oregon to assess polypharmacy for Members taking antipsychotic medication. While this project is focused on Medicare Members, many of the Members are dual-eligible Members, and any improvement in overall prescribing practices would undoubtedly have benefit on the Medicaid Members living in the region. While FamilyCare does not currently hold the MHO contract in that service area, presumably those services would be contained in the CCO contract, and we would expect to specifically include Medicaid Members in this important activity.

We have current Performance Improvement Projects aimed at improving the access to PCP services for our Members with Schizophrenia, and ensuring they are receiving the recommended laboratory screenings related to the antipsychotic medications used for that SPMI condition.

Finally, we have a collaborative relationship with a provider group that cares for approximately 15,000 of our Members, meeting with them almost weekly to review pharmacy and other utilization data which they distribute and review with their individual offices and providers. Efforts thus far have focused on appropriate prescribing of Asthma and ADHD medications, with goals of improving the care of these chronic conditions.

**C.2.3.c.**
FamilyCare aligns wellness and health improvement efforts with national health awareness activities throughout the year. FamilyCare engages Members, providers and internal staff to improve the health quality of the community through activities including: mailings, telephone contact, community health fairs, FamilyCare's website and newsletters. FamilyCare sponsors several walks every year supporting the diversity of the staff and community in which we serve. For internal staff, FamilyCare has an agreement with a local health club to offer membership at reduced rates and we subsidize a Weight Watchers program. We also offer on-site massages bi-monthly for all interested employees.

FamilyCare is committed to giving back to the communities we serve and believes that supporting non-profit programs can help improve the health of all Oregonians. Each year our employees have the opportunity to participate in many fundraising and charitable events. By providing company paid time off to volunteer, our employees are encouraged to get involved in ways that both support the company's giving philosophy and fulfill their personal interests. FamilyCare will allow each employee two paid days per calendar year to volunteer at the organization of their choice.

**C.2.3.d.**
FamilyCare has consistently demonstrated our capacity to report measures per CMS and DMAP requirements as detailed throughout this application. FamilyCare employs experienced staff in the areas of Information Technology, Quality Improvement, Health Services, Compliance, Claims and Finance that have the ability to leverage data resources. With support from its Pharmacy Benefits Manager (PBM), other qualified vendors and internal informatics staff, FamilyCare collects data involving encounter, enrollment, pharmacy, Members, providers, etc. FamilyCare analyzes and uses this data to monitor, incentivize and hold providers accountable to performance benchmarks and to improve care and the delivery of services. Appendices A, B and C of this application fully explain FamilyCare's ability to meet regular performance benchmarks and accountability metrics to ensure quality care is provided for our Members.

**C.2.3.e.**
FamilyCare is innovative in our strategies to improve patient care outcomes and to provide effective and efficient services. FamilyCare partners with community providers to improve quality outcomes of our Members through data reporting and strategic counsel to our provider groups. One way we are reaching

out to community providers is through a one-day pain management summit that FamilyCare developed in partnership with another local health plan. The summit is open to all providers in the community and offers Continuing Medical Education (CME) credit. We are bringing in experts in the field of pain management and opioid use to help providers find appropriate alternatives to prescribing pain medication for their patients.

FamilyCare mentors physician groups to analyze data to affect treatment choices and financial trends. Building upon its unique Service Coordination model, FamilyCare will expand the role of non-traditional health care workers in services provided by our organization and the providers with whom we collaborate. For example, the FamilyCare Utilization Management (UM) Committee, which includes the Medical Director, Director of Finance, Director of Health and Network Services and Information Technology Manager, reviews utilization patterns of community providers and discusses with the providers ways to use predictive modeling strategies to reduce costs.

**C.2.3.f.**
Refer to Appendix B, Section 3, Medicaid Assurance 2: Continuity of Care.

| Name of publicly funded program | Type of public program (i.e.County Mental Health Department) | County in which program provides service | Specialty/Sub-Specialty Codes |
|---|---|---|---|
| Central City Concern, Inc | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Clackamas County Community Health, including School Based Health Centers | FQHC | Clackamas | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Legacy St. Helens Clinic | RHC | Columbia | 14 - Rural Health Clinic<br>095 - Rural Health |
| Multnomah County Health Department, including School Based Health Centers | FQHC | Multnomah | 15 - FQHC<br>084 - FQHC - Public Health, State or Local<br>097 - Federal Qualified Health Cntr (FQHC) |
| NARA of the Northwest | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Outside In (contracting in process) | FQHC | Multnomah | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Virginia Garcia- Cornelius | FQHC | Washington | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |
| Yakima Valley Farm Workers Clinic | FQHC | Multnomah, Umatilla | 15 - FQHC<br>097 - Federal Qualified Health Cntr (FQHC) |

## SECTION 1 – BACKGROUND INFORMATION

FamilyCare will begin providing services through the Demonstration to dually eligible individuals on January 1, 2014

## SECTION 2 – ABILITY TO SERVE DUALLY ELIGIBLE INDIVIDUALS

**D.2.1.**
FamilyCare Health Plans has been operating Medicare Advantage Prescription Drug (MA-PD) plan since the fall of 2005. FamilyCare currently operates a Dual Eligible Special Needs Plan (D-SNP) plan as well as offering several individuals Medicare plans. The D-SNP, operating under CMS contract – H3818, meets all of the CMS requirements for managing the population, including operating under its approved Model of Care as well as meeting NCQA structure and process requirements.

D.2.2.a.
FamilyCare has no limits on initial capacity serving dual eligible Members in January 2014.

D.2.2.b.
FamilyCare already fully meets the requirements to serve the dual eligible population. FamilyCare's current MA-PD plan service area covers Clatsop, Clackamas, Morrow, Multnomah, Umatilla and Washington counties. We are committed to creating innovative programs for the dual eligible population. We recently had great success in a pilot program for our Medicare Advantage population where clinicians went in to the home to obtain an in-depth health history, check for environmental and safety concerns, medication reconciliations, and assess for other health and safety needs. FamilyCare's Medicare Advantage Plan and has experience in managing transitions in alignment with CMS requirements and guidelines.

D.2.2.c.
FamilyCare will participate in the Medicare/Medicaid Alignment Demonstration in combination with its own affiliated MA Plan.

RFA #3402

FamilyCare, Inc.

Contract Review and Proposed Scope of Work

In lieu of responding to Appendix H, FamilyCare, Inc. submits this document which outlines proposed changes to the draft core contract (Appendix G), per Section 3.1 of RFA #3402. The core contract terms and conditions are included, with the exception of those requested to be removed.

Due to the late arrival of the draft contract (late afternoon of the last working day, Friday, April 27) and the extensive changes (over one thousand changes were noted in the document, including changes to definitions, and removal of entire sections) FamilyCare, Inc. is submitting the following changes and requests for clarification, and reserves the right to submit other necessary changes and clarifications to be discussed during the contract negotiation process.

In addition to the changes noted in the core contract, the scope of work described in our responses to the questionnaires in Appendices A, B and C is the proposed starting point for the negotiated Statement of Work for the CCO contract. FamilyCare's responses explain in detail how it will achieve the goals of the Triple Aim through integrated and coordinated care systems, which incorporate proposals for Member and community engagement, CCO and provider accountability and elimination of disparities in health outcomes.

Payment methodologies and other financial proposals will be met subject to the successful negotiation of the CCO global budget described in Appendix F.

Below are the contract change requests:

Definitions:
Service Coordination. This term has a distinct meaning within EOHA's medical management structure and may be confused with OHA's term.

Exhibit B, Part 1:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, Part 2:
2.a.(6) – remove, the limited hospital benefit is no longer in place?
5.a. – CCOs cannot arrange non-emergent medical transportation

Exhibit B, Part 4:
7. Subcontract requirements. Vendors and providers should not be included in the same definition as there are different levels of oversight. Recommend that subcontractor does not include care or service providers.
Additional language for Part 4 is not being proposed at this time.

Exhibit B, Part 5:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, part 6:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, Part 8
11.a. – the MCOs were allowed to opt out of the APAC because info was submitted to MMIS. Is that option still available?

Exhibit C,
2. Optional categories of service
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit C, Attachment 2
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit D
29. Media disclosure - remove
30. mandatory reporting - remove
These sections should not apply.

Exhibit G –
Section 3 doesn't exist. Not sure what requirements are. Subject to negotiation.
Also, hospital adequacy report is due in the past (March 2011)

RFA #3402

FamilyCare, Inc.

Contract Review and Proposed Scope of Work

In lieu of responding to Appendix H, FamilyCare, Inc. submits this document which outlines proposed changes to the draft core contract (Appendix G), per Section 3.1 of RFA #3402. The core contract terms and conditions are included, with the exception of those requested to be removed.

Due to the late arrival of the draft contract (late afternoon of the last working day, Friday, April 27) and the extensive changes (over one thousand changes were noted in the document, including changes to definitions, and removal of entire sections) FamilyCare, Inc. is submitting the following changes and requests for clarification, and reserves the right to submit other necessary changes and clarifications to be discussed during the contract negotiation process.

In addition to the changes noted in the core contract, the scope of work described in our responses to the questionnaires in Appendices A, B and C is the proposed starting point for the negotiated Statement of Work for the CCO contract. FamilyCare's responses explain in detail how it will achieve the goals of the Triple Aim through integrated and coordinated care systems, which incorporate proposals for Member and community engagement, CCO and provider accountability and elimination of disparities in health outcomes.

Payment methodologies and other financial proposals will be met subject to the successful negotiation of the CCO global budget described in Appendix F.


Below are the contract change requests:

Definitions:
Service Coordination. This term has a distinct meaning within EOHA's medical management structure and may be confused with OHA's term.

Exhibit B, Part 1:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, Part 2:
2.a.(6) – remove, the limited hospital benefit is no longer in place?
5.a. – CCOs cannot arrange non-emergent medical transportation

Exhibit B, Part 4:
7. Subcontract requirements. Vendors and providers should not be included in the same definition as there are different levels of oversight. Recommend that subcontractor does not include care or service providers.
Additional language for Part 4 is not being proposed at this time.

Exhibit B, Part 5:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, part 6:
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit B, Part 8
11.a. – the MCOs were allowed to opt out of the APAC because info was submitted to MMIS. Is that option still available?

Exhibit C,
2. Optional categories of service
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit C, Attachment 2
This section is empty and EOHA reserves the right to negotiate the term and conditions inserted.

Exhibit D
29. Media disclosure - remove
30. mandatory reporting - remove
These sections should not apply.

Exhibit G –
Section 3 doesn't exist. Not sure what requirements are. Subject to negotiation.
Also, hospital adequacy report is due in the past (March 2011)

**Applicant Name:**  FamilyCare, Inc.

**Instructions for completing this form:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Appendix B, Section 2, Standard #8, (f) "Describe Applicant's contractual arrangements with a PBM, including...
_____

> This contract arrangement is exempt from disclosure under Oregon Public Records Law pursuant to ORS 192.501(2) 'trade secret', and is not to be disclosed except in accordance with the Oregon Public Records Law, ORS 192.410 through 192.505."

2. _____

3. _____

*[This list may be expanded as necessary.]*

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

*In the space provided below, state Applicant's justification for non-disclosure for each item in the list in Part I of this Attachment:*

1. The contractual arrangement meets the four criteria listed above: The contract is not patented. The
_____

details of the contract are limited to certain individuals who are responsible for the negotiation and execution of the contract. The contract terms have potential commercial value because such information would inform other insurance carriers of the competitiveness of their own contracts. Users of such

information gives users an opportunity to gain a business advantage by negotiating a contract with more advantages terms with a PBM.

2. _____

3. _____

*[This list may be expanded as necessary.]*