Cascade Health Alliance, LLC

Executive Summary

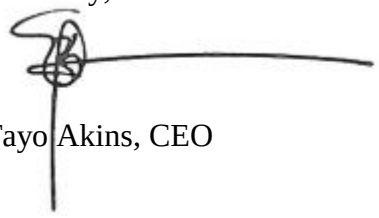
Cascade Health Alliance (CHA) and our parent company, Cascade Comprehensive Care (CCC), have provided health care services to Klamath County members for over 27 years. We provide services to over 18,000 Medicaid members and about 4,000 Medicare members through our partner company, ATRIO Health Plans. It is our mission to improve the health of our members by joining with our community partners to advocate for reliable, accessible, high-quality healthcare that empowers the residents of our community to improve their health and wellbeing.

CHA is a catalyst for community improvement. We have followed a carefully thought out plan and made tremendous strides in addressing social determinants of health. Over the past five years, we have assisted the shift of healthcare from a reactive to a proactive approach countywide while maintaining a focus on the overall wellbeing of our members. Through collaboration and partnerships, we have increased accessibility, reduced emergency department visits, advocated for evidence-based, high-quality healthcare, engaged our members and providers, established our Community Projects Advisory Committee, which works in conjunction with the Community Advisory Council to determine endowments to social-determinants-of-health projects, and more.

Our success is supported by data-driven decisions, strategic diplomacy, understanding the voice of our members, and exceeding expectations set by the State Health Improvement Plan. CHA leverages the Oregon Health Authority (OHA) framework and has established a collaborative governance structure by leveraging alliances between our members and other influencing community partners. We have consistently stayed beneath the OHA's sustainable growth target and have developed a strategy to beat the target for Coordinated Care Organization 2.0 (CCO 2.0). As we increase capacity, our devotion to value-based partnerships, financial transparency, sustainable cost growth, behavioral health integration, and addressing social determinants of health and health equity remains unchanged.

Our application for the CCO 2.0 RFA focuses on the details of our organizational structure, deliverables, strategies, community engagement and partnerships, data manipulation, and more. By collaborating efforts and developing successful relationships and programs to support the Klamath County healthcare social ecosystem, we have increased the integration between physical health, oral health, and behavioral health. Our application demonstrates our dedication to the process by investing in people, technology, and infrastructure to improve the outcomes of our members. Through our systems, we can transform industry standards and establish higher standards for improving the quality of the lives of the members we serve.

Sincerely,



Tayo Akins, CEO

Cascade Health Alliance, LLC

Full County Coverage Exception Request

Cascade Health Alliance (CHA) is a Coordinated Care Organization (CCO) in Klamath County, Oregon — a region in which we have cultivated strong relationships with community partners and healthcare providers to provide exceptional care to our members. Our current service area includes the following zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639. We are aware of OHA's policy on county boundaries for CCO 2.0, which states that applicants that intend to draw boundaries *not* along county lines will need to seek exceptions and provide appropriate justification.

CHA formally requests an exception from this policy to continue operating according to our existing parameters. Residents in our existing coverage territory benefit from receiving services in Klamath County due to geographic proximity to high-quality healthcare. CHA has a steadfast commitment to improving the health outcomes of its population. We meet members where they are and provide excellent care while reducing costs. CHA's dedication to these endeavors is evident in our history of award-winning work as a CCO in Klamath County, including the honor of the Culture of Health prize from the Robert Wood Johnson Foundation. Our approach is to invest in people, processes, technology and infrastructure to deliver superior service and outcomes for Klamath County members.

Retaining our current boundaries for CCO 2.0 ensures members in rural and frontier areas receive access to care equal to those in urban regions as well as work toward achieving the transformational goals of CCO 2.0 effectively.

Behavioral Health integration and access – CHA bridges physical, behavioral and oral healthcare; we have developed successful relationships and programs to support the Klamath County healthcare ecosystem and have changed the culture around healthcare to drive true integration of physical health and behavioral health.

Social determinants of health and health equity – CHA is a convener in Klamath County – facilitating collaboration between our members and community partners. We are uniquely positioned to support our members and have shown our allegiance to Klamath County for 27 years related to the appropriate resources our members may need.

Value-based payments and cost containment – CHA will contain costs through strategic and mutually beneficial provider network contracts. We will continue working to enhance our payment structure in collaboration with our providers, which will ensure value-based payment requirements are met aligned with the sustainable growth rate and quality outcome objectives.

Financial viability – CHA will continue to meet the cost growth expectations of OHA as it has done so in the past three years using our provider network and contracts.

CHA is an integral part of its local community. Our deep and ongoing efforts to understand the needs of our members gives us the assuredness to request full-county exception. In 2018, 98% of CHA members received services in Klamath County (our service area). Over the last several years, we have awarded grants to numerous organizations that with more than 7,000 individuals directly benefitting from our social investments. We assure that this exception request is not designed to minimize financial risk and will not create adverse selection.

KLAMATH COUNTY

Board of Commissioners

Donnie Boyd, Commissioner
Position One

Kelley Minty Morris, Commissioner
Position Two

Derrick DeGroot, Commissioner
Position Three

February 26, 2019

Office of Contracts and Procurement, Oregon Health Authority

Re: Cascade Health Alliance Full County Coverage Exception Request

To Whom It May Concern:

Cascade Health Alliance (CHA) is a Coordinated Care Organization (CCO) in Klamath County, Oregon that bridges physical, behavioral and oral healthcare to operate as one of the state's most trusted and forward-thinking CCO organizations. The Klamath County Board of Commissioners greatly supports the application of CHA to continue providing exceptional care to its members in the following zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639.

Our board is aware of Oregon Health Authority's policy on county boundaries for CCO 2.0. Please accept this letter as a strong form of support for CHA's request to an exception from this policy.

CHA has developed successful relationships and programs to support the Klamath County health care ecosystem and has changed the culture around healthcare for the greater good. The organization values the voice of its members and understands the critical approach of meeting them where they are to consistently deliver optimum care.

CHA has a resolute pledge to improve health outcomes of people in the communities it serves, and our letter of support is submitted on the strength of our belief in CHA's capability to meet and exceed OHA transformational goals. In 2018, 98% of CHA members who received services received those services in Klamath county (our service area). The organization has also contracted with several primary care locations to provide care for mental illness, substance use disorders, health behaviors that contribute to chronic conditions, and physical symptoms related to stress.

Over the last several years, CHA has awarded grants to community organizations that have been used to impact more than 7,000 individuals. We are confident CHA's exception request is not designed to minimize financial risk nor is it to create adverse selection. CHA invests in people, processes and technology. As a CCO, CHA is committed to delivering the best service and outcomes for Klamath County members.

Sincerely,

Not Present

Donnie Boyd
Chair

Kelley Minty Morris
Vice Chair

Derrick DeGroot
Commissioner

305 Main Street, Klamath Falls, Oregon 97601
Phone: (541) 883-5100 | Fax: (541) 883-5163 | Email: bocc@klamathcounty.org

CASA
Court Appointed Special Advocates
FOR CHILDREN
CASA FOR CHILDREN OF KLAMATH COUNTY

Mission Statement

The Mission of the CASA program is to provide trained advocates for abused and neglected children who are dependent on the juvenile court to ensure their right to a safe and permanent home.

Staff

Karri Mirande
Executive Director
Karri.Mirande@klamathfallscasa.org

Nancy Zarosinski
Program Coordinator
NancyZ@klamathfallscasa.org

Dana Thompson
Program Coordinator
DanaT@klamathfallscasa.org

Andrew Sparkes
Program Coordinator
Andrews@klamathfallscasa.org

Candice Bumpus
Executive Assistant
candiceb@klamathfallscasa.org

Non-Profit 501(c)(3)

All donations are tax deductible. CASA needs and appreciates the support we receive that allows us to advocate for the most vulnerable children in Klamath County. For every $1200 raised, CASA provides full advocacy for a foster child for one year. Tax ID #: 93-1261640

Board of Directors

Jeanette Rutherford, Chair
Brittany Thoma, Secretary
Honorable Dan Bunch, Judicial Liaison
John Adkisson, CASA Liaison
Donna Shelley, Treasurer
Misty Barney, Board Member
Katie Harman Ebner, Board Member
Tonie Kellom, Board Member
Doug McInnis, Board Member
Jay Otero, Board Member
Justin Rodriguez, Board Member

"Like" CASA on Facebook

CASA for Children of Klamath County
731 Main St. Suite 202, Klamath Falls, OR 97601
(541) 885-6017 Phone (541) 884-9310 Fax
www.KlamathFallsCasa.org

April 03, 2019

Office of Contracts and Procurement, Oregon Health Authority

Re: Cascade Health Alliance Applicant

To Whom It May Concern:

CASA for Children of Klamath County supports Cascade Health Alliance (CHA) application for CCO 2.0 without reservation. CHA has been a bedrock of the Klamath County healthcare community and is a clear choice to lead the next phase of Coordinated Care Organizations (CCOs) in the region.

CHA has a 26-year history of investing in Klamath County residents and honoring its pledge to uplift the communities in which it operates. The company continues to leverage local organizations to tackle social determinants of health and improve its member population health.

CASA for Children of Klamath County was awarded two grants since 2017 to continue funding for the support of foster children. These foster children will be supported through providing highly trained volunteer advocates who will seek a timely and appropriate disposition in the best interest of each child and ensure these children their rights to a safe and permanent home. These volunteers are sometimes the only consistent caring adult in the life of a child in foster care. The children we serve will likely spend less time in foster care, are twice as likely to find a safe and permanent home, and will receive more health and wellness services. We appreciate our partnership with Cascade Health Alliance to continue to serve Klamath County's most vulnerable children.

CASA is currently focused on serving 100% of the children referred to our program with advocacy, a self-care back pack when entering care, and providing for unfunded sports camps, experiences, and needs through our CASA Kid Fund. Since January 1st, 2018 we have been able to train an additional 20 advocates with CHA's support.

CHA is a local healthcare organization that values the voice of its members, respects the parameters in which it must operate and brings to reality a standard of excellence that sets the bar for others to reach. CHA's mission to improve health outcomes, invest in the community and do business better makes it an obvious choice for CCO 2.0.

Please accept this letter as a formal display of our support.

Thank you for your time,

Karri Mirande

Karri Mirande, Executive Director

Klamath Health Partnership, Inc.

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

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

March 12, 2019

Office of Contracts and Procurement, Oregon Health Authority

Re: Cascade Health Alliance, Applicant

To Whom It May Concern:

Klamath Health Partnership (KHP) supports Cascade Health Alliance's (CHA) application for CCO 2.0. CHA has been a bedrock of the Klamath County healthcare community and is a clear choice to lead the next phase of Coordinated Care Organizations (CCOs) in the region.

CHA has a 26-year history of investing in Klamath County residents and honoring its pledge to uplift the communities in which it operates. The company continues to leverage local organizations to tackle social determinants of health and improve its member population health.

KHP has been doing business with CHA and their parent company, Cascade Comprehensive Care, for over 20 years. CHA has proven to be an even stronger partner since becoming a CCO. We partner closely on quality and access on a monthly basis. They are innovative and proactive in their search to improve the health of Klamath County residents. CHA provided us with funds to purchase a transport van for our patient transport program. It is now a full time fully functioning program. Together we have successfully improved the access and quality of care for our patients thru CHA's support of our panel management program.

Our most recent successful partnership is the opening or our School Based Health Center. Cascade Health Alliance provided funding for Klamath County School District to remodel their existing building to make our medical services available to all Klamath County students.

CHA is a local healthcare organization that values the voice of its members, respects the parameters in which it must operate and brings to reality a standard of excellence that sets the bar for others to reach. CHA's mission to improve health outcomes, invest in the community and do business better makes it an obvious choice for CCO 2.0.

Please accept this letter as a formal display of our support.

Thank you for your time,

Signe Porter

Signe Porter, CEO

(541) 851-8110 (541) 880-2090 (541) 783-2292

KLAMATH OPEN DOOR
2074 South Sixth Street
Klamath Falls, Oregon 97601
Fax (541) 851-8114

KLAMATH OPEN DOOR DENTAL
2074 South Sixth Street
Klamath Falls, Oregon 97601
Fax (541) 880-2092

CHILOQUIN OPEN DOOR
PO Box 695
Chiloquin, Oregon 97624
Fax (541) 783-3160

www.klamathopendoor.org

March 11, 2019

Office of Contracts and Procurement, Oregon Health Authority

Re: Cascade Health Alliance, Applicant

To Whom It May Concern:

Klamath County Public Health fully supports Cascade Health Alliance's (CHA) application for CCO 2.0. CHA has been a strong leader in the healthcare community in Klamath County and is a clear choice to lead the next phase of Coordinated Care Organizations (CCOs) in the region.

CHA has a 26-year history of investing in Klamath County residents and honoring its pledge to uplift the communities in which it operates. The company continues to leverage local organizations to tackle social determinants of health and improve its member population health.

CHA is one of the 'Core Four' partners in the Healthy Klamath Coalition and has truly demonstrated its commitment to health improvement. CHA has actively participated in the community health assessment process and uses the community health improvement plan in earnest to determine where to focus its community efforts. For example, physical activity is consistently a focus area of local health improvement needs, so CHA invested in a protected bike lane that runs through a low income neighborhood, which now connects residents with a grocery store and city park. Additionally, CHA invested in the renovation of two city parks to make them more attractive and enticing to utilize.

CHA also values collaboration and innovation. They have recently begun Performance Improvement Projects and have enlisted the help of diverse stakeholders to participate. This level of collaboration ensures a broad perspective and realistic solutions that each agency can support.

CHA values the voice of its members and its community partners. They have built strong relationships in this community. They work diligently to achieve a high level of excellence that sets the bar for others to reach. CHA's mission to improve health outcomes, invest in the community and do business better makes it an obvious choice for CCO 2.0.

Please accept this letter as a formal display of our support.

Sincerely,

Jennifer Little
Director

3314 Vandenberg Rd, Klamath Falls, Oregon 97603 | Phone: (541) 882-8846 | Fax: (541) 885-3638

Attachment 2 - Application Checklist

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

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

Attachment 3 - Application Information and Certification Sheet

Legal Name of Proposer: Cascade Health Alliance, LLC

Address: 2909 Daggett Avenue, Suite 225
Klamath Falls, OR 97601

State of Incorporation: OR **Entity Type:** LLC

Contact Name: Annette Fowler **Phone:** (541) 851-2080 **Email:** annettef@cascadecomp.com

Oregon Business Registry Number: 845434-96

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

1. Applicant understands and accepts the requirements of this RFA. By submitting an Application, Applicant acknowledges and agrees to be bound by (a) all the provisions of the RFA (as modified by any Addenda), specifically including RFA Section 6.2 (Governing Laws) and 6.4 (Limitation on Claims); and (b) the Contract terms and conditions in Appendix B, subject to negotiation and rate finalization as described in the RFA.
2. Applicant acknowledges receipt of any and all Addenda to this RFA.
3. Application is a firm offer for 180 days following the Closing.
4. If awarded a Contract, Applicant agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract.
5. I have knowledge regarding Applicant's payment of taxes. I hereby certify that, to the best of my knowledge, Applicant is not in violation of any tax laws of the state or a political subdivision of the state, including, without limitation, ORS 305.620 and ORS chapters 316, 317 and 318.
6. I have knowledge regarding Applicant's payment of debts. I hereby certify that, to the best of my knowledge, Applicant has no debts unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts.
7. Applicant does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, gender, disability, sexual orientation, national origin. When awarding subcontracts, Applicant does not discriminate against any business certified under ORS 200.055 as a disadvantaged business enterprise, a minority-owned business, a woman-owned business, a business that a service-disabled veteran owns or an emerging small business. If applicable, Applicant has, or will have prior to Contract execution, a written policy and practice, that meets the requirements described in ORS 279A.112 (formerly HB 3060), of preventing sexual harassment, sexual assault and discrimination against employees who are members of a protected class. OHA may not enter into a Contract with an Applicant that does not certify it has such a policy and practice. See https://www.oregon.gov/DAS/Procurement/Pages/hb3060.aspx for additional information and sample policy template.
8. Applicant and Applicant's employees, agents, and subcontractors are not included on:
   a. the "Specially Designated Nationals and Blocked Persons" list maintained by the Office of Foreign Assets Control of the United States Department of the Treasury found at: https://www.treasury.gov/ofac/downloads/sdnlist.pdf., or
   b. the government wide exclusions lists in the System for Award Management found at: https://www.sam.gov/portal/

9. Applicant certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Applicant, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFA, except as disclosed in writing in this Application. If any changes occur with respect to Applicant's status regarding conflict of interest, Applicant shall promptly notify OHA in writing.
10. Applicant certifies that all contents of the Application (including any other forms or documentation, if required under this RFA) and this Application Certification Sheet are truthful and accurate and have been prepared independently from all other Applicants, and without collusion, Fraud, or other dishonesty.
11. Applicant understands that any statement or representation it makes, in response to this RFA, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a False Claim under that Act.
12. Applicant acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment 10 at the time of Contract execution.

Signature: _____ **Title:** CEO **Date:** 4/19/2019

(Authorized to Bind Applicant)

State of Oregon)

) ss:

County of Klamath)

Signed and sworn to before me on 4/19/19 (date) by Eyitayo Atcins (Affiant's name).

Mason Louis Otero

Notary Public for the State of Oregon

My Commission Expires: 1/28/23

OFFICIAL STAMP
MASON LOUIS OTERO
NOTARY PUBLIC-OREGON
COMMISSION NO. 983643
MY COMMISSION EXPIRES JANUARY 28, 2023

Attachment 4 - Disclosure Exemption Certificate

Tayo Akins ("Representative"), representing Cascade Health Alliance, LLC ("Applicant"), hereby affirms under penalty of False Claims liability that:

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

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

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

4. I have checked Box A or B as applicable:

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

1. A formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information that:

i. is not patented,

ii. is known only to certain individuals within the Applicant's organization and that is used in a business the Applicant conducts,

iii. has actual or potential commercial value, and

iv. gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.

Or

2. Information, including a drawing, cost data, customer list, formula, pattern, compilation, program, device, method, technique or process that:

i. Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and

ii. Is the subject of efforts by the Applicant that are reasonable under the circumstances to maintain its secrecy.

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

5. The Applicant has submitted a copy of the Application that redacts any information the Applicant believes is Exempt Information and that does not redact any other information. The Applicant represents that all redactions on its copy of the Application are supported by Valid Claims of exemption on Exhibit A.
6. I understand that disclosure of the information referenced in Exhibit A may depend on official or judicial determinations made in accordance with the Public Records Law.

Representative's Signature _____

Exhibit A to Attachment 4

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

Section Redacted	ORS or other Authority	Reason for Redaction
Attachment 6 Q# C.1.b Subcontractors and Delegated Entities Report	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	1. Trade Secrets
Attachment 7 RTS = Redact Trade Secrets DSN Provider Report 7.6.a.12 , 7.12.a.1, 7.12.f.6-7 7.12.g.1, 7.4.a.3, 7.6.a.11 7.12.g.2, 7.3.a.1	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	2. Trade Secrets
Attachment 8 RFA VBP Data Template 8.c.5 8.c.4 8.c.2.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	3. Trade Secrets
Attachment 9 HIT Roadmap & Narrative 09B.1.f. HIT Roadmap Items and Tools 09B.1.f. Roadmap Items and Tools 9.D.2.b 9.D.2.g.3 9.D.2.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	4. Trade Secrets
Attachment 10 RTS = Redact Trade Secrets Policies and Procedures Community Engagement Plan Community Engagement Plan Tables THW Integration & Utilization Plan 10.B.1.e 10.F.1.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	5. Trade Secrets

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

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

Representative's Signature

_____

Exhibit A to Attachment 4

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

Section Redacted	ORS or other Authority	Reason for Redaction
Attachment 6 Q# C.1.b Subcontractors and Delegated Entities Report	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**1.** Trade Secrets
Attachment 7 RTS = Redact Trade Secrets DSN Provider Report (all) 7.6.a.12 , 7.12.a.1, 7.12.f.6-7 7.12.g.1, 7.4.a.3, 7.6.a.11 7.12.g.2, 7.3.a.1	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**2.** Trade Secrets
Attachment 8 RFA VBP Data Template 8.c.5 8.c.4 8.c.2.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**3.** Trade Secrets
Attachment 9 HIT Roadmap & Narrative 09B.1.f. HIT Roadmap Items and Tools 09B.1.f. Roadmap Items and Tools 9.D.2.b 9.D.2.g.3 9.D.2.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**4.** Trade Secrets
Attachment 10 RTS = Redact Trade Secrets Policies and Procedures Community Engagement Plan Community Engagement Plan Tables THW Integration & Utilization Plan 10.B.1.e 10.F.1.a	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**5.** Trade Secrets

Exhibit A to Attachment 4 - Continued

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

Section Redacted	ORS or other Authority	Reason for Redaction
Attachment 11 RTS = Redact Trade Secrets 11.E.4.c 11.D.2	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**6.** Trade Secrets
Attachment 12 Pro Forma Financial Statement Workbooks UCAA Supplemental Financial Analysis 12.C.3, 12.A.3, 12.A.4 12..D.1	192.345(2) Trade Secrets. ""Trade secrets," as used in this section, may include, but are not limited to, any formula, plan, pattern, process, tool, mechanism, compound, procedure, production data, or compilation of information which is not patented, which is known only to certain individuals within an organization and which is used in a business it conducts, having actual or potential commercial value, and which gives its user an opportunity to obtain a business advantage over competitors who do not know or use it.	**7.** Trade Secrets
Attachment 12 Biographical Affidavits	192.355(2)(a) Information of a personal nature such as but not limited to that kept in a personal, medical or similar file, if public disclosure would constitute an unreasonable invasion of privacy, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy. 192.377 Required redaction of certain personal information. A public body that is the custodian of or is otherwise in possession of information that was submitted to the public body in confidence and is not otherwise required by law to be submitted, must redact all of the following information before making a disclosure described in ORS 192.355 (4): (1) Residential address and telephone numbers; (2) Personal electronic mail addresses and personal cellular telephone numbers; (3) Social Security numbers and employer-issued identification card numbers; and (4) Emergency contact information.	**8.** Information of a personal nature Required Redaction
		9.
		10.
		11
		12.
		13.

Attachment 5 - Responsibility Check Form

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

1. Does Applicant have available the appropriate financial, material, equipment, facility and personnel resources and expertise, or ability to obtain the resources and expertise, necessary to demonstrate the capability of Applicant to meet all contractual responsibilities?

YES ☒ **NO** ☐**.**

2. Within the last five years, how many contracts of a similar nature has Applicant completed that, to the extent that the costs associated with and time available to perform the contract remained within Applicant's Control, Applicant stayed within the time and budget allotted, and there were no contract claims by any party? Number: 1

How many contracts did not meet those standards? Number: 0 If any, please explain.

Response:

3. Within the last three years has Applicant (incl. a partner or shareholder owning 10% or more of Applicant's firm) or a major Subcontractor (receiving 10% or more of a total contract amount) been criminally or civilly charged, indicted or convicted in connection with:

- obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract,
- violation of federal or state antitrust statutes relating to the submission of bids or proposals, or
- embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?

YES ☐ **NO** ☒

If "YES," indicate the jurisdiction, date of indictment, charge or judgment, and names and summary of charges in the response field below.

Response:

4. Within the last three years, has Applicant had:

- any contracts terminated for default by any government agency, or
- any lawsuits filed against it by creditors or involving contract disputes?

YES ☐ **NO** ☒

If "YES," please explain. (With regard to judgments, include jurisdiction and date of final judgment or dismissal.)

Response:

5. Does Applicant have any outstanding or pending judgments against it?

YES ☐ **NO** ☒.

Is Applicant experiencing financial distress or having difficulty securing financing? **YES** ☐ **NO** ☒.

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

YES ☒ **NO** ☐

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

Response:

6. Within the last three years, has Applicant filed a bankruptcy action, filed for reorganization, made a general assignment of assets for the benefit of creditors, or had an action for insolvency instituted against it?

YES ☐ **NO** ☒.

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

Response:

7. Does Applicant have all required licenses, insurance and/or registrations, if any, and is Applicant legally authorized to do business in the State of Oregon?

YES ☒ **NO** ☐.

If "NO," please explain.

Response:

8. Pay Equity Certificate. This certificate is required if Applicant employs 50 or more full-time workers and the prospective Contract price is estimated to exceed $500,000. [This requirement does not apply to architectural, engineering, photogrammetric mapping, transportation planning or land surveying and related services contracts.] Does a current authorized representative of Applicant possess an unexpired Pay Equity Certificate issued by the Department of Administrative Services?

YES ☒ **NO** ☐ **N/A** ☐.

Submit a copy of the certificate with this form.

Response:

AUTHORIZED SIGNATURE

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

Applicant Name: Cascade Health Alliance, LLC	RFA: #4690-19 Project Name: CCO 2.0

Signature: _____ **Title:** Chief Executive Officer **Date:** April 18, 2019

(Authorized to Bind Applicant)

Certificate of Completion

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

CASCADE HEALTH ALLIANCE

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *1/28/2019*

Attachment 6 - General Questions

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.
Page limits for this General Questionnaire is five pages, items that are excluded from the page limit will be noted in that requirement.

Section A. Background Information About Cascade Health Alliance (CHA)

06.A.1 Questions
In narrative form, provide an answer to each of the following questions.
Describe the Applicant's Legal Entity status, and where domiciled. 06.A.1.a Describe Applicant's Affiliates as relevant to the Contract

Cascade Health Alliance (CHA) is affiliated with Cascade Comprehensive Care (CCC), which is our parent company.

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

No. CHA is not currently invoking alternative dispute resolution concerning any provider.

06.A.1.c What is the address for the Applicant's primary office and administration located within the proposed Service Area?

Our primary office and administration are located within Klamath County at 2909 Daggett Ave, Suite 225, Klamath Falls, OR 97601.

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

CHA's service area is Klamath County excluding zip codes 97425, 97733, 97737 and 97731. To ensure members' access to public health care and services, CHA is currently in valid agreements with Klamath County Public Health, Oregon Department of Human Services Aging and People with Disabilities Office District 11, and Klamath Basin Behavioral Health (KBBH) the Community Mental Health Program.

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

Yes, CHA has a contract with OHA as a CCO as of January 1, 2019.
06.A.1.f Current experience as an OHA contractor, other than as a Current CCO. Does this Applicant (or an Affiliate of Applicant) currently have a contract with the OHA as a licensed insurer or health plan third party administrator for any of the following (hereinafter called

"Current OHA Contractor")? If so, please provide that information in addition to the other information required in this section.

- ***Public Employees Benefit Board***
- ***Oregon Educators Benefit Board***
- ***Adult Mental Health Initiative***
- ***Cover All Kids***
- ***Other (please describe)***

In addition to our status as the Current CCO, CHA is also an OHA contractor for Cover All Kids, which connects low-income children up to age 19 to health care services regardless of immigrant status.

06.A.1.g Does the Applicant (or an Affiliate of Applicant) have experience as a Medicare Advantage contractor? Does the Applicant (or an Affiliate of Applicant) have a current contract with Medicare as a Medicare Advantage contractor? What is the Service Area for the Medicare Advantage plan?

CHA's contractor experience with Medicare Advantage is indirectly through our affiliate, ATRIO Health Plans, which provides coverage for our dual eligible members in Klamath County. ATRIO Health Plans has a current contract as a Medicare Advantage organization and a Coordination of Benefits Agreement with OHA. A Letter of Agreement is included as additional documents; please see page 9.

06.A.1.h Does Applicant have a current Dual Special Needs Coordination of Benefits Agreement with OHA to serve Fully Dual Eligible Members?

As the current CCO, CHA is obligated to serve Fully Dual Eligible Members according to the 2019 OHA CCO Contract. CHA does not currently have a separate Dual Special Needs Coordination of Benefits Agreement with OHA.

06.A.1.i Does the Applicant (or an Affiliate of Applicant) hold a current certificate of authority for transacting health insurance or the business of a health care service contractor, from the Department of Consumer and Business Services, Division of Financial Regulation?

Our affiliate, ATRIO Health Plans holds a current certificate of authority and is a licensed Healthcare Services Contractor with the State of Oregon. CHA does not hold a current certificate of authority for transacting health insurance or the business of a health care service contractor.

06.A.1.j Does the Applicant (or an Affiliate of Applicant) hold a current contract effective January1, 2019, with the Oregon Health Insurance Marketplace?

CHA nor any of its affiliates hold a current contract with the Oregon Health Insurance Marketplace.

06.A.1.k Describe Applicant's demonstrated experience and capacity for engaging Community members and health care Providers in improving the health of the Community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among Applicant's enrollees and in Applicant's Community.

CHA is a convener in Klamath County. We facilitate collaboration between our members and other influencing community partners. We are uniquely positioned to support our members and have shown allegiance to the Klamath community for 27 years. CHA vigilantly analyzes surveys, demographics and population data to understand the community and its members. CHA's Community Advisory Committee (CAC) meets monthly to identify, discuss, and develop actions to address health care disparities in the Klamath County community.

06.A.1.l Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):
• Chief Executive Officer
• Chief Financial Officer
• Chief Medical Officer
• Chief Information Officer
• Chief Administrative or Operations Officer
(résumés do not count toward page limit; each resume has a two page limit)

Resumes for CHA's key leaders are included as additional documents; please see pages 10-17.

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

CHA's key contact chart is included as an additional document; please see pages 18-21.

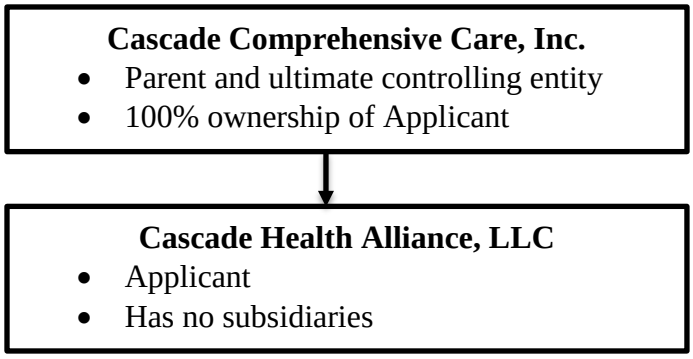
06.A.2 Required Documents
• Background Narrative
• Résumés (excluded from pages limit)
• Contact list (excluded from pages limit)

Section B. Corporate Organization and Structure

06.B.1 Questions
06.B.1.a Provide a certified copy of the Applicant's articles of incorporation, or other similar legal entity charter document, as filed with the Oregon Secretary of State or other corporate chartering office.

A copy of CHA's certified Articles of Organization is included as an additional document; please see page 22.

06.B.1.b Provide an organization chart listing of ownership, Control or sponsorship, including the percentage Control each person has over the organization.



06.B.1.c Describe any licenses the corporation possesses.

We currently possess no licenses.

06.B.1.d Describe any administrative service or management contracts with other parties where the Applicant is the provider or Recipient of the services under the contract. Affiliate contracts are excluded in this item and should be included under Section C.

Aside from affiliate contract, CHA is neither the provider nor recipient of any administrative or management contracts with other parties.

06.B.2 Required Documents
• Articles of Incorporation (excluded from page limit)
• Narrative of Items b through d

Section C. Corporate Affiliations, Transactions, Arrangements

06.C.1 Questions
06.C.1.a Provide an organization chart or listing presenting the identities of and interrelationships between the parent, the Applicant, Affiliated insurers and reporting entities, and other Affiliates. The organization chart must show all lines of ownership or Control up to Applicant's ultimate controlling person, all subsidiaries of Applicant, and all Affiliates of Applicant that are relevant to this Application. When interrelationships are a 50/50% ownership, footnote any voting rights preferences that one of the entities may have. For each entity, identify the corporate structure, two–character state abbreviation of the state of domicile, Federal Employer's Identification Number, and NAIC code for insurers.

A copy of CHA's Organization Chart is included as an additional document; please see page 23.

06.C.1.b Describe of any expense arrangements with a parent or Affiliate organization. Provide detail of the amounts paid under such arrangements for the last two years. Provide footnotes to the operational budget when budgeted amounts include payments to Affiliates for services under such agreements.

REDACTED

06.C.1.c Describe Applicant's demonstrated experience and capacity for Managing financial risk and establishing financial reserves, Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

CHA has successfully demonstrated experience and capacity for managing financial risk, establishing financial reserves, and meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350.

CHA has consistently stayed beneath OHA's sustainable growth target, and we have developed a strategy to beat the target for CCO 2.0 while improving the quality of the lives of the members we serve.

Section D. Subcontracts

06.D.1 Informational Questions
06.D.1.a Please identify and describe any business functions the Contractor subcontracts or delegates to Affiliates.

CHA currently subcontracts the following business functions:

- Processing pharmacy claims (PBM)
- Non-Emergency Medical Transportation (NEMT)
- Secondary review of dental prior-authorizations

06.D.1.b What are the major subcontracts Applicant expects to have? Please provide an example of subcontracted work and describe how Applicant currently monitors Subcontractor performance or expects to do so under the Contract.

CHA expects to continue subcontracts for PBM, NEMT, and secondary reviews of dental prior-authorizations. We review monthly and quarterly utilization and activity reports to ensure service level agreements are met.

06.D.2 Required Documents
Narrative for Items a and b

Section E. Third Party Liability (TPL)

06.E.1 Informational Questions
06.E.1.a How will Applicant ensure the prompt identification of Members with TPL across its Provider and Subcontractor network?

CHA loads eligibility files received from OHA daily. On the import of the HIPAA 834 files, we capture the TPL segment and load it into the member record. Member records are flagged with the TPL and pushed out to all eligibility systems both at the Provider and Subcontractor level. CHA staff also verifies all TPL when reported by providers, a subcontractor or other CHA departments, and the member record is not flagged. The TPL information is verified then reported to OHA, and the member record is updated to reflect the TPL coverage.

06.E.1.b How will Applicant ensure the prompt identification of Members covered by Medicare across its Provider and Subcontractor network?

Providers and subcontractors identify CHA members with Medicare coverage via real-time updates, daily reports or weekly uploads of member files.

06.E.2 Required Documents
Narrative for Items a and b

Section F. Oversight and Governance

06.F.1 Informational Questions
06.F.1.a Applicant's governing board, how board members are elected or appointed, how the board operates, and decisions that are subject to approval by a person other than Applicant.

CHA's governing board is made up of thirteen Board of Directors appointed by CCC. With written notice of the time and place, the CHA Board of Directors meet no less than every three months and consults with CHA's CAC. A majority of the directors constitutes a quorum, and CHA's Board of Directors can act on behalf of CHA as a body. CHA's Board of Directors is responsible for overall company management and has decision making authority. CCC makes all decisions regarding:

- Any change in location, nature or purpose of the business of CHA
- Any sale, lease, mortgage, pledge or transfer of assets not in the ordinary course of business
- The merger or consolidation, conversion or dissolution of CHA
- Any joint venture with another person or entity

06.F.1.b Please describe Applicant's key committees including each committee's composition, reporting relationships and responsibilities, oversight responsibility, monitoring activities and other activities performed.

All of CHA's key committees are charged by and report to the CHA Board of Directors.

Alternative Payment Method (APM) Committee - CHA staff supports our APM Committee, which includes members who represent primary care providers, specialty providers, institutional providers, behavioral health providers, and CHA Board of Directors representative(s). The APM Committee is responsible for enhancing CHA's shared saving arrangements (incentive/ performance) so the level of shared risk/savings distributed to providers are tied to the provider's performance quality and outcome measures. The APM Committee will perform analysis, assessment and make recommendations on value-based payments to the CHA Board of Directors. APM Committee duties include identifying where value-based payment structures could be effective and to recommend various methodologies for consideration by the Board.

Compliance Committee - Our Compliance Committee is supported by CHA staff and includes representatives of the CHA Board of Directors and CHA's Compliance and Privacy Officer. The Compliance Committee performs risk framing/assessment activities and makes recommendations to the CHA Board for action and response to reduce regulatory, privacy and compliance risks facing the organization. The responsibilities of the Compliance Committee include:

- Help ensure compliance objectives are adequately addressed and high-impact compliance risks are identified, assessed and reported to the CHA Board.
- Identify, review and assess compliance/risk issues brought forward by CHA staff, external stakeholders, plan members and other risk framing information sources.
- Create a compliance risk response plan that includes prioritizing high-risk areas and making recommendations for addressing risk areas.
- On-going assessment of progress with compliance work plans.
- Completes analysis of grievance system, and ensures data is reviewed and consistent with contractual requirements for CCO Quality improvement

CHA's Compliance Committee oversees the development of strategies to assess and analyze information from varying sources and identify regulatory and compliance risks. It also makes recommendations to the CHA Board on the importance, severity, and priority of exposure areas facing the organization as well as to remedy and lessen present or anticipated risks. The committee also oversees the implementation and progress of action and monitoring plans designed to reduce risk and support compliance with applicable laws, regulation, and company policies.

Pharmacy and Therapeutics Committee (P&T) - Our P&T Committee is supported by CHA staff and is comprised of practitioners from a variety of specialties who actively prescribe for CHA members. The P&T Committee develops a formulary of pharmaceutical agents, review such formulary periodically, and make additional recommendations regarding the formulary. P&T Committee's responsibilities include:

- Periodically conduct therapeutic drug class reviews.
- Consider the relative safety, effectiveness, cost, and other pertinent factors in recommending pharmaceuticals to be included in the formulary.
- Recommend an implementation period and medical necessity criteria for all pharmaceuticals placed on the non-formulary status.
- Identify pharmaceuticals for prior authorization and recommend prior authorization criteria.
- Identify pharmaceuticals for quantity limits and recommend the appropriate criteria.

The P&T Committee oversees access to clinically sound and cost-effective medications, the operation of the formulary system and drug policy development, formulary recommendations, and establishing formulary management policies.

Quality Management Committee (QMC) - The QMC is supported by CHA's CMO and Quality Management staff; it is comprised of providers, including at minimum one Behavioral Health and one Dental Provider; and staff of partner organizations. The QMC engages providers and subcontractors to provide analysis and assessment. The QMC oversees the annual Transformation and Quality Strategy, reviews CHA performance on OHA Incentive Metrics, provides support and recommendations to address deficiencies and set targets for ongoing performance improvement in relation to Performance Improvement Projects, and oversees the provider credentialing process. The QMC also oversees the effectiveness of CHA's Quality Improvement Plan.

Utilization Review Committee (URC) - CHA's CMO and staff support our URC; the committee is comprised of contracted providers and partner organizations' administrative staff. They engage providers and subcontractors to provide case review, utilization monitoring, and clinical expertise. The URC's responsibilities include identifying and reviewing utilization issues and monitoring against practice guidelines, evaluating assigned member cases to address the appropriateness of denials, limitations, or changes in services, ensuring clinical objectives are being successfully addressed, and monitoring progress on assigned projects. The URC oversees and analyzes over/under utilization patterns, data, and metrics. When opportunities to improve clinical or financial outcomes are noted, the URC explores strategies to address those opportunities. The URC coordinates the integration of services within the provider network, including Transition of Care, Grievances, Utilization Management, Disease Management, and assures evidence-based best practices and community standards are adopted and used.

Community Projects Advisory Committee (CPAC) - Our CPAC is comprised of members appointed to evaluate community funding requests and to recommend projects related to social determinants of health, quality metrics, and the Community Advisory Council's Community Health Improvement Plan (CHIP). CPAC recommends projects to CHA's Board for funding and provides oversight of the grants and project results.

06.F.1.c The composition, reporting responsibilities, oversight responsibility, and monitoring activities of Applicant's CAC.

CHA values the voice of our members and meets them where they are to consistently deliver high-value member satisfaction experience. The Community Advisory Council (CAC) Chair is a member of CHA's Board of Directors and is on the board agenda to represent the CAC and present the "voice of the members." The CAC's Vice-Chair is being trained to take over as CAC Chair in 2020.

The CAC includes members representing the community, government entities, and behavioral health – over half of the CAC are CHA members or caretakes of CHA members. The CAC's purpose is to provide input on metric and communication strategies, and to ensure the healthcare and community needs are being addressed for CHA members.

CAC duties include:

- Identifying and advocating for preventative care practices
- Input on SDOH-HE projects that are considered by CPAC.
- Overseeing a Community Health Assessment and adopting a strategic population health care system service plan for the community
- Publishing an annual progress report on the Community Health Improvement Plan

06.F.2 Required Documents
Narrative for Items a, b and c

Cascade Health Alliance, LLC

Letter of Agreement

March 1, 2019

This Letter of Agreement is between **Cascade Health Alliance, LLC (CHA)** and **ATRIO Health Plans**. It is mutually agreed that CHA and ATRIO are affiliated to effectively integrate and coordinate health care and care management for fully dual eligible members in accordance with the Oregon Health Authority (OHA) Coordination of Benefits Agreement and the OHA CCO contract.

ATRIO Health Plans

SIGNATURE

WENDY EDWARDS
PRINT NAME

4.3.2019
DATE

Cascade Health Alliance

SIGNATURE

PRINT NAME

4/3/2019
DATE

TAYO AKINS

TAYOA@CASCADECOMP.COM

SUMMARY OF QUALIFICATIONS:

Accomplished health care executive with a proven record of developing innovative strategies to improve the delivery and quality of health services, increase access to care and stabilizing struggling organizations. Innovative leader with progressive experience providing visionary direction. Thrives in high-volume and high-pressure environments with the ability to optimize ever-changing needs of health care consumers, improve outreach and continuously drive financial success.

EXPERIENCE:

2015-Present **CASCADE COMPREHENSIVE CARE & CASCADE HEALTH ALLIANCE KLAMTH FALLS, OR**

President & CEO

- Develops and drives strategic development, growth and operations of the firm
- Directed over $5M in capital improvement projects to improve the quality and transformation of care
- Established and monitors operational and financial performance for the firm
- Oversaw the transition of the organization becoming a benefit corporation
- Develop a new culture of social responsibility by creating and managing a $2M community health care project fund to impact social determinants of health to improve quality and outcome of health
- Work closely with state regulators and legislators to drive health care policy changes
- Achieved finalist status for a highly regarded “Game Changer” award

2011-2015 **THE AMERIHEALTH CARITAS FAMILY OF COMPANIES PHILADELPHIA, PA**

Director of Corporate Development and Market Leader

- Served as the lead executive responsible for coordinating, directing, and managing the market development efforts in strategic targeted states
- Executed four joint-venture transactions and two acquisitions
- Lead sourcing and evaluating potential strategic acquisitions and partnerships; and champion the financial and strategic rationale from conception to board of directors’ approval
- Responsible for developing the corporate growth plan and champion the development of new products like Medicare, DSNP, FIDE, Long-term Care, Health Insurance Exchanges and ACO
- Managed pipeline opportunities and responsible for generating new strategic opportunities
- Worked closely with other business leaders to identify and explore opportunities outside of the near-term strategies; and play a critical role in building a collaborative approach

2008-2011 **GAM ASSET MANAGEMENT PORTLAND, OR**

Senior Vice President & GM of GAM Emerging Markets

Vice President, Strategic Initiatives

- Led new market expansion efforts into emerging market countries
- Developed and executed go-to-market plans which included partnerships and strategic alliances
- Researched and analyzed current health care trends and companies in the US and emerging markets using fundamental analysis to make investment decisions
- Led and managed the $25-50 M GAM Emerging Market Fund launch

- Conducted M&A analysis on targeted health care companies
- Developed, led, and implemented idea generation and identification of new opportunities to generate revenue
- Supervised and developed market research, financial analysis and presentations for evaluating deals and capital raise
- Responsible for screening new private deals and conducted due diligence
- Sourced, structured, and negotiated transactions over $3 billion

2005-2008 **PROVIDENCE HEALTH PLAN** **PORTLAND, OR**
Head of Medicare Products
Lead Strategist, Strategic Planning & Product Development

- Responsible for the overall Medicare product portfolio line of business that generated $348M in annual revenue
- Led the entire product portfolio development and marketing life cycle from strategic planning to tactical activities
- Developed product road-maps and launched new products and regional expansion
- Successfully developed annual applications and bids to the Center for Medicare and Medicaid Services (CMS) leading to consistent program growth year-over-year
- Developed and led company-wide go-to-market plan which included sales strategies to capitalize on market opportunities
- Redesigned the distribution channel to maximize growth targets
- Achieved a 97% membership growth on a repositioned product in a very price sensitive market
- Led operational initiatives, and cross-functional teams of directors and executives

2002-2005 **TENET HEALTHCARE CORPORATION** **NEW ORLEANS, LA**
Chief Operating Officer, St. Charles General Hospital
Associate Administrator, Northshore Regional Hospital

- Instrumental in turn-around. Led the facility through Department of Health and Hospitals/Center of Medicare & Medicaid de-certification survey. Redeemed hospital certification and deemed status in 112 days
- Provided analytical support in areas of strategic planning and forecasting
- Performed rigorous financial analysis of hospital budgets. Made recommendations regarding cost savings and profit generating opportunities
- Led all outpatient services with a result-driven approach
- Actively recruited physicians to enhance growth in specific product lines
- Led a team of 70 FTE with P&L responsibility of $210M

EDUCATION:

STANFORD UNIVERSITY **STANFORD, CA**
Master of Business Administration with a focus in Finance & Strategic Management

BOSTON UNIVERSITY **BOSTON, MA**
Professional Certificate in Client Server Application Development

HOWARD UNIVERSITY **WASHINGTON, DC**
Bachelor of Science in Chemical Engineering (minor Mathematics)

COMMUNITY INVOLMENT:

- Steering Committee Member, Blue Zones
- Board Member, Pacific Crest Credit Union
- Advisor, Gainfy (Health care Blockchain Platform)

DAWNA D. OKSEN, CPA, CMA

DAWNA.O@HOTMAIL.COM

EXPERIENCE

Cascade Comprehensive Care, Inc. Klamath Falls, OR
Chief Financial Officer June 2015 – Current

- Oversee all finance and accounting related activities including accounts payable, accounts receivable, cash flow/working capital planning and investment oversight
- Develop financial reports, metrics, and benchmarks to perform analysis for stakeholders
- Prepare monthly financial statements and Board and Committee meeting packets
- Prepare quarterly reports for submission to State of Oregon
- Oversee rate redetermination process with State of Oregon and ensure financial compliance
- Develop provider compensation models
- Perform analysis of healthcare costs and trends
- Review all general ledger accounts for processing accuracy
- Prepare annual budget and oversee budget variance reporting
- Manage relationships with actuaries, auditors, financial institutions and investors
- Review and file annual tax returns
- Evaluate and recommend corporate property and liability insurance coverages
- Provide HR functions including placing advertisements, interviewing, new hire orientation
- Maintain personnel handbook and other HR policies and procedures
- Obtain annual quotes on employee benefits
- Oversee annual performance reviews of staff
- Oversee payroll function and tax reporting
- Write policy and procedures for the department

Klamath Orthopedic Clinic Klamath Falls, OR
Business Office Manager September 2013 – May 2015

- Provide leadership and supervision of Business Office and Accounting Department staff
- Prepare financial statements for 8 entities
- Review all general ledger accounts for processing accuracy
- Prepare all payroll tax reports, Federal and State
- Process Accounts Receivable and Accounts Payable
- Prepare annual 1099's and maintain vendor files and records
- Balance all bank statements monthly
- Prepare board reports monthly
- Process patient refunds
- Research industry coding and billing changes and implement within department
- Process adjustments on patient accounts
- Provide HR functions including placing advertisements, interviewing, new hire orientation

South Valley Bank & Trust Klamath Falls, OR
Vice President & Controller April 1994 – May 2013

- Provide leadership and supervision of Accounting Department and HR Department staff
- Prepare financial analysis of operations, including interim and annual financial statements with supporting schedules
- Responsible for the company's accounting practices and policies
- Maintain all accounting records including general ledger, accounts payable, fixed assets, payroll, and investments using generally accepted accounting principles and practices
- Coordinate and prepare the annual budget
- Prepare and analyze quarterly variance reports of actual to budget
- Evaluate and recommend corporate property and liability insurance coverages
- Responsible for implementation and ongoing monitoring of internal controls in department
- Review and write policy as necessary
- Provide training, monitoring and procedure review of Compliance regulations
- Complete annual risk assessments of the Accounting and HR Departments
- Assist with preparation of quarterly Asset Liability Interest Rate Risk model
- Complete quarterly regulatory reports for the Bancorp and the Bank
- Loss share accounting and quarterly certificate balancing
- Review and file annual tax returns
- Evaluate software for effectiveness and recommend and implement change when necessary
- Review and update Personnel policies and handbooks
- Administration of all benefit plans including annual renewals and recommendations
- Maintain the Employee Stock Ownership Plan records and complete the annual accounting
- Serve on various internal committees; Audit, ALCO, Leadership Council, IS Steering, Operations, Compliance
- Maintain EEOC and Affirmative Action Plans and serve as officer
- Prepare salary surveys and compare results to ensure industry competitiveness
- Assist with writing of job descriptions and job postings for recruitment purposes
- Oversee the employee review program and assist with personnel issues

EDUCATION

ASSOCIATE DEGREE: General Education, Salinas, CA
Hartnell Community College June 1993

ASSOCIATE DEGREE: Accounting Technology, Klamath Falls, OR
BACHELOR OF SCIENCE: Industrial Management
Oregon Institute of Technology June 1995

CERTIFICATIONS

- Certified Public Accountant
- Certified Management Accountant

DAVID SHUTE, MD | DAVIDS@CASCADECOMP.COM

SUMMARY: Seasoned physician leader with proven track record of driving successful quality improvement initiatives; versed in measurement and reporting of health care quality, utilization, and patient experience; adept at engaging and leading both clinicians and non-clinician audiences; successfully collaborates with health care providers, purchasers and payors.

EXPERIENCE:

Cascade Comprehensive Care | Klamath Falls, OR

*Chief Medical Officer and Vice President of Clinical Transformation*2018-Present

- Lead medical management team including pharmacy, quality, utilization review and case management.
- Engage providers and community partners to drive towards triple aim results

GreenField Health | Portland, OR

Medical Director, Consultant and Practicing Physician 2006 - 2017

GreenField Health is a 12-provider innovative primary care medical group in Portland, OR with a mission of inspiring patients to health.

- Collaborated with the GreenField team to design, implement, and manage an innovative primary care model that delivered high-quality comprehensive primary care with Press Ganey satisfaction results above the 98th percentile
- Provided continuity care to panel of 450 patients as well as consulting services to local, regional and national organizations working to achieve triple aim results

Pacific Source Health Plans | Springfield, OR

Board of Directors 2000 - 2017

PacificSource is a regional, tax-paying not-for-profit health plan that provides commercial Medicare Advantage, Medicaid, and dental insurance products as well as administrative services for self-insured employers.

- Provided leadership and oversight through the turbulent implementation of the Affordable Care Act
- Served as board chair from 2014 to 2016 during a period of evaluation of restructuring opportunities that eventually led to a transaction with Legacy Health System

Choosing Wisely Campaign

American Board of Internal Medicine Foundation | Philadelphia, PA

Physician Advisor 2013-2015

Choosing Wisely builds coalitions of physician specialty societies to identify tests and treatments that have limited benefits or causes harm and engages physicians, consumers and health systems to decrease the use of these services.

- Delivered educational presentations to providers outlining common practices that are not evidence based and which may cause harm
- Convened and led peer-to peer learning groups for providers

Oregon Health Care Quality Corporation | Portland, OR
Medical Director 2006-2013
Oregon Health Care Quality Corporation is an independent, nonprofit organization dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information.

- Physician leader for the design, development and implementation of a program to measure and publicly report quality, cost, and patient satisfaction data for Oregon health care providers
- Successfully engaged providers and provider organizations to support public reporting of quality measurement

Acumentra Health | Portland, OR
Medical Director and Interim CEO 1999-2006
Acumentra Health, which is now HealthInsight Oregon, is a nonprofit organization dedicated to improving the quality and effectiveness of healthcare.

- Led the development and implementation of the Oregon Diabetes Collaborative, modeled after the IHI Breakthrough Series Collaborative to support Oregon health care organizations and implement the Wagner Chronic Care Model
- Responsible for oversight of CMS required Medicaid and Medicare peer review and utilization review for care provided to Oregon beneficiaries
- Led the CMS-sponsored Doctor's Office Quality-Information Technology (DOQ-IT) Initiative supporting provider implementation of EHRs

HealthFirst Medical Group | Portland, OR
Physician, Site Medical Director and Executive Committee Member 1988-1999

- HealthFirst's utilization review (UR) process was resulting in unacceptable delays in care. Led UR redesign team to streamline our processes resulting in improved patient and provider satisfaction
- HealthFirst's financial difficulties resulted in declining provider income. Successfully chaired the compensation committee tasked with equitably decreasing provider compensation while maintaining a stable provider work force

EDUCATION:
MD, University of Illinois, Peoria, IL 1984
BS, Biology, University of Illinois, Urbana, IL 1980

Residency
Internal Medicine, Oregon Health and Sciences University, 1987 Board Certified, Internal Medicine, 1987

Selected Additional Training
Breakthrough Series College, Institute for Healthcare Improvement, 2001 Physicians in Management III, American College of Physician Executives, 1998 Physicians in Management II, American College of Physician Executives, 1998 Physicians in Management I, American College of Physician Executives, 1997

ANNETTE L. FOWLER
AFOWLER707@GMAIL.COM | WWW.LINKEDIN.COM/IN/ALFOWLER1

SUMMARY Highly motivated executive change-agent within operations, program and project management, quality (Six Sigma Black Belt Certified), process improvement and business development; Innovative leader with experience developing positive team environments through dynamic people management skills and exceeding customer expectations; consistently exceeds customer experience.

PROFESSIONAL EXPERIENCE

Cascade Health Alliance, Klamath Falls, OR 2018-2019
Chief Operations Officer

- Oversee business, state, federal and administrative regulations and compliance and audits
- Develop and implement short and long-term strategies and tactics to optimize personnel, materials, resources, and system to meet or exceed operational goals
- Implement provider network strategies to improve access to care
- Spearhead the development and implementation of member experience strategies
- Spearhead the RFP/RFA processes for re-contracting
- Develop and implement information technology strategy
- Lead Government relations, communications and public relations
- Develop and direct claims processing and risk adjustment program
- Build and maintain strong key stakeholder relations
- Maintain accountability for design, execution and effectiveness of systems and internal controls to provide reasonable assurance that operations are regulatory compliant

Physician Anesthesia Services, Inc. (PAS) (Current United Anesthesia Partners)
Chief Operating Officer – Seattle, Washington 2015-2016

- Established strategy, business development, recruitment for 100+ physicians' anesthesia practice including 10+ CRNA's and 2 ARNP's
- Drove RFP development, competitive bid for contracts and negotiated service contracts
- Increased shareholder revenue by negotiating increased reimbursement in payer contracts
- Directed the initial development and implementation of budget in a $50M+ company
- Led process improvement and implemented project management tools and software
- Led the development of financial, operational and clinical metrics and scorecards

Fresenius Medical Services, Portland, Oregon 2014-2015
Regional Vice President Operations – Oregon, Washington, Alaska

- Directed operations, clinical, technical, and financial teams for 3 modalities in 55 clinics, 22 acute, 12 stands alone for home care in 3 states – operating 24 hours daily
- consolidated team of 20 direct administrative members and 100+ physician medical directors, including a $300M+ P&L statement to work efficiently as one unit striving for operational excellence.

Regions Hospital, St. Paul, MN **2011-2014**
Senior Director, Quality, Program/Project Management

- Directed collaboration between 5 hospital systems, health plan and physician practices. Developed organizational redesign and deploy vision, strategy, and goals
- Integrated and direct patient and customer experience programs, safety and quality initiatives
- Re-designed sentinel events and near-misses root cause analysis and trending to identify and improve patient safety and quality of care – improved action plans events by 25%
- Developed and initiated project prioritization process, Six Sigma and Lean Sigma tools and training to develop consistent process with improved outcomes with cost containment

Medtronic – CRDM, Mounds View, Minnesota **2008 – 2011**
Director, Post Market Quality

- Managed $2M+ budget. Directed 200+ FTE's and oversaw complaint management system throughout the multiple U.S. and international sites.
- Executed leadership and oversight in a cross functional business team to implement a Global Complaint Handling processes and systems across 6 business segments to gain synergies.
- Represented Post Market Quality in FDA, TUV and governmental inspections
- Developed strategies to streamline operations for work in process from 18 months to 30 days
- Eliminated backlog of requests from regulatory bodies from 2 years to within 30 days or less in 5 months. Maintained the gain and further reduced inventory to average of 2.5 weeks

United Health Group – Ovations, Minnetonka, Minnesota **2005 - 2008**
Vice President of Quality and Process Improvement – Medicare and Medicare

- Lead integration initiatives to align acquired organizations as Ovations transitioned from a $9B company to over $28B between 2005 and 2006
- Realize over $47M in annualized savings through execution of Six Sigma program in 2 ½ years
- Develop and oversee the strategy to implement a corporate wide process for project submission, prioritization, capacity model and resource in alignment with corporate goals and strategies
- Direct the development and implementation of yellow belt, green belt, black belt, lean training, tools and discipline

Blue Cross-and Blue Shield of Minnesota – Eagan, MN **2002-2005**
Director, Provider Relations, Process and Operations Improvement

- Direct physician relations, operations and contracting for Minnesota and boarding states

EDUCATION

- MASTER OF BUSINESS ADMINISTRATION, University of Findlay – Ohio
- BACHELOR OF ARTS Business Administration Spring Arbor College – Michigan
- SIX SIGMA BLACK BELT CERTIFICATION, University of St. Thomas – Minnesota

CHA's Key Contact Chart

Attachment 6. Section A.1.m

CHA's Contact	Name	Telephone #	Email Address
Application	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Letter of Intent to Apply Form			
Application Checklist			
Application Information and Certification Sheet			
Disclosure Exemption Certificate			
Responsibility Check Form			
General Questions			
Provider Participation and Operations Questionnaire			
Value-Based Payment Questionnaire	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Health Information Technology	**Michael Donarski**	**(541) 851-2052**	**michaeld@cascadecomp.com**
Social Determinants of Health and Health Equity	**Susan Boldt**	**(541) 851-2016**	**susanb@cascadecomp.com**
Behavioral Health Questionnaire	**David Shute, MD**	**(541) 851-2017**	**davidm@cascadecomp.com**
Cost and Financial Questionnaire	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**

CHA's Contact	Name	Telephone #	Email Address
Attestations	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Assurances			
Representations			
Member Transition Plan	**David Shute, MD**	**(541) 851-2017**	**davidm@cascadecomp.com**
Sample Contract	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit A Definitions			
Exhibit B Statement of Work – **Part 1** Governance and Organizational Relationships			
Exhibit B Statement of Work – **Part 2** Covered and Non-Covered Services	**David Shute, MD**	**(541) 851-2017**	**davidm@cascadecomp.com**
Exhibit B Statement of Work – **Part 3** Patient Rights and Responsibilities, Engagement and Choice	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit B Statement of Work – **Part 4** Providers and Delivery System			
Exhibit B Statement of Work – **Part 8** Operations			

CHA's Contact	Name	Telephone #	Email Address
Exhibit B Statement of Work – **Part 9** Program Integrity	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit B Statement of Work – **Part 10** Quality, Transformation, Performance Outcomes and Accountability	**David Shute, MD**	**(541) 851-2017**	**davidm@cascadecomp.com**
Exhibit C Consideration	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Exhibit D Standard Terms and Conditions	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit E Required Federal Terms and Conditions			
Exhibit F Insurance Requirements	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Exhibit G Reporting Delivery System Network Providers, Cooperative Agreements and Hospital Adequacy	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit H Value Based Payment	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Exhibit I Grievance and Appeal System	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**

CHA's Contact	Name	Telephone #	Email Address
Exhibit J Health Information Technology	**Michael Donarski**	**(541) 851-2052**	**michaeld@cascadecomp.com**
Exhibit L Solvency Plan and Financial Reporting Cost	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Exhibit M Behavioral Health	**David Shute, MD**	**(541) 851-2017**	**davidm@cascadecomp.com**
Exhibit N Social Determinants of Health	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Exhibit N Health Equity	**Susan Boldt**	**(541) 851-2016**	**susanb@cascadecomp.com**
Rates and solvency	**Dawna Oksen**	**(541) 851-2075**	**dawnao@cascadecomp.com**
Readiness Review	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**
Membership and enrollment	**Annette Fowler**	**(541) 851-2080**	**annettef@cascadecomp.com**

845434-96

FILED

MAR 28 2012

OREGON
SECRETARY OF STATE

ARTICLES OF ORGANIZATION
OF
CASCADE HEALTH ALLIANCE LLC

ARTICLE I

The name of the limited liability company (the "Company") is Cascade Health Alliance LLC.

ARTICLE II

The Company shall have perpetual existence.

ARTICLE III

The name of the initial registered agent is Barbara L. Nay, and the address of the initial registered office is 900 SW Fifth Avenue, Suite 2600, Portland, Oregon 97204.

ARTICLE IV

The address where the Division may mail notices is 2909 Daggett Ave, Suite 200, Klamath Falls, Oregon 97601.

ARTICLE V

The Company shall be manager-managed by a manager.

ARTICLE VI

The name and address of the organizer of the Company are Barbara L. Nay, 900 SW Fifth Avenue, Suite 2600, Portland, Oregon 97204.

DATED this 27th day of March, 2012.

Barbara L. Nay

Barbara L. Nay, Organizer

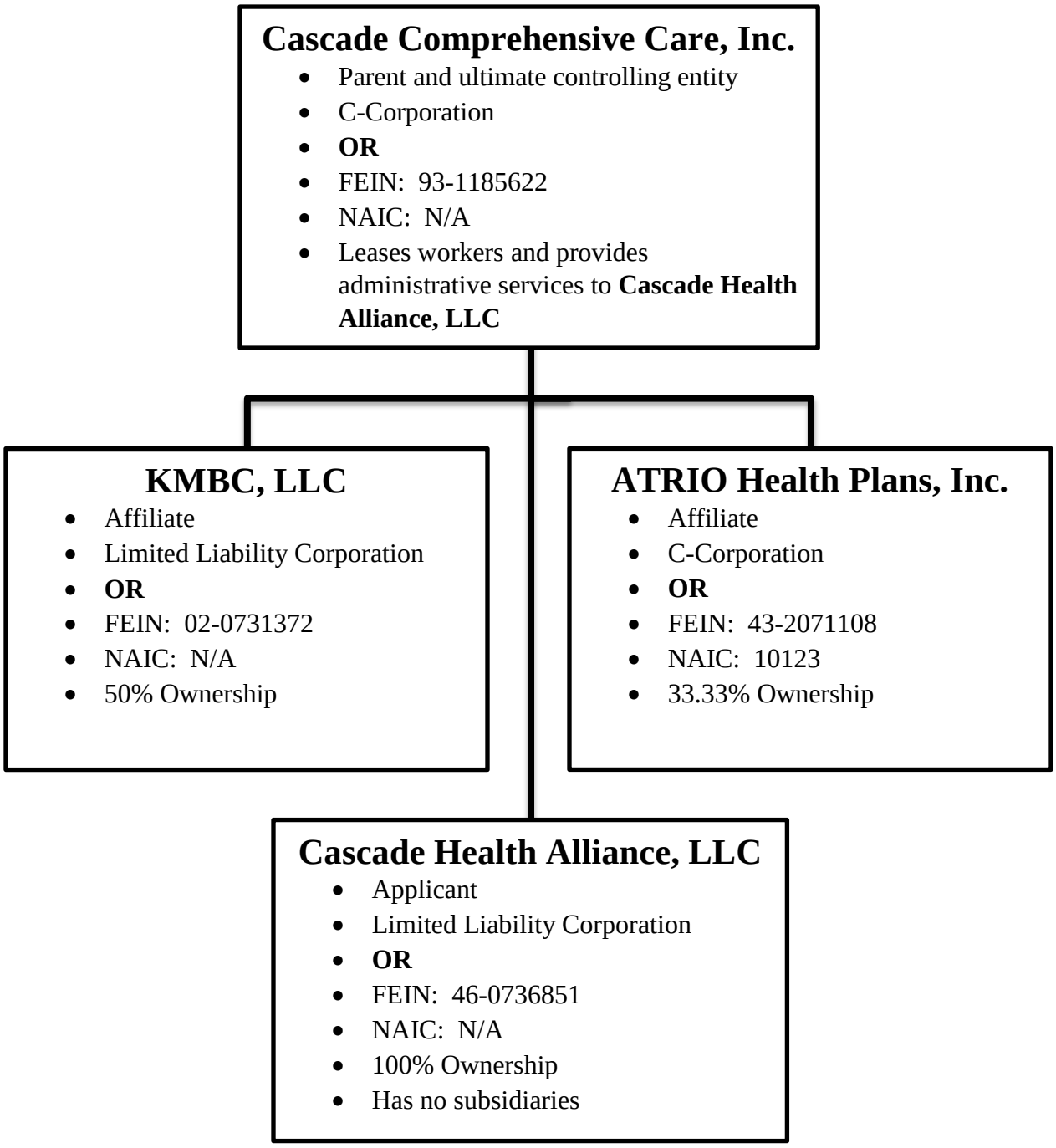
CASCADE HEALTH ALLIANCE LLC

84543496-13408688 NEWORG

71365367.1 0040147-00001

CHA Detailed Interrelationships Organization Chart

Attachment 6. Section C.1.a



Attachment 7 - Provider Participation and Operations

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this Provider Participations and Operations Questionnaire is 40 pages. Items that are excluded from the page limit will be noted in that requirement.

Section 1. Governance and Organizational Relationships

07.1.a Governance - This section will describe the Governance Structure, Community Advisory Council (CAC), and how the governance model will support a sustainable and successful organization that can deliver health care services within available resources, where success is defined through the triple aim. Please describe:

07.1.a.1 The proposed Governance Structure, consistent with ORS 414.625.

Cascade Health Alliance's (CHA) corporate structure follows ORS 414.625 which created Coordinated Care Organizations in Oregon. Our governing board is composed of risk sharing providers that represent primary care, specialist, dentists, Behavioral Health (BH), the local non-profit hospital, the Community Advisory Council (CAC) chair, and community members at large. We manage financial risk and have the financial reserves required by our contract with OHA. CHA institutes alternative payment methodologies for our providers which support improved health outcomes and quality of care.

CHA is committed to the integration of physical, behavioral, oral health, and pharmacy services. We are the only existing CCO to bring dental care in-house. When our three-year contract with the Dental Care Organization (DCO) expired in July 2017, CHA created a dental provider network and eliminated the silo that existed preventing us from fully integrating dental services.

07.1.a.2 The proposed Community Advisory Council (CAC) in each of the proposed Service Areas and how the CAC was selected consistent with ORS 414.625.

As an established CCO, CHA's CAC was originally chosen per statute by an ad hoc selection committee that included local government representatives and providers. Applications were requested and nominations made by providers. The selection committee vetted the applications and chose the most qualified applicants. From its inception, CAC has been composed of at least 51% OHP members or caretakers of members.

07.1.a.3 The relationship of the Governance Structure with the CAC, including how the Applicant will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.

The CAC is a standing agenda item at Board of Directors meetings. The CAC Chair provides updates and represents CAC recommendations including applicants for CAC membership when

there is a vacancy. Both the CAC and CHA Board meeting minutes are publicly posted on CHA's website to ensure transparency and accountability.

07.1.a.4 The CCO Governance Structure will reflect the needs of Members with severe and persistent mental illness and Members receiving DHS Medicaid-funded LTC services and supports through representation on the Governing Board or CAC.

The needs of members with Severe Persistent Mental Illness (SPMI) are represented on the Board by our Community Mental Health Program (CMHP)/Local Mental Health Authority (LMHA), Klamath Basin Behavioral Health (KBBH).

07.1.b Clinical Advisory Panel - An Applicant is encouraged but not required to establish a Clinical Advisory Panel as a means of assuring best clinical practices across the CCO's entire network of Providers and facilities.

07.1.b.1 If a Clinical Advisory Panel is established, describe the role of the Clinical Advisory Panel and its relationship to the CCO governance and organizational structure.

CHA does not currently have a Clinical Advisory Panel but will explore the development of one based on feedback from community partners and providers. While we do not have a panel, we believe our existing committee structure serves this function of the panel well.

07.1.b.2 If a Clinical Advisory Panel is not established, the Applicant should describe how its governance and organizational structure will achieve best clinical practices consistently adopted across the CCO's entire network of Providers and facilities.

The achievement of best clinical practices across CHA's network will be the responsibility of the following Board committees. All committees are appointed by the Board and report to the Board.

- The Pharmacy and Therapeutics Committee will be responsible for adopting best practices for prescribing and clinical activities related to prescribing.
- The Quality Management Committee will oversee credentialing and re-credentialing, approves the adoption of clinical guidelines, and evaluates care that may not meet best practices.
- The Utilization Review Committee will approve the best clinical practices related to utilization management and evaluate patterns of utilization.
- The Compliance Committee will oversee CHA provider compliance with policies and procedures and will conduct an audit as needed.

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

While DHS Medicaid-funded LTC services are legislatively excluded in HB 3650 from CCO responsibility and will be paid for directly by the Department of Human Services, CCOs will still be responsible for providing physical and Behavioral Health services for individuals receiving DHS Medicaid-funded LTC services and will be responsible for coordinating with the DHS Medicaid-funded LTC system. To implement and formalize coordination and ensure

relationships exist between CCOs and the local DHS Medicaid-funded LTC Providers, CCOs will be required to work with the local Type B AAA or DHS' APD local office to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving DHS Medicaid-funded LTC services.

07.1.c.1 Describe the Applicant's current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

CHA has a valid MOU with the Department of Human Services Local Aging & People with Disabilities District 11 office (DHS APD).

DHS APD District 11 covers Klamath County. Our agreement applies to members receiving long term services and supports. CHA and APD (via interdisciplinary care teams and by sharing internal case management roster of clients) coordinate care and develop individual treatment plans for mutually identified high-need members.

07.1.c.2 If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain the MOU or contract.

This is not applicable to CHA as we have a current MOU with DHS APD District 11.

07.1.d Agreements with Community Partners Relating to Behavioral Health Services

To implement and formalize coordination, CCOs will be required to work with local mental health authorities and Community Mental Health Programs to develop a Memorandum of Understanding (MOU) or contract, detailing their system coordination agreements regarding Members receiving mental health services.

07.1.d.1 Describe the Applicant's current status in obtaining MOU(s) or contract(s) with LMHAs and CMHPs throughout its proposed Service Area.

As an established CCO, CHA is currently contracted with KBBH which serves as both the LMHA and CMHP for Klamath County.

07.1.d.2 If MOUs or contracts have not been executed, describe the Applicant's efforts to do so and how the Applicant will obtain the MOU(s) or contract(s).

This is not applicable to CHA as we have a current contract with KBBH as the LMHA and CMHP.

07.1.d.3 Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area, such as:

- ***DHS Child Welfare and Self Sufficiency field offices in the Service Area***
- ***Oregon Youth Authority (OYA) and Juvenile Departments in the Service Area***
- ***Department of Corrections and local Community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the Service Area, including for individuals with mental illness and substance abuse disorders***
- ***School districts, education service districts that may be involved with students having special needs, and higher education in the Service Area***

- ***Developmental disabilities programs***
- ***Tribes, tribal organizations, Urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives***
- ***Housing organizations***
- ***Community-based Family and Peer support organizations***
- ***Other social and support services important to communities served***

CHA has established existing relationships with the social and support services in Klamath County as part of delivering its current CCO model in 2019. We anticipate collaborating with and maintaining the existing relationships as part of the CCO 2.0 application reward to deliver care.

Section 2. Member Engagement and Activation

07.2 Member Engagement and Activation

Members should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultations regarding cultural preferences and goals for health maintenance and improvement. Member choices should be reflected in the selection of their Providers and in the development of Treatment Plans while ensuring Member dignity and culture will be respected.

07.2.a Describe the ways in which Members (and their families and support networks, where appropriate) are meaningfully engaged as partners in the care they receive as well as in organizational Quality Improvement activities.

CHA is developing a digital engagement plan to improve how we communicate and engage our members about their health, services and overall wellbeing. CHA's Customer Service Department proactively contacts all new members within 30 days of enrollment to initiate immediate engagement. We ask new members a series of questions to assure that they are aware of their benefits and that they have received their member ID card and member packet. CHA also inquires if new members already have an established primary care provider, dentist, etc. If members are established with a provider, we assign them to that primary care provider or dentist. If they have not established a relationship with a provider, we reinforce the importance of making an appointment to become established, which ensures they are considered a patient for future care. CHA also inquires if the new member has any cultural barriers to care and if they do, we refer them to a Case Manager (CM) to help the member overcome the identified barriers to care. The CM engages the care team, which may include the member's family and/or support networks, to develop a member-driven care plan to best meet the member's needs. CHA also collaborates with community partners via referral to trigger a visit from a traditional health care worker when appropriate. Our goal is facilitating member-driven care planning. CHA works closely with members or their legal representatives in all aspects of care planning.

Members – or their caretakers – participate in Quality Improvement activities through their involvement on the Community Advisory Council (CAC). Through this venue, CAC members receive information on and provide input to CHA's performance improvement projects and the

transformation and quality strategy. CHA will begin seeking member involvement in performance improvement projects through targeted focus groups and surveys.

07.2.b Describe how the Applicant will ensure a comprehensive communication program to engage and provide all Members, not just those Members accessing services, with appropriate information related to benefits and accessing physical health, Behavioral Health and oral health services, including how it will:

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

CHA is developing a digital engagement plan to improve how we communicate and engage our members about their health, services and overall wellbeing. CHA will ensure a comprehensive communication program with members from the moment a new member enrolls. Within 30 days of enrollment, we perform new member outreach to all members. We contact each member or household to assure the member or members have received their new member cards, and new member packet.

The new member packet covers the following areas: Member Rights and Responsibilities, establishing care with the assigned provider, Provider Directory, Making Appointments, Emergency Care , Urgent Care, Who to Call for Questions, Service Area, American Indian Rights, Choosing a Primary Care home, Finding a provider, How to make appointments, Missed Appointments, Getting Specialty Care, OHP Benefits, Appeal and Complaints, Member Responsibility for Charges, Specialty Programs, Community Health Care Workers, Transportation, Wellness Program, Advanced Directives, Privacy notice, and Words to Know. Information is also provided for accessing the services of Traditional Healthcare Workers (THW).

CHA addresses a series of questions with the member to ensure they understand the importance of becoming established with their provider. We ask if they have had a chance to look at our provider directory, do they have benefits or Handbook questions, and provide information on age-appropriate screenings for preventative care. We also capture the language in which they prefer to receive communication, how they want to receive communication and if they have any cultural barriers to health care or if they have any health needs that hinder their day to day activities.

CHA's Customer Service Department refers members to a Registered Nurse (RN) CM who addresses cultural barriers or health needs, including SDOH needs, that hinder their day to day activities. All calls end by reiterating the importance of establishing care with their provider so that their assigned providers have their information on file, and they are established members with the provider to prevent delays in their care. CHA also reminds the member that the use of Translink is a covered benefit should they need transportation to appointments.

CHA's CAC is very active in recruiting members to the CAC and making sure they are engaged and participate in our programs. CAC members have participated in our community events, including health fairs, speaking to OHP members and educating them on the CAC and the benefits of being a CHA member. CAC members have also provided feedback to CHA on member surveys and our new Patient Talk program that uses a tablet for ease of members participating in satisfaction surveys.

Section 3. Transforming Models of Care

07.3 Transforming Models of Care (recommended page limit 1 page)

Transformation relies on ensuring that Members have access to high quality care: "right care, right place, right time." This will be accomplished by the CCO through a Provider Network capable of meeting Health System Transformation (HST) objectives. The Applicant is transforming the health and health care delivery system in its Service Area and communities – taking into consideration the information developed in the Community health assessment – by building relationships that develop and strengthen network and Provider participation, and Community linkages with the Provider Network.

07.3.a Patient Centered Primary Care Homes - Integral to transformation is the Patient-Centered Primary Care Home (PCPCH), as currently defined by Oregon's statewide standards in OAR. These standards advance the Triple Aim goals of better health, better care, lower costs by focusing on effective wellness and prevention, coordination of care, active management and support of individuals with Special Health Care Needs, a patient and Family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.

07.3.a.1 Describe Applicant's PCPCH delivery system.

CHA and its provider partners have a well-developed PCPCH delivery system, with most of our providers practicing in medium to large medical groups. REDACT

CHA's PCPCH delivery system will continue to evolve to be better able to achieve triple aim goals. To support individuals with special healthcare needs and advance integration our two largest PCPCHs have hired BH providers, and our largest BH provider is embedding a PH

provider. PCPCH BH and PH case managers are now regularly meeting to coordinate and align their case management activities.

07.3.a.2 Describe how the Applicant's PCPCH delivery system will coordinate PCPCH Providers and services with DHS Medicaid-funded LTC Providers and services.

CHA members are assigned to a capitated PCPCH provider to provide all primary care services. Assignment to a PCPCH helps to clarify roles and responsibilities for members, PCPCH providers and Medicaid funded LTC providers. In addition to PCPCH providers offering primary care services, they are responsible for coordinating care with all providers including LTC providers. Coordination occurs through multiple interactions including certification of medical need, managing referrals, and periodic evaluation and updating of treatment plans.

07.3.a.3 Describe how the Applicant will encourage the use of Federally Qualified Health Centers (FQHC), Rural health clinics, migrant health clinics, school-based health clinics and other safety net providers that qualify as Patient-Centered Primary Care Homes.

CHA strongly supports school-based health centers and recently provided grant funding to open an SBHC at Mazama High school which is operated by KHP (our FQHC). We have a strong relationship with KHP who is always open to additional members. CHA meets members where they are to consistently deliver a high-value member satisfaction experience and will continue encouraging the use of FQHCs. There are currently no Rural or Migrant health clinics with whom to partner in Klamath County.

07.3.b Other models of patient-centered primary health care

07.3.b.1 If the Applicant proposes to use other models of patient-centered primary health care in addition to the use of PCPCH, describe how the Applicant will assure Member access to Coordinated Care Services that provides effective wellness and prevention services, facilitates the coordination of care, involves active management and support of individuals with Special Health Care Needs, is consistent with a patient and Family-centered approach to all aspects of care, and has an emphasis on whole-person care in order to address a patient's physical, oral and Behavioral Health care needs.

CHA does not propose using any other models of patient-centered primary healthcare other than PCPCH. We believe our current model meets the Triple Aim, is aligned with our value-based payment methodology, and addresses the member's physical, oral and behavioral health care needs.

07.3.b.2 Describe how the Applicant's use of this model will achieve the goals of Health System Transformation.

CHA is currently supporting our local Certified Community BH Clinic aligned with OHA intentions of BH and physical health integration. We will continue supporting this model as part of enhancing and transforming our delivery of care.

Section 4. Network Adequacy

07.4 Network Adequacy (recommended page limit 3 pages)

Applicant's network of Providers must be adequate to serve Members' health care and service needs, meet access to care standards, including time and distance standards and wait time to appointment, and allow for appropriate choice for Members, and include Traditional Health Workers including Community Health Workers, Personal Health Navigators and certified, qualified interpreters.

07.4.a Evaluation Questions

07.4.a.1 How does Applicant intend to assess the adequacy of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how adequacy will be evaluated.

CHA assesses its provider network to validate the delivery of the right care at the right time in locations as close as possible to where our members reside. The Provider Network Department assesses the availability of primary care, BH, oral health, and specialty care for routine, urgent, and emergency care and services 24 hours a day, seven days a week, as medically appropriate to meet our members' needs. The adequacy of our Provider Network uses OHA's access standards as a baseline.

Our provider network is analyzed routinely in areas of primary care, BH, oral health, and specialty care to assure an adequate number of contracted providers are available to meet our members' needs, including culturally responsive and linguistically appropriate services. CHA uses geo-mapping software to establish the location of our providers in relation to our members. The data points include travel time and distance to providers for primary care, specialty care, oral health, and BH services. CHA also uses provider and member zip code data to identify deficiencies in access to our provider network. If a deficiency is identified, CHA uses geo-mapping to target potential providers in a geographic region outside of Klamath County to provide services to our members.

07.4.a.2 How does Applicant intend to establish the capacity of its Provider Network? Please include specific data points used to inform the assessment and the methodology for how capacity will be evaluated.

CHA will maintain and monitor a participating provider panel that has enough capacity and expertise to provide adequate, timely and medically appropriate access to covered services for our members across the age span, including our dual eligible members. CHA will contract with an appropriate number of providers to ensure members' access to a full continuum of behavioral, physical and oral health services. CHA has developed and implemented a methodology to establish and monitor network provider capacity based on the following data points:

- Anticipated Medicaid enrollment and fully dual eligible members
- Range of preventative and specialty services for the members we serve in Klamath County
- Expected utilization of services which includes oral, physical and BH care needs of our members in Klamath County
- Number and types of providers required to provide services to our members

- Geo-mapping of providers and members which will include distance, travel time and disability access
- Collect and trend grievance and appeal data by provider
- Collect and monitor member wait time for an appointment
- Create network adequacy reports to evaluate access to services for our members
- Distribute geo-graphic mapping that evaluates access to covered services
- Monitor providers who are not accepting new members
- Monitor the number of members assigned to PCPCHs

CHA generates a capacity report which is shared and reviewed with individual providers to assess potential gaps in services and to share and assess any past, present or future capacity issues. CHA has established baseline policies that require:

- Contracted providers to submit notification a minimum of 90 days prior written notice of their intent to close their practice to all new members
- Contracted providers to submit notification a minimum of 90 days prior written notice of intent to relocate out of the area
- Where providers have not fulfilled their agreed upon capacity assignments, providers may not "close" their practice to new members while continuing to accept commercially insured patients

07.4.a.3 How does Applicant intend to remedy deficiencies in the capacity of its Provider Network?

CHA's internal Provider Network Management Committee (PNMC) meets routinely to review provider network capacity reports and identify deficiencies. CHA will create its Corrective Action Plans (CAP) when deficiencies are identified. The CAP will include geographic assessment of the identification of provider types and culturally and linguistically appropriate services in locations as geographically close as possible to where our members reside. A strategy is then developed to contract with the provider to resolve the deficiency in capacity.

Examples of remedies for deficiencies which CHA has provided include mobile health services and school-based clinics. CHA intends to expand telehealth and remote monitoring.

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07.4.a.4 How does Applicant intend to monitor Member wait times to appointment? Please include specific data points used to monitor and how that data will be collected.

CHA will continue monitoring member wait times for appointments in two distinct ways.

First, through a quarterly secret shopper program to ensure compliance with their contractual obligations in offering timely access for members. For example, we ask "are you accepting new patients and if so, how long would it be to schedule an appointment?" We also ask if there are

walk-in times and same day appointments for urgent matters. This data is then collected and reviewed by the PNMC and addressed with the provider.

Second, CHA monitors member wait times for appointments through our grievance and appeals process. Wait times or access complaints are captured, analyzed and reviewed at the PNMC and then discussed individually with the provider.

The specific data points used to monitor wait times for members include:

- Provider capacity/accepting new patients
- Length of time for "new patient" appointment
- Length of time to schedule appointment
- Walk-in times
- Same day appointments
- Grievances
- Appointment adherence/no-show rates

07.4.a.5 How will Applicant ensure sufficient availability of general practice oral health Providers and oral health specialists such as endodontists? Please provide details on how the full-time equivalent availability of Providers to serve Applicant's prospective Members will be measured and periodically validated.

An oral health capacity report is monitored by the Provider Network Department to assess the adequacy of oral health providers for our members. This report details the number of members assigned to each provider and the available capacity for additional members. New members are assessed for assignment to oral health providers. CHA also uses grievances and appeal data to identify member access concerns in our geographic area. At CHA, data drives everything we do to ensure optimal performance as an organization.

CHA currently has an adequate capacity of oral health providers to provide dental services to our members. This will be monitored at the PNMC. If a need is identified, a CAP will be developed to address identified deficiencies in the oral health provider network.

CHA continually evaluates the oral health specialist needs of our members. The data is monitored at the PNMC. If a need is identified, a CAP will be developed to address identified deficiencies in our oral health provider network.

CHA is in the process of developing a report to allow for analysis of the full-time equivalent availability of providers to serve our prospective members in the future. This will include the measurement, periodic validation, and monitoring of the process.

07.4.a.6 Describe how Applicant will plan for fluctuations in Provider capacity, such as a Provider terminating a contract with the Applicant, to ensure that Members will not experience delays or barriers to accessing care.

CHA continually monitors its provider network for potential fluctuations which may impact our provider capacity. The provider contract requires a provider to notify CHA no less than 90 days when they intend to cease providing services to our members.

Once notified, and to mitigate delays or barriers in access to care, the Provider Network Department identifies which members may be impacted and a geo-mapping analysis using the member's primary address is conducted to triangulate providers accepting new members. New provider options are then offered to the member to meet their health care needs.

07.4.b Requested Documents Completion of the DSN Provider Report (does not count towards page limitations)

Please see *RFA4690-CHA-ATT07-DSN Provider Report.xls*

Section 5. Grievance & Appeals

07.05 Please describe how Applicant intends to utilize information gathered from its Grievance and Appeal system to identify issues related to each of the following areas:

07.5.a Access to care (wait times, travel distance, and subcontracted activities such as Non-Emergent Medical Transportation).

Access to care issues identified through the Grievance and Appeal system (G&A) are referred to the Provider Network Department and disseminated to the providers and subcontractors to inform and educate, as well as improve access to services provided to our members. When CHA identifies trends and patterns, a CAP, to include monitoring, is created to address identified concerns. Complaints with the potential to create an adverse event, or pose a high risk to our members, are addressed immediately.

07.5.b. Network adequacy (including sufficient number of specialists, oral health and Behavioral Health Providers).

Network adequacy issues identified by the G&A are referred to the Provider Network Department. The information will be reviewed at the PNMC for review and recommendations. Also, the information will be disseminated to the providers and subcontractors to inform and educate and improve access to services provided to our members. When CHA identifies trends and patterns, a CAP, to include monitoring, is created to address identified concerns. Complaints with the potential to create an adverse event, or pose a high risk to our members, are immediately addressed.

07.5.c. Appropriate review of prior authorized services (consistent and appropriate application of Prior Authorization criteria and notification of Adverse Benefit Determinations down to the Subcontractor level).

Appropriate review of prior authorized services is captured through an interrater reliability report. This report is generated and monitored by CHA's Compliance Department and disseminated to the Case Management Department for analysis of the process. When CHA identifies trends and patterns, a CAP is developed to correct identified concerns. Issues related to

an appropriate review of prior authorized services are referred to the Case Management Department for utilization review.

All notifications of adverse benefit determinations are compiled and logged, and a random selection is submitted to the State. CHA monitors for dates to ensure compliance with the 14-day notice of determination timeline or 72-hours for expedited review. When CHA identifies trends and patterns, a root cause analysis is performed, and a CAP is developed to address identified concerns. The Compliance Department monitors the process to ensure the sustainability of improvements.

Section 6. Coordination, Transition and Care Management

07.6.a Care Coordination

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

CHA will continue using MOUs to support the flow of information with community partners and providers. Our CMs receive notification of medical and mental health concerns impacting our members through various avenues, i.e., corrections facilities report, hospital census, Collective Medical (formerly PreManage). CMs share this information with the appropriate providers/partners so that members receive proper care following a hospitalization or other health-related event. Community partners/providers stay in frequent contact via meetings, secure emails and telephonically, to ensure that members are receiving the right care at the right time, and to avoid duplication of services. CHA plays a vital role in making sure the appropriate providers/partners are aware of the needs of the member, current services and possible gaps in services; CHA CMs coordinate, facilitate and drive the care planning process for members.

07.6.a.2 Describe how the Applicant will work with its providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services, and Community prevention and self-management programs.

CHA works closely with all providers and our community partners to ensure members connect with the appropriate social and support services. KHP and **RTS** routinely screen for SDOH and connects members with resources based on their identified needs.

CHA works with providers in its community through participation in outreach events aimed at prevention and self-management. CHA serves as a convener in Klamath County, participating in Klamath Promise, Healthy Klamath Coalition, Blue Zones, Community Resource Team, Older Adult Initiative, Wraparound, Hoarding Task Force, Local Alcohol and Drug Planning Committee, and the Early Learning Hub. These groups allow CHA to facilitate collaboration, interface with community partners and providers to share information and resources.

We collaborate with KBBH and Lutheran Community Services (LCS) to provide crisis support services through ongoing programs such as mobile crisis care, Healthy Families, in-home

services, day treatment, ACT, case management, skills building, Wraparound, supported employment, rent subsidy, and respite care for youth and adults. This collaboration is made possible by the daily relationship building between CHA, KBBH, and LCS to ensure the care of our mutual members. Daily informal discussions and routine formal treatment team meetings allow CHA and its providers to identify and eliminate barriers to member care. CHA uses Klamath and Lake Community Action Services (KLCAS) and RTS to fill any identified care gaps. CHA is committed to delivering the best services possible to improve health outcomes for our members.

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

CHA will continue working with providers to accurately identify and address the various cultural and linguistic needs of our members. CHA will leverage several relationships for technical assistance: local health equity experts at Klamath County Public Health (KCPH), the Southern Oregon Health Equity Coalition, the Healthcare Coalition of Southern Oregon, and the Office of Equity and Inclusion's Regional Outreach Coordinator of Central and South Central Oregon. CHA has a Delta Program graduate on staff in the Quality Management Department who will also help inform the development of a tool for provider use. CHA will use its membership in the National Association for Healthcare Quality to network and gather resources to us in developing a tool that has proven success in other like-rural communities.

07.6.a.4 Describe how the Applicant will work with Providers to implement uniform methods of identifying Members with multiple diagnoses and who are served with multiple healthcare and service systems.

CHA's Intensive Care Coordination Management (ICCM) follows members with SPMI, multiple diagnoses, and other qualifying diagnoses to coordinate care with PCPs and other providers as well as facilitate care coordination through the continuum of care. CHA ICCMs identify this member cohort through the analysis of claims-based data, ER admissions, and member health surveys. CHA conducts provider education on ICCM services and identifies members who may benefit from these services. Providers submit a referral to CHA for ICCM services. CHA is enhancing its strategy by creating a referral form for providers to use to refer members for ICCM services. We are exploring ways to integrate this process into our provider portal.

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

CHA will continue working with local providers to identify the various health care needs of our ICM members. CHA CM will facilitate a patient-driven PCPCH centric plan of care to meet the members' unique needs. CHA collaborates with PCP and all other appropriate community care teams to develop and facilitate the members care plan. CHA CMs review records and carry out

audits to assure members needs are met. CHA CMs also attend regular care coordination meetings where providers from various community agencies can collaborate to meet the care needs of members to avoid duplication of services. APD and AAA attend these meeting and give input and assist with action plans for members needing these services.

CHA will leverage data analytics through claims-based and other systems, to improve identification of ICM members and to enhance care planning processes.

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

CHA will continue working with its community partners to coordinate care for members with SPMI. Regardless of reimbursement structure, members with SPMI are closely followed by CHA's BH CM to ensure they have access to the appropriate care and the right providers. The BH CM monitors these members and continues to coordinate their care (whether they are local or out of the area) through their full course of treatment. When the members are in town, the majority receive care through KBBH and are case managed through the SPMI or ACT program. When these members are placed Out of the Area (OOA), their care needs are coordinated by the CHA BH CM in partnership with the Exceptional Needs Care Coordinator (ENCC) through KBBH. CHA receives clinical updates every 7 days, and contacts facility staff as needed to coordinate OOA treatment needs as well as to coordinate local care following discharge from the respective program. The ENCC through KBBH participates on the treatment team at the facility, which includes the member, to coordinate care and prepare for discharge. For OOA placements, every effort is made to ensure the ENCC attends these meetings in person as much as possible.

Additionally, CHA is receiving technical assistance from OHA in coordination with its ED PIP. As a value-added service, the group (composed of local providers, clinic administrators, triage nurses, community health workers, and BH providers) is piloting two projects; both focused on care coordination.

The first project is a group composed of care and/or CMs to focus on sharing best practices across the service delivery spectrum. The second project brings together clinic administrators or those with the authority from their respective organizations to make decisions on behalf of their clinic that will impact the provision of services for the patient to improve the patient's health outcome.

ED utilization is being tracked monthly to determine if these two pilot projects, along with an increase in member education regarding ED use, are having an impact not only on the overall ED utilization rate in the community but also improved health outcomes through targeted care coordination.

07.6.a.7 Describe the evidence-based or innovative strategies the Applicant will use within their delivery system network to ensure coordinated care, including the use of Traditional

Health Workers, especially for Members with intensive Care Coordination needs, and those experiencing health disparities.

CHA will use innovative strategies within our delivery system network to ensure coordinated care that challenges the norm. CHA partners with RTS and its BH providers for the services of THWs. RTS conducts member home visits and assists with addressing SDOH identified through those assessments. RTS refers members to community resources and services, and arranges transportation as needed. RTS completes medication reconciliation and provides education during home visits. Information obtained during these home visits are sent to the member's PCPCH. CHA and OHA CMs collaborate to maximize the care and services provided to members.

Additionally, CHA partners with RTS to engage members in the home for such things as wellness checks, blood draws for HbA1c testing, drop off/pick up of FIT tests and delivery to the lab for processing, and assessments for SDOH.

07.6.a.8 Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a Primary Care Provider or primary care team that is responsible for coordination of care and transitions.
07.6.a.8.a Describe the Applicant's standards that ensure access to care and systems in place to engage Members with appropriate levels of care and services beginning not later than 30 days after Enrollment with the CCO.

CHA's Customer Service Department performs member outreach on all new members within 30 days of enrollment to initiate immediate engagement. We ask new members a series of questions to assure they are aware of their benefits and that they have received their member ID card and member packet. CHA also inquires if new members already have an established primary care provider, dentist, etc. If members are established with a provider, we assign them to that primary care provider or dentist. If they have not established a relationship with a provider, we reinforce the importance of making an appointment to become established, which ensures they are considered a patient for future care. CHA also inquires if the new member has any cultural barriers to care and if they do, we refer them to a CM to help the member overcome identified barriers. The CM engages the care team, which may include the member's family and/or support networks, to develop a member-driven care plan to best meet the member's needs. CHA also collaborates with community partners via referral to trigger a visit from a traditional health care worker when appropriate. Our goal is facilitating member-driven care planning. CHA CMs work closely with members or their legal representatives in all aspects of care planning.

If the member does not contact CHA to pick a provider, or if CHA is unable to reach the member during new member outreach, we will auto-assign a Primary Care provider as well as an oral health provider and notify the member of the assignment via a letter.

07.6.a.8.b Describe how the Applicant will provide access to primary care to conduct culturally and linguistically appropriate health screenings for Members to assess individual care needs or to determine if a higher level of care is needed.

CHA uses Language Line Service for translation which is accessible to members, staff, and Providers. CHA also has several Spanish speaking staff members whose language expertise is accessible by our internal CMs as needed to determine the appropriate level of care for a member. CHA CMs can assist members and Providers in ensuring that members have translation and interpretation services available to them on the day of their appointment. CHA uses this interpretation line when required, patients are set up with Primary Care offices that are culturally and linguistically appropriate for the patient. We also have bilingual staff to assist with issues and selection of primary care.

New and re-determined members receive an outreach call within 20 days of being assigned/enrolled with CHA. Through this outreach, CHA staff conduct a brief assessment of the member and/or family. Any findings related to the assessment, be it cultural service needs or other special healthcare service needs are referred to case management for follow-up and further needs review. Once a Case Manager has been notified, the RN follows up with Primary Care Provider, specialist providers, and member to track care plans and incorporation of any special needs into each member's care plan, The RN continues to track member and care plan to check for adequacy and review of needs.

07.6.a.9 Comprehensive Transitional Care: The Applicant must ensure that Members receive comprehensive Transitional Care so that Members' experiences and outcomes are improved. Care coordination and Transitional Care should be culturally and linguistically appropriate to the Member's need.

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

CHA is fortunate to be in Klamath County where strong partnerships exist between multiple agencies and organizations. CHA's dedicated Transitions of Care Managers monitor hospital admissions reports daily and proactively reach out to the members' care team as early as possible to initiate discharge planning. CHA Transitions of Care Managers follow the member through the continuum of care until the member is at their previous baseline or newly determined appropriate baseline. CHA Transitions of Care Managers collaborate internally with the BH CMs to provide the best possible discharge plan.

CHA collaborates with local and statewide agencies to promote appropriate discharge planning for adults with SPMI. When members are hospitalized, the BH CM monitors their care by direct contact with provider care teams. At CHA, discharge planning begins at the time of admission, and members are followed from the date of admission to discharge. The facility notifies CHA of admission and CHA requires regular clinical updates to the BH CM. The BH CM works closely with KBBH staff to facilitate appropriate follow-up care. When the member is discharged, their local treatment team is notified to ensure follow-up within seven days can be achieved. The BH

CM reaches out to the member and/or treatment team to offer additional services as needed. CHA also coordinates with community-based organizations to address SDOH needs.

07.6.a.9.b Describe the Applicant's plan to coordinate and communicate with Type B AAA or APD to promote and monitor improved transitions of care for Members receiving DHS Medicaid-funded LTC services and supports, so that these Members receive comprehensive Transitional Care.

APD and AAA attend weekly community care management conferences. Information obtained through this process is used by CHA CMs in collaboration with APD, AAA, and other community resources to develop and monitor transition plans to LTC services and supports as appropriate.

07.6.a.9.c Describe the Applicant's plan to develop an effective mechanism to track Member transitions from one care setting to another, including engagement of the Member and Family Members in care management and treatment planning.

CHA collaborates with community, hospital, SNF and other care teams to facilitate member transitions. Our Transitions of Care CMs keep members and/or families engaged in the care management process through the development of an appropriate care plan. CHA Transitions of Care CMs attend family care plan meetings at the hospital and local SNF to assure members and families are involved the creation of the member's plan for transition from one level of care to another. CHA CM utilizes care management software to track all members and their transitions through the healthcare system. CHA will continue to maximize the capabilities of its software tools.

07.6.a.10 Individual care plans: As required by ORS 414.625, the Applicant will use individualized care plans to address the supportive and therapeutic needs of Members with intensive Care Coordination needs, including Members with severe and persistent mental illness receiving home and Community-based services covered under the State's 1915(i) State Plan Amendment. Care plans will reflect Member or Family/caregiver preferences and goals to ensure engagement and satisfaction.

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

CHA works with our local providers to develop the best possible patient-centric care plans for our members including those with high BH needs. Care plans are individualized, and care is prioritized based on the members most urgent needs. Care plans may contain the following services based on the members' unique needs: case management, medication management, individual therapy, group therapy, care navigation, peer support services, and respite care. The member and family (as appropriate) are a part of this planning process. CHA CMs, community partners, and providers collaborate on the development of these plans through the care team process.

CHA collaborates closely with providers, including BH, to ensure that members who choose to remain in the community for their care can do so. This is achieved through intensive care coordination to provide long term care, services, and supports at the local level. This allows the member to continue to work with their established treatment team while remaining close to their natural supports. Additionally, KBBH offers intensive case management, in-home services, community-based services, respite care, residential care, and a 24-hour crisis line to manage the high needs of the SPMI population.

07.6.a.10.b Describe the Applicant's universal screening process that assesses individuals for critical risk factors that trigger intensive Care Coordination for high needs Members; including those receiving DHS Medicaid-funded LTC services.

CHA uses multiple assessment tools to identify critical risk factors indicating a member is appropriate for intensive care coordination. This information is gathered from several sources: correctional facility reports, Collective Medical, and ED census reports, and provider referrals. Once identified, CHA coordinates care with its provider partners to ensure these members are receiving appropriate behavioral, physical, and oral health care coordination. CHA utilizes the same assessment process to identify the need for intensive care coordination services to include members receiving DHS Medicaid-funded LTC services.

07.6.a.10.c Describe how the Applicant will factor in relevant Referral, risk assessment and screening information from local Type B AAA and APD offices and DHS Medicaid-funded LTC Providers; and how they will communicate and coordinate with Type B AAA and APD offices.

CHA meets with the APD team during hospital and SNF level discharge planning meetings where mutual members transitioning out of the hospital and into their homes or another long-term placement are discussed and reviewed for the need for additional resources, services, and/or supports. KBBH participates in this planning process if the discharging member(s) has high BH needs. In collaboration with the member, the team reviews all available information from APD, AAA, DHS risk assessments, and other available resources to inform the development of appropriate aftercare plans and facilitate referrals as needed.

07.6.a.10.d Describe how the Applicant will reassess high-needs Members at least semi-annually or when significant changes in status occur to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.

Using clinical and encounter data, CHA conducts a reassessment of high needs members every six months in coordination with a review of care plans. The insight from the data is reviewed in partnership with our BH providers and APD to drive future care intervention.

Often a review is triggered by a new event such as hospitalization (via daily reports), arrest (via correctional facility reports), or missed appointments (appointment adherence report). These events provide an opportunity to meet with the member and their team to ensure the current plan is sufficient in meeting their needs. Once a care plan is developed and finalized, CHA CM will review and update as needed.

07.6.a.10.e Describe how individualized care plans will be jointly shared and coordinated with relevant staff from Type B AAA and APD with and DHS Medicaid-funded LTC Providers and Medicare Advantage plans serving Fully Dual Eligible Members.

CHA CM and MA health plan CMs work collaboratively to share information and mutually develop care plans. CHA, the MA plan, and APD meet to review care plans of shared members during care conferences. This also provides an opportunity for referrals to additional resources and services.

07.6.a.11 Describe the Applicant's plan for coordinating care for Member oral health needs, prevention and wellness as well as facilitating appropriate Referrals to oral health services.

CHA's case management team includes a dedicated Oral Health CM. The Oral Health CM collaborates with the medical and BH CMs to facilitate the overall health needs of members, including emergent and routine oral health care.

CHA's Pharmacy Department assists members with diabetes in seeking oral health care when members come to the office to receive their diabetic supplies. Each member is asked if they have a PDP and when was their last cleaning and exam. If the member is not established with a PDP, CHA assists them with contacting a provider and scheduling an appointment.

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07.6.a.12 Describe Applicant's plan for coordinating Referrals from oral health to physical health or Behavioral Health care.

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07.6.b Care Integration
07.6.b.1 Oral Health
07.6.b.1.a Describe the Applicant's plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

CHA currently facilitates coordination of care amongst all providers by providing PCP and oral health provider assignment information through our case management system portal. This has proven useful for providers to know where to refer members and with whom to communicate for care coordination.

CHA's behavioral, medical and oral health CMs work collaboratively to coordinate delivery of oral health services. CMs reach out to providers in physical, oral and behavioral systems of care to share important information and facilitate necessary services.

We have one contracted fully integrated clinic that provides behavioral, physical and oral health care at one location, KHP (FQHC). Having one electronic medical record system allows adequate and efficient integration of care on behalf of the members.

07.6.b.1.b Describe Applicant's plan for ensuring that preventive oral health services are easily accessible by Members to reduce the need for urgent or emergency oral health services.

Members are assigned to an oral health provider who is responsible for providing preventive, urgent, and emergent services. CHA will measure and report through claims-based data the percent of assigned patients seen annually for preventive care. CHA will set performance targets for percent of assigned members receiving preventive services and use this performance as part of the APM methodology for oral health providers.

Providers who perform poorly and do not demonstrate meaningful improvement over time will be required to submit a CAP and demonstrate sustained improvement or may be excluded from the network. CHA's Provider Network Department meets with oral health providers on a routine basis to review the provider dashboard to ensure providers are aware of their current performance against targets, including any member complaints or concerns regarding accessibility.

CHA plans to begin proactive coordination of preventive oral health care for its members with diabetes. CHA's Quality Department will provide gap lists to oral health providers of members that need preventive oral health services to perform direct outreach to those members. CHA's Pharmacy Department meets face to face with most of our members with diabetes and is currently assisting those members in scheduling visits for preventive oral screening exams.

CHA also provides NEMT for members who do not have transportation to ensure that they can attend their appointments. CHA's dedicated Oral Health CM also assists members in accessing needed oral health services.

07.6.b.2 Hospital and Specialty Services
Adequate, timely and appropriate access to Hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of Patient-Centered Primary Care Homes. Describe how the Applicant's agreements with its Hospital and specialty care Providers will address:

CHA currently provides adequate timely and appropriate access to hospital and specialty services for our members.

07.6.b.2.a Coordination with a Member's Patient-Centered Primary Care Home or Primary Care Provider

CHA has a contract in place with the local hospital that allows the facilitation of care between the PCPCH/PCP, hospital and specialty care providers to promptly align communication and coordination of care.

07.6.b.2.b Processes for PCPCH or Primary Care Provider to refer for Hospital admission or specialty services and coordination of care.

CHA has a contract in place with the PCPCHP/PCP that allows for the facilitation of referrals to the hospital and specialty services to facilitate the coordination of care in a timely manner.

07.6.b.2.c Performance expectations for communication and medical records sharing for Hospital and specialty treatments, at the time of Hospital admission or discharge, for after-hospital follow up appointments.

CHA has a contract in place with the hospital and specialty care providers with the expectation to perform timely communication and coordination of care by using an EHR or electronic health information technology.

07.6.b.2.d A plan for achieving successful transitions of care for Members, with the PCPCH or Primary Care Provider and the Member in central treatment planning roles.

CHA has a contract in place with PCPCH/PCPs which aims to achieve the successful transition of care for members that is appropriate for the member. This plan includes a member-centric treatment plan.

07.6.c.1 DHS Medicaid-funded Long Term Care Services (recommended page limit 2 pages) CCOs will be responsible for the provision of health services to Members receiving DHS Medicaid-funded LTC services provided under the DHS-reimbursed LTC program. DHS Medicaid-funded LTC services include, but are not limited to, in-home supports/services, Adult Foster Care, Residential Care Facilities, Assisted Living Facilities, DHS Medicaid-funded LTC Nursing Facility state plan, State Plan Personal Care for APD, Adult Day Services, Contract Nursing Program, administrative examinations and reports, non-medical transportation (except in some areas where contracted to transportation brokerages) and PACE state plan (including Medicare benefits).

07.6.c.1 Describe how the Applicant will:

07.6.c.1.a Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, Community-based care or Nursing Facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including the role of Type B AAA or the APD office;

CHA Director of Case Management (DCM) and Transition Care Managers (TCM) have weekly meetings with our local SNF and meetings with the local acute care hospital to discuss discharge/transition planning of members. The Case Management team follows members who are in out-of-area facilities through weekly discussions with the facility about the member's needs and progress towards transition. Local DHS/APD representatives attend these meetings as well.

CHA's BH CM follow members admitted to out-of-area BH facilities through attendance at weekly care conferences with involved BH providers. The BH provider directly monitors these members. CHA works with the BH provider, and the out of area facility, to provide input and to monitor the coordination of care. Meetings are attended by all local BH services providers in

addition to DHS and APD. CHA ensures that regardless of location, members receive the health services they need.

07.6.c.1.b Use best practices applicable to individuals in DHS Medicaid-funded LTC settings including best practices related to Care Coordination and transitions of care;

CHA follows members in LTC settings both in and out of the area and collaborates with each care team to align practices with the inter-disciplinary model of transitions of care to provide the best possible experience for our members.

We will continue to explore opportunities to develop best practices. Through the CHA ED PIP, a case management pilot project is underway whereby community case managers convene to share best practices, successes, challenges, and barriers and how the barriers were mitigated. From this forum, new best practices will be developed tailored to the unique needs of our community and members.

07.6.c.2 Describe how Applicant will use or participate in any of the following models for better coordinating care between the health and DHS Medicaid-funded LTC systems, or describe any alternative models for coordination of care:

07.6.c.2.a Co-Location: co-location of staff such as type B AAA and APD case managers in healthcare settings or co-locating Behavioral Health specialists in health or other care settings where Members live or spend time.

BH providers are currently co-located in a Level 4 PCPCH and BH is fully integrated at Klamath Health Partnership (FQHC). CHA has no plans to co-locate its CMs in external facilities due to case management services already being offered in several PCPCHs as well as RTS which coordinates care by referral for all community members. APD participate in care meetings but are not currently co-located in any of these facilities.

07.6.c.2.b Team approaches: care coordination positions jointly funded by the DHS Medicaid-funded LTC and health systems, or team approaches such as a multi-disciplinary care team including DHS Medicaid-funded LTC representation.

CHA is heavily invested in the multi-disciplinary approach to care coordination to best benefit our members. We collaborate with all local providers and conduct multiple weekly care team meetings throughout the community. CHA continues to pursue a “total community collaborative” for our members to ensure that all available resources, supports, and services are “at the table” and utilized for the benefit and continued success of the member.

For members placed in out of area LTC facilities, CHA CMs develop the same collaborative relationship with the facility’s staff to identify and coordinate the resources, services, and supports that the member will need upon transition. This approach ensures that each of these needs is in place on the day of transition to either a lower level of care or to a community setting, which will assure a smooth transition and continued success of the member as they work toward a successful resolution of their treatment goals.

07.6.c.2.c Services in Congregate Settings: DHS Medicaid-funded LTC and health services provided in congregate settings, which can be limited to one type of service, such as “in home”

personal care services provided in an apartment complex, or can be a comprehensive model, such as the Program of All-Inclusive Care for the Elderly (PACE).

CHA addresses the need for Medicaid funded home care attendants on a case by case basis in our different community care meetings. Currently, there are no DHS congregate settings within the CHA network or Klamath County.

07.6.c.2.d Clinician/Home-Based Programs: increased use of Nurse Practitioners, Physician Assistants, or Registered Nurses who perform assessments, plan treatments, and provide interventions to the person in their home, community-based or nursing facility setting.

RTS provides services in the home and utilizes RNs, NPs, and/or PAs depending on the needs of the member. CHA also contracts with RTS which provides limited services in the home by provider order (i.e., blood pressure checks, blood draws for HbA1c testing). CHA will continue exploring opportunities to use the services of PAs, NPs, or RNs for home or facility-based care.

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

The CHA authorization process does not differ by level of care.

07.6.d.2 Describe the methodology and criteria for identifying over- and under-utilization of services.

CHA monitors over-utilization of care through analysis of reports from both our claims-based system and Collective Medical on hospital admissions and ED utilization. Once identified, CHA CMs work with members and providers through the care management process to better coordinate the members care and provide needed resources to decrease unnecessary use of services. Using claims-based data, we assess under-utilization to identify members who have not established care with their provider or utilized any healthcare services in their first 6-9 months on the plan. CHA Case Management and Customer Service Departments reach out to identified members to ensure there are no barriers to care. CHA continues to challenge and evolve UM-tailored to address the needs of diverse populations (e.g., SPMI, I/DD, etc.).

Section 7. Accountability

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a public process in collaboration with culturally diverse stakeholders. During the development of CCO 2.0, OHA committed to shared accountability for Health System Transformation across the state. This included a commitment to Members, Providers, and to CCOs that performance expectations would be clear and that the monitoring and enforcement

of those requirements would be applied consistently, transparently and equitably. Accountability for the performance of Contract requirements is critical to the success of Health System Transformation. The quality outcomes of CCO performance are publicly measured and reported through both the State performance and core metrics and CCO incentive metrics. In addition to public accountability for quality, health equity and efficiency, Successful Applicants will remain accountable for the performance of Contract requirements. This includes accountability for the performance of subcontracted and delegated activities, the oversight and monitoring of subcontracted entities, and the timely and complete submission of reporting deliverables. CCO 2.0 Accountability Standards include:

- ***Standardized requirements for Contract deliverables including formatting, structure, timeliness, completeness, and accuracy***
- ***A clear relationship between performance issues and contract enforcement mechanisms***
- ***An escalation process for resolving performance issues***
- ***Consistent and fair application of contract enforcement mechanisms***
- ***Prioritizing the resolution of performance issues which impact Member access and care***
- ***Efforts to improve the clarity and consistency of OHA guidance to CCOs on issues where misinterpretation or ambiguity may exist***

CHA is currently developing Policy and Procedures to align with the CCO 2.0 Accountability Standards. We will continue to address the policies as part of this transformational effort.

07.7.a Describe any quality measurement and reporting systems that the Applicant has in place or will implement in Year 1.

CHA currently has existing measurement and reporting systems that allow it to analyze and create actionable plans relative to its quality initiatives which include its value-based payment methodology. We will continue exploring opportunities to enhance our quality system for additional opportunities to support the transformational efforts of CCO 2.0.

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

We participate in the HEDIS reporting program through our Medicare Advantage line of business, ATRIO. To the extent necessary, CHA will participate in an external quality measurement and reporting program.

07.7.c Explain the Applicant's internal quality standards or performance expectations to which Providers and Subcontractors are held.

CHA providers are held to the OHA incentive measures' targets for each measure through its contracts as well as CHA's alternative payment methodology for metrics achievement. Providers are given gap lists for all claims-based measures routinely so they can contact members assigned to their clinics to close gaps in care. CHA's Case Management Department collaborates with providers and members who have complex or chronic conditions to assist in closing care gaps and ensure our members have timely, adequate access to necessary providers, assistance with

making appointments, and making transportation arrangements, if necessary. We value the voices of our members and providers and are dedicated to consistent, high-quality care.

CHA currently delegates credentialing responsibilities to four subcontracted BH providers via formal delegation agreements. The delegation agreement specifies expectations for the credentialing process as well as how providers are monitored for compliance. Our audit tool covers eleven overall areas for review, each item being weighted based on risk to members should the provider be non-compliant. Delegated entities must provide an annual list of all employed and/or contracted providers/staff, including their designated credentials to CHA. Providers are expected to notify CHA of any staff changes a minimum of 90 days before any licensed and/or certified provider, or contracted employee will cease to provide services to CHA members. CHA also requires notice within 30 days of the hiring or credentialing of a new licensed or certified provider or contracted employee.

Delegated entities must comply with all CHA credentialing policies. CHA audits providers for compliance with these policies on an annual basis, including license verification, Office of Inspector General (OIG)/ System of Award Management (SAM) monthly checks, and yearly NPDB checks. CHA delivers a formal report after each delegation review with findings and recommendations for improvement. Providers are expected to submit a Plan of Correction within 45 days of receipt of the report. Based on the nature of the findings, CHA reserves the right to perform interim audits to ensure the sustainability of the Plan of Correction before the next annual review.

07.7.d Describe the mechanisms that the Applicant has for sharing performance information with Providers and contractors for Quality Improvement.

CHA meets with its PCPs and largest BH provider monthly to review CHA overall and individual clinic performance on all metrics. The metrics are presented in multiple formats: dashboard table with clearly visible targets, benchmarks and current performance, bar graphs demonstrating performance against target, and trendlines showing performance against target as well as performance against last year.

These meetings serve as a forum for providers to share best practices leading to sustained improvement in individual clinics that may be generalized to other, less successful clinics, as well as to share ideas for collaboration toward improving the health of members. Upon request, CHA's Quality Department meet with providers individually to review performance data and discuss areas for improvement, as well as to provide technical assistance. In addition to this group meeting, the Provider Network Department meets individually with each oral health provider on a regular basis to provide the same information regarding metric performance. These meetings also include information on grievances and performance toward meeting the minimum threshold of members served. All physical, behavioral, and oral health providers are brought together annually for training.

Section 8. Fraud, Waste and Abuse Compliance

07.8.a. Please describe how Applicant currently engages in activities designed to prevent and detect Fraud, Waste and Abuse.

CHA provides compliance and Fraud, Waste, and Abuse (FWA) training to new employees within 14 days of hire and Board members within 30 days of appointment, and annually thereafter for both. Employees are required to annually attest to receipt and review of our FWA policy. FWA information is posted on CHA's website, office lobby, and throughout our worksite. CHA conducts FWA and Compliance training annually for providers.

CHA's Member Handbook and website both contain information and direction for enrollees to anonymously report suspected FWA. CHA's FWA policy includes whistleblower and non-retaliation protection for employees, providers, and members.

07.8.b. Please describe how Applicant intends to monitor and audit its Provider Network, Subcontractors, and delegated entities for potential Fraud, Waste and Abuse activities.

CHA's policies establish the process for executing clinic audits. Subcontractors, providers and delegated entities are audited and monitored annually for the detection of potential FWA activities. CHA is exploring new audit strategies and analytical reports to detect and prevent FWA issues.

The Claims Department assesses claims trends and conducts upcoding audits. Members are randomly selected to receive a letter verifying services were provided and no out of pocket costs were incurred. CHA requires a physical address to pay claims. CHA monitors member grievances and provider reporting for potential FWA.

Section 9. Quality Improvement Program

Oregon will continue to develop and maintain a Transformation and Quality Strategy to assess and improve the quality of CCO services and to ensure compliance with established standards. CCO accountability measures and related incentives will be core elements of the state's Quality Strategy.
Oregon will continue its robust monitoring of CCO system performance and will continue to assure that established standards for quality assessment and improvement are met.
07.9.a Please describe policies, processes, practices and procedures you have in place that serve to improve Member outcomes, including evidence-based best practices, emerging best practices, and innovative strategies in all areas of Health System Transformation, including patient engagement and activation.

CHA has invested in relationships with its members through its Signature Programs. These programs include Weight Management, Tobacco Cessation (free classes start approximately every 8 weeks), and Chronic Diseases such as respiratory and diabetes through case management (all supplies are dispensed from CHA's office). CHA Maternity Case Management Department employs a comprehensive prenatal Program that follows mothers through their pregnancy. The program provides monetary incentives for participation. CHA Maternity Case Management Department is deeply invested in the Community Baby Shower event as well, which provides giveaways to assist new mothers with needs.

Our Case Management Department contacts high-risk members with complex chronic diseases to better engage them in their healthcare, health choices, and to achieve improved outcomes. CHA ensures members have the resources and information they need to better manage and improve their health. We focus on delivering high-quality care and are dedicated to building and maintaining an exceptional member experience.

CHA will continue providing sponsorships for the Weight Management program and continue increasing the number of members engaged in our Tobacco Cessation program.

CHA's Quality Department simultaneously engages providers individually and as a group. CHA facilitates a monthly meeting with providers to discuss best practices for engaging members and sharing successes. CHA has judiciously incentivized specific member populations using gift cards for successful completion and submission of FIT kits and annual adolescent wellness visits—both are populations that can be a challenge to engage.

CHA collaborates with a mobile dental sealant program staffed by an expanded practice dental hygienist who provides screenings, fluoride treatments, and dental sealants in the local city and county schools. As part of our community engagement initiative to improve oral health, there were 331 sealants performed on CHA members in 2018, and 602 on non-members. This program is an excellent addition to the community as it does not discriminate based on insurance coverage.

CHA finds continuous success in converging providers from different disciplines to offer services to members in a central location. This teamwork spearheaded by CHA makes it easier for members to receive care and close care gaps. Combined adolescent well care, immunization, and dental sealant clinics are scheduled throughout the year, which allows busy parents to economize transportation and time by having several visits to the same location on the same day.

CHA also supports RTS which is deployed to those members who are unable to come into town (for example, poor health preventing them from leaving the house) to eliminate the barriers to receiving care. RTS is utilized for follow up care after hospital discharge, blood draws for HbA1c testing, drop off and/or pick up FIT kits, wellness checks for house-bound members, and SDOH screening to identify needed resources. CHA values the voice of our members. We meet them where they are to deliver high-value member satisfaction experience consistently.

CHA supports the needs of pregnant members through our Maternity Case Management Program. The maternity CM staff reach out to newly diagnosed pregnant members to offer them prenatal incentive program. They verified the member has registered the pregnancy with OHA in Salem, OR. If not, we coordinate with OHA and the member to facilitate this process. The members are connected with community resources, Heathy Family, WIC, Pregnancy Hope Center and more. Assist the members with Maternity needs such as prenatal vitamins, car seats, strollers, and more.

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

CHA has a history of successfully engaging providers in health improvement activities for our members. We will continue to engage members in their health choices and outcomes by improving health literacy and encouraging positive behavior change. CHA is exploring ways to interact with members through multiple social media platforms linking the messages members receive from Public Health, the local hospital system, and other community partners and providers in the Klamath County health care community. Communications also include national messages from prominent, reputable sources such as the American Heart Association and the American Diabetes Association.

Our goal is to leverage the community's use of social media via mobile devices to educate members and direct them to sites with specific information on how to make positive, sustainable health changes. CHA's strong partnerships create the opportunity to promote each entity's work to leverage limited resources and reach the maximum number of members in the community. Our Quality Department distributes a monthly newsletter for staff (the "Q-Tip") that outlines the CHA's focus for the month (for example, March is National Colorectal Cancer Awareness Month) and includes educational materials and suggestions on how staff can engage members at each touchpoint. This approach fosters cross-department collaboration and engages every staff member in the health outcomes of our members.

CHA is committed to the health and wellness of our employees. We have created a Wellness Committee (WC) which has representatives from each department. The purpose of the WC is to promote health and wellness amongst our employees through quarterly activities. Upcoming activities include participating in a 5K walk for charity in May and through the Summer months participating in a community-wide Blue Zone Project walking "moai" (Japanese word meaning a group of people meeting for a common purpose) in competition with other worksites in Klamath County, and the ever popular Biggest Loser weight loss challenge with prizes for employees who are successful and make improvements in their weight loss. CHA's insurance company provides employees with an incentive program that includes an annual general health assessment and biometric screening. Employees also have a choice of traditional desks or standing desks to encourage employees to be active while they work to counter the negative impacts of being sedentary. On Fridays, employees receive inspirational email messages to assist with our mental health and well-being.

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

We have a framework which aligns the incentives and quality metrics to meet the OHA metrics and improve care and the delivery of services for our members. CHA has a robust system for gathering and analyzing data to use toward the improvement of member outcomes. Our Business Intelligence Department consists of four staff dedicated to using multiple platforms to create reports which are further analyzed by the requesting department. Quality Management (QM) works closely with Business Intelligence to ensure a complete picture of the statistic in question

is obtained, aggregated and analyzed. We have a formalized process for data requests and analysis. All data is validated before dissemination to ensure accuracy and that the final product is targeted to the correct audience.

QM reports CHA's overall performance and individual clinic performance monthly during the Providers meeting. When clinics are underperforming to quarterly targets, including comparison to other clinics, the data is further analyzed to ensure the correlation and data source is valid. Further analysis occurs in the form of a root cause or barrier analysis. QM offers technical assistance to clinics toward improvement projects, or the development of workflows to improve efficiency, coordination of member outreach and incentives, and sharing of best practices. Efforts are focused on community/clinic-wide health improvement and not just that of CHA members.

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

CHA care management policies state case management will be responsible for coordinating services as requested and/or needed by the member. If necessary, we will coordinate payment with out-of-network providers for covered services. Members are not to be billed for authorized services provided by out-of-network providers. If a procedure is denied, we will send a Notice of Action (NOA) to the member explaining the appeal process. The member may request an appeal through us, or the requesting provider may submit for reconsideration

CHA's policy and procedure establish standards for prior authorization of services to ensure we conform to Oregon Health Plan (OHP) administrative rules relating to medical necessity, member eligibility, and benefit coverage. The Policy provides guidance and standards for utilization review staff, the Chief Medical Officer (CMO), and Utilization Review Committee for prior authorizations. Authorizations are processed based on the oldest date received. Standard authorization requests must be processed within 14 days and expedited authorization requests must be processed within 72 hours in accordance with Oregon Administrative Rule (OAR) 410-141-3225.

Providers submit an authorization request form, along with requisite supporting clinical documentation. Authorization request forms can be sent via portal or fax. Utilization Management (UM) and Case Management (CM) staff request additional information as necessary before approving an authorization request and issuing a payment authorization number. CHA sends an authorization summary, via fax, to the provider indicating an approved status of the authorization.

For denials, UM and CM staff request additional information as necessary prior to issuing a denial for all procedures. All denials or reduction of services are sent to the CMO for review. If the denial is upheld, CHA sends an authorization summary, via fax, to the provider indicating denied status of the authorization. The member is sent a written notice of the denied service.

Under limited circumstances, an authorization may be modified. A modification can be made if the reviewer has received a written request from the provider that clearly explains the

modification and reason for the request. The reviewer must attach the written request to the authorization. The reviewer must refer to the attachment in the authorization notes. Staff sends an authorization summary, via fax, to the provider indicating a modified status as well as send the member a written notice of modified authorization.

The CMO reviews cases as requested by UM staff for medical necessity, denials, and reduction of services for appropriateness. The UR Committee reviews any cases that are referred via UM and the CMO as necessary.

All authorizations are tracked with CHA's UR software. We run daily reports of all pending authorizations to assure timely processing and that coordination of care will not be delayed.

Section 10. Medicare/Medicaid Alignment

07.10.a Is Applicant under Enrollment and/or Marketing sanction by CMS? If so, please describe?

No. CHA is not under enrollment or marketing sanctions by CMS.

07.10.b Is Applicant currently Affiliated with a Medicare Advantage plan? If no, how will Applicant ensure they are contracted or Affiliated with a Medicare Advantage plan prior to the Effective Date of the Contract?

Yes. CHA is an affiliate of ATRIO Health Plans, a Medicare Advantage plan.

Section 11. Service Area and Capacity

07.11.a List the Service Area(s) the Applicant is applying for and the maximum number of Members the Applicant is proposing to accept in each area based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services.

CHA is applying to provide services in areas that cover the following zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639. We have cultivated strong relationships with community partners and healthcare providers to provide exceptional care to our members within the boundaries of these zones.

Currently, the maximum number of members CHA is proposing to accept for our requested service area is 22,000.

Service Area Table	
County (List each desired County Separately	**Maximum Number of Members - Capacity Level**
Klamath County	22,000

07.11.b Does Applicant propose a Service Area to cover less than a full County in any County?

CHA proposes to continue to provide services to our current geographic footprint in Klamath County which excludes four zip codes closest to the northern border of Klamath County where members have better access to providers in Deschutes County. PacificSource Community

Solutions has indicated they will continue to serve these four zip codes to align with the care of members.

If so, please describe how:
07.11.b.1 Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:
• Community engagement, governance, and accountability

CHA is an integral part of its local community. Our deep and ongoing efforts to understand the needs of our members give us the assuredness to request a full-county exception. Over the last several years, we have awarded grants to numerous organizations that with more than 7,000 individuals directly benefitting from our social investments. Retaining our current boundaries for CCO 2.0 ensures members in rural and frontier areas receive access to care equal to those in urban regions as well as work toward achieving the transformational goals of CCO 2.0 effectively.

• Behavioral Health integration and access

CHA bridges physical, behavioral and oral healthcare; we have developed successful relationships and programs to support the Klamath County healthcare ecosystem and have changed the culture around healthcare to drive true integration of physical health and behavioral health.

• Social Determinants of Health and Health Equity

CHA is a convener in Klamath County – facilitating collaboration between our members and community partners. We are uniquely positioned to support our members and have shown our allegiance to Klamath County for 27 years related to the appropriate resources our members may need.

• Value-Based Payments and cost containment

CHA will contain costs through strategic and mutually beneficial provider network contracts. We will continue working to enhance our payment structure in collaboration with our providers, which will ensure value-based payment requirements are met aligned with the sustainable growth rate and quality outcome objectives.

• Financial viability

CHA will continue to meet the cost growth expectations of OHA as it has done so in the past three years using our provider network and contracts.

07.11.b.2 Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county

CHA is aware of OHA's policy on county boundaries for CCO 2.0, which states that applicants that intend to draw boundaries not along county lines will need to seek exceptions and provide appropriate justification. CHA formally requests an exception from this policy to continue operating according to our existing parameters.

OHP members who reside in the rural northern part of Klamath County are outside of OHA's time and distance standards and would need to travel over two hours to visit their healthcare provider or hospital (120 miles versus the 60-mile standard set by OHA). PacificSource Community Solutions has indicated they will continue to serve OHP members in these four zip codes. These OHP members are better served by providers in Deschutes County where they would only travel half the distance.

Residents of our current coverage territory benefit from receiving services in Klamath County due to geographic proximity to high-quality health care. CHA meets members where they are and is committed to improving the health outcomes of its population.

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

CHA assures this exception request is not designed to minimize financial risk and will not create an adverse selection. There is a natural divide in the zip codes we are currently servicing, and it keeps us in line with OHA's time and distance standards, which in turn benefits OHP members. Our coverage area eliminates the need for members to travel long distances for care. PacificSource Community Solution has indicated they will continue to serve the members in these four zip codes.

Please see *RFA4690-CHA-ATT07-Service Area Table.xls*

OHA reserves the right to set the maximum number of Members an Applicant may contract to serve and define the area(s) an Applicant may serve based upon OHA's evaluation of the Applicant's ability to serve Members, including dually eligible Members, OHA's needs and the needs of its Members. OHA may require an Applicant to accept OHA's additional Service Area request(s) as a condition of receiving an award or a Notice to Proceed as OHA and its Members' needs warrant. Applicants must apply for Service Area on a county-wide basis. An Applicant that requests to cover less than a full County will be required to provide additional information and its reasoning for the request in its Application. OHA will consider requests during Application evaluation. These Applicant requests and subsequent OHA responses do not limit OHA in any way from requiring additional changes to an Applicant's proposed Service Area based on OHA's needs and the needs of its Members. Applicants should submit this information in an Excel document according to naming conventions identified elsewhere in this RFA.
In some areas the patterns of care may be such that Members seek care in an adjoining county. Applicant may choose to contract with Providers located outside the Service Area covered to ensure sufficient access to care for Members. The Service Area places no restriction on the location or distribution of an Applicant's Provider Network. The Applicant will receive rates for each county. If a prospective Applicant has no Provider Panels, the Applicant must submit information that supports their ability to provide coverage for those Members in the Service Area(s) they are applying. In determining Service Area(s) Applicants must consider the allowable driving distance and time to Primary Care Physicians (PCP) and any other Provider type outlined in contract or OAR 410-141-3220.

Section 12. Standards Related to Provider Participation

***07.12.a* – Standard #1 - Provision of Coordinated Care Services**

The Applicant has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable.

In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, to assess whether the Applicant has the ability to deliver services, the delivery system network data must be submitted in the required formats and evaluated.

Based upon the Applicant's Community health assessment and plan for delivery of integrated and coordinated health, mental health, and substance use disorder treatment services and supports and oral health services, describe Applicant's comprehensive and integrated care management network and delivery system network serving Medicaid and dually eligible Members for the following categories of services or types of service Providers that has agreed to provide those services or items to Members, whether employed by the Applicant or under subcontract with the Applicant:

- ***Acute Inpatient Hospital Psychiatric Care***
- ***Addiction treatment***
- ***Ambulance and emergency Medical Transportation***
- ***Assertive Community Treatment***
- ***Community Health Workers***
- ***Community prevention services***
- ***Dialysis services***
- ***Family Planning Services***
- ***Federally Qualified Health Centers***
- ***Health Care Interpreters (qualified/certified)***
- ***Health education, health promotion, health literacy***
- ***Home health***
- ***Hospice***
- ***Hospital***
- ***Imaging***
- ***Intensive Case Management***
- ***Mental health Providers***
- ***Navigators***
- ***Non-Emergent Medical Transportation***
- ***Oral health Providers***
- ***Palliative care***
- ***Patient-Centered Primary Care Homes***
- ***Peer specialists***
- ***Pharmacies and durable medical Providers***
- ***Rural health centers***
- ***School-based health centers***
- ***Specialty Physicians***
- ***Substance use disorder treatment Providers***

• Supported Employment
• Tertiary Hospital services
• Traditional Health Workers
• Tribal and Urban Indian Health Services
• Urgent care center
• Women's health services
• Others not listed but included in the Applicant's integrated and coordinated service delivery network.

INSTRUCTIONS: Submit the information in about each Provider or facility using the DSN Provider Report Template in Excel for all Provider or facility types in Applicant's Provider Network. The DSN Provider Report does not count toward overall page limits.
Note: As part of the Readiness Review process, Applicants will need to provide signature pages and credentialing details for Physician and Provider contracts that the OHA reviewers select based upon the OHA DSN Provider Report and Facility tables that are a part of the initial Application submission.

***07.12.a* – Standard #1 - Provision of Coordinated Care Services**
The Applicant has the ability to deliver or arrange for all the Coordinated Care Services that are Medically Necessary and reimbursable.

Please see *RFA4690-CHA-ATT07-DSN Provider Report.xls*

In order to facilitate the appropriate delivery of coordinated care and integrated health care services that are medically necessary and reimbursable, CHA is committed to the organization of patient care coordination utilizing the Community Health Assessment to inform the development of provider network strategy. CHA's provider network represents the capability to deliver an integrated and coordinated health care model for our members. CHA develops, implements and engages our provider network and key stakeholders to sustain a continuum of care for our members. This approach integrates Behavioral Health, Oral Health, and Physical Health initiatives to ensure a seamless and holistic health care system for our members. The strategy incorporates communications to address the integration of the PCPCH approach.

REDACT

07.12.b Standard #2 – Providers for Members with Special Health Care Needs
In the context of the Applicant's Community health assessment and approach for providing integrated and coordinated care, Applicant shall ensure those Members who have Special Health Care Needs such as those who are aged, blind, disabled, or who have high health care

needs, multiple chronic conditions, mental illness or substance use disorder or who are children/youths placed in a substitute care setting by Children, Adults and Families (CAF) and the Oregon Youth Authority (OYA) (or children receiving adoption assistance from CAF), or any Member receiving DHS-funded Medicaid LTC or home and Community-based services, have access to Primary Care and Referral Providers with expertise to treat the full range of medical, oral health, and Behavioral Health and Substance Use Disorders experienced by these Members.

From those Providers and facilities identified in the DSN Provider Report Template (Standard #1 Table), identify those Providers and specialists that have special skills or sub-specialties necessary to provide a comprehensive array of Medical Services to the elderly, disabled populations and children/youths in substitute care or Members who have high health care needs, multiple chronic conditions, mental illness or substance use disorder. In narrative form, describe their qualifications and sub-specialties to provide Coordinated Care Services to these Members.

Please see *RFA4690-CHA-ATT07-DSN Provider Report.xls*

CHA utilizes the Community Health Assessment to inform and address providing integrated and coordinated health care for our special health care needs members as defined by OHA. This includes having access to primary care and referral providers with the expertise to the treat the full range of medical, oral health, BH, and SUD which our members may experience. CHA ensures access to providers and specialists which have special skills or subspecialties, necessary to provide comprehensive array of medical services to our special health care needs population.

All types of providers, including physical health, dental health and BH providers, are required to meet the comprehensive care of the special needs members. Certain providers play a critical role in providing coordinated care. These providers share qualifications that allow them to be particularly effective in caring for members with special needs. These include:

- The ability to provide whole person care that is patient centered
- The ability to evaluate and manage multiple complex clinical issues concurrently
- The ability to communicate well with the healthcare ecosystem
- The ability to the advocate for their patients' and families' needs

Primary care providers play a central role in care coordination, and this has been underscored by the importance of the OHA PCPCH model. Other provider CHA has identified as qualified to deliver coordinated care services include:

- Community Health Workers
- ESRD service providers
- Federally Qualified Health Centers
- Home health workers
- Hospice agencies
- Intensive Case Management

- Mental health Providers
- Navigators
- School-based health centers
- Women's health services

07.12.c Standard #3 – Publicly funded public health and Community mental health services (recommended page limit 1½ pages)
Under ORS 414.153, Applicants must execute agreements with publicly funded Providers for authorization of and payment for point-of-contact services (i.e. immunizations, sexually transmitted diseases and other communicable diseases) and for cooperation with the local mental health authorities unless cause can be demonstrated that such an agreement is not feasible.
Submit the following table in an Excel format, detailing Applicant's involvement with publicly funded health care and service programs. Include those publicly funded health care and service programs with which you have subcontracts. Table does not count toward overall page limits.
Other formatting conventions that must be followed are: all requested data on Applicant's Provider Network must be submitted in the exact format found in the DSN Provider Report Template (Standard #1).

07.12.c.1 Describe how Applicant has involved publicly funded providers in the development of its integrated and coordinated Application.

Please see *RFA4690-CHA-ATT07-Publicly Funded Health Care and Service Table.xls*

Please see *RFA4690-CHA-ATT07-DSN Provider Report.xls*

CHA has executed agreements with the following publicly funded providers: Klamath County Public Health, Klamath Basin Behavioral Health and Klamath Health Partnership. CHA has engaged with these providers in the development of the overall strategy for this integrated and coordinated application including consulting on specific questions and providing letters of support to meet CHA's obligations in meeting CCO 2.0. These partners were also instrumental in the collaborative development of the Community Health Assessment and CHP.

07.12.c.2 Describe the agreements with counties in the Service Area that achieve the objectives in ORS 414.153(4). If any of those agreements are under negotiation, the Applicant must submit the executed agreement prior to OHA issuing the CCO Contract.

CHA has a fully executed contract with the Klamath County Public Health to provide services and receive payments for said treatment. These services include pregnancy tests, contraceptive management, well woman exams, immunizations, treatment for sexually transmitted diseases and other communicable diseases.

CHA has a fully executed contract with the Klamath Basin Behavioral Health (KBBH) to provide BH services to our members and receive payments. KBBH serves as our LMHA in Klamath County. This agreement provides our members with services to maintain their BH. These services include:

- Children and adults at risk of entering or who are transitioning from the Oregon State Hospital or residential care
- Care coordination of residential services and supports for adults and children
- Management of the mental health crisis system and mobile crisis service
- Management of community-based specialized services, including but not limited to supported employment and education, early psychosis programs, assertive community treatment or other types of intensive case management programs and home-based services for children
- Management of specialized services to reduce recidivism of individuals with mental illness in the criminal justice system.

07.12.c.3 If Applicant does not have signed agreements with counties, as providers of services or as required by ORS 414.153(4), describe good faith efforts made to obtain such agreements and why such agreements are not feasible.
Not applicable as CHA currently has signed agreements with Klamath County's LMHA.

07.12.d.1 Standard #4 – Services for the American Indian/Alaska Native Population (AI/AN) (recommended limit ½ page)
Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

We offer all coordinated care services for AI/AN members who are on our plan as we do for all members as needed. We are expanding our relationship with the executive offices of the Klamath Tribes to expand upon our culturally and linguistically capabilities to ensure we are meeting the member's individualized needs.

CHA will continue to collaborate with The Klamath Tribes to strengthen our community, relationship, and service to members in Klamath County. The Klamath Tribes have indicated they are a closed system and cannot contract with the CCO.

07.12.e Standard #5 – Indian Health Services (IHS) and Tribal 638 facilities
07.12.e.1 From among the providers and facilities listed in the DSN Provider Report Template, please identify any that are Indian Health Service or Tribal 638 facilities.
The Klamath Tribes have a closed system and not included in CHA's DSN Provider Report. CHA will continue to collaborate with The Klamath Tribes to strengthen our community, relationship, and service to members in Klamath County.

07.12.e.2 Please describe your experience working with Indian Health Services and Tribal 638 facilities.
• Include your referral process when the IHS or Tribal 638 facility is not a participating panel provider.
• Include your prior authorization process when the referral originates from an IHS or Tribal 638 facility that is not a Participating Provider.

The Klamath Tribes (Klamath, Modoc, and Yahooskin) operate as a closed system and have expressed that their structure does not allow them to contract with and serve non-tribal members. CHA will continue to collaborate with The Klamath Tribes to strengthen our community, relationship, and service to members in Klamath County. CHA maintains a working relationship with the local Klamath Tribal Health Center as a non-contracted provider. The same referral policy and procedure process is followed as for any other non-participating provider. If a member chooses to see a Tribal Health provider, the member's claim is submitted to DMAP by the Tribal clinic for adjudication. CHA will be responsible for covered services provided by the member's CHA contracted provider.

07.12.f Standard #6 – Pharmacy Services and Medication Management
07.12.f.1 Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.

CHA continues to provide prescription drug benefits as we have since before becoming a CCO in 2012. We currently employ a full-time Oregon-registered Pharmacist and Certified Pharmacy Technicians who administer pharmacy benefit requests. CHA provides a pharmacy benefit to its members for funded conditions/treatment pairs through a PBM and a network of pharmacies.

07.12.f.2 Specifically describe the Applicant's:
Ability to use a restrictive formulary as long as it allows access to other drug products not on the formulary through some process such as prior authorization.

Providers, members, and pharmacies may request coverage for non-formulary medications through a prior authorization process. Requests are reviewed for medical appropriateness, generic options, step therapies or other therapies. Appeals and grievance processes are available to all members when services have been denied.

Formulary development that includes FDA approved drug products for each therapeutic class and at least one item in each therapeutic class of over-the-counter medications sufficient to ensure the availability of covered drugs with minimal prior approval intervention by the providers of pharmaceutical services, e.g. pharmacies.

CHA's Formulary is developed to be in alignment with the State's PDL. Drugs from each major therapeutic class are included. The formulary is reviewed periodically, and new drugs are reviewed by the plan's Pharmacy & Therapeutics Committee (P&T) for formulary inclusion. The Formulary is also reviewed by the P&T Committee when best practices are brought forward through local practice standards, regional and or national standards and guidelines.

Over-the-counter (OTC) products for covered conditions are also included. This list includes (but is not limited to) analgesics/antipyretics, multivitamins, contraceptives, and simple vaginal yeast infections.

Development of clinically appropriate utilization controls.

CHA has physicians engaged in active practice on the P&T Committee to develop utilization tools, such as appropriateness, dosing, and length of therapy. Frequent review of medication utilization reports by drug, class, cost, member population, outcomes, and clinical guidelines

help direct future use and guideline development, provider education, and member treatment adherence.

Ability to revise a formulary periodically and a description of the evidence-based review processes utilized (including how information provided by the Oregon Pharmacy & Therapeutics Committee is incorporated) and whether this work will be subcontracted or performed internally.

CHA's internal P&T Committee reviews the formulary periodically, and new products are reviewed as needed. Evidence-based guidelines are reviewed and incorporated internally including from the Global Initiative for Chronic Obstructive Lung Disease and The American Diabetes Association. Information provided by the Oregon Pharmacy & Therapeutics Committee is reviewed and incorporated when appropriate.

07.12.f.3 Describe Applicant's ability to ensure an adequate pharmacy network to provide sufficient access to all enrollees and how Applicant will communicate formulary choices and changes to the network and other medical professionals and how to make non-formulary, i.e. prior authorization, requests.

CHA's pharmacy network is administered by a PBM and provides for adequate coverage. The locations of the pharmacies meet the access needs of our members. The formulary is available on the provider portal and CHA's website.

07.12.f.4 Describe Applicant's capacity to process pharmacy claims using a real-time claims adjudication and provider reimbursement system and capture all relevant clinical and historical data elements for claims paid in their entirety by the CCO and when the coordination of benefits is needed to bill Third Party Liability (TPL) when the CCO is the secondary coverage.

Through our PBM, CHA's contracted network pharmacies are electronically linked for real-time claims adjudication. The PBM participates actively in the National Council for Prescription Drug Programs (NCPDP) to ensure compliance with industry standards for use of real-time, point-of-service technology across health care segments. Information captured with claims submission includes the necessary clinical and historical data elements which CHA uses for case management, formulary management and quality initiatives such as diabetic and asthma medication adherence. In addition, the information captured at the pharmacy is used to create the monthly encounter data files sent to the State.
Through CHA's PBM, electronic coordination of benefits (eCOB) occurs at the point of sale. The purpose of an eCOB program is to allow pharmacies to seamlessly process secondary coverage claims at the point of service. The eCOB process is as follows: The pharmacy electronically transmits the claim to the primary payer. The primary payer returns an electronic confirmation of charges approved for payment and the remaining unpaid balance. The pharmacy then transmits the remaining charges electronically to the secondary payer. The secondary payer approves payment at which time the secondary electronic claim is processed, and the pharmacy is paid.

07.12.f.5 Describe Applicant's capacity to process pharmacy Prior Authorizations (PA) within

the required timeframes either with in-house staff or through a Pharmacy Benefits Manager and the hours of operation that prescribers or pharmacies will be able to submit PAs.

CHA's Pharmacy Department reviews PA requests and enters the approvals directly into the PBM adjudication system for real-time adjudication of pharmacy claims. The office hours are Monday-Friday from 8 am to 5 pm, however; providers may submit requests for prior authorization 24/7/365. All requests are acted upon with 24 hours (with rotating internal staff coverage on weekends and holidays).

The PBM manages pharmacy calls 24/7 but does not handle member or provider calls during business hours. However, PBM may enter clinical or operational authorizations into the system only under the direction from Authorized Personnel at CHA. These individuals are authorized to approve anything that falls outside the standard procedures during and after plan business hours when calling PBM's Contact Center for assistance. Any individuals making a request that are not identified as Authorized Personnel will be advised to have an Authorized Personnel contact PBM for assistance.

For Emergencies, PBM will enter a five-day override, only after CHA's business hours, if the pharmacy states that it is for an emergency. Specific to Natural Disasters, PBM will enter a one-time refill-too-soon override, per medication, if the pharmacy states the member has had to evacuate due to a disaster.

07.12.f.6 Describe Applicant's contractual arrangements with a PBM, including:

- ***The contractual discount percentage(s) from Average Wholesale Price (AWP) or the percentage above Wholesale Acquisition Cost (WAC) the Contractor will receive from the PBM including rebate and incentive agreements or other funds received from the PBM by the CCO or any other type of any pricing arrangements between the CCO and PBM not based on a percentage discount from AWP or the percentage above WAC.***
- ***The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).***

REDACTED

- ***The administrative fee to be paid to the PBM by CCO on a quarterly basis including a description of the associated administrative fee for each category or type and a description of the amount and type of any other administrative fees paid to PBM by Contractor.***

REDACT

07.12.f.7 Describe Applicant's ability to engage and utilize 340B enrolled Providers and pharmacies as a part of the CCO including:

- ***Whether Applicant is currently working with FQHCs and Hospitals; and if so,***

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

REDACT

07.12.f.8 Describe Applicant's ability and intent to use Medication Therapy Management (MTM) as part of a Patient-Centered Primary Care Home.

CHA is actively exploring options of a suitable vendor to provide MTM services to eligible members with complicated medical and drug-related needs. We will leverage our relationship with CHA's PBM to explore a contract to offer or look at a third-party vendor to provide the service.

07.12.f.9 Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Medical Records (EMR).

Approximately 65% of CHA's provider network (includes physical, oral, BH providers) has Electronic Medical Records (EMR) systems, and most local providers use e-prescribing software. CHA interfaces with Reliance which provides access to parts of the EMR for nearly all our members. CHA also has direct read-only access to Epic which is used by our local hospital and approximately 65% of our providers.

07.12.f.10 Describe Applicant's capacity to publish formulary and Prior Authorization criteria on a public website in a format useable by Providers and Members.

CHA's Drug Formulary and prior authorization criteria are transparent and fully available on the provider portal, CHA's website, and available in print upon request.

07.12.g Standard #7 – Hospital Services (recommended limit 4 pages)
07.12.g.1 Describe how the Applicant will assure access for Members to Inpatient and outpatient Hospital services addressing timeliness, amount, duration and scope equal to other people within the same Service Area.

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

REDACTED

- ***Describe any contractual arrangements with out-of-state hospitals.***

REDACTED

- ***Describe Applicant's system for monitoring equal access of Members to Referral Inpatient and outpatient Hospital services.***

CHA will collaborate with the local hospital to explore developing a proactive monitoring process and tools to ensure CHA members have equal access to inpatient and outpatient hospital services. CHA will continue to monitor through appeals and grievances.

07.12.g.2 Describe how the Applicant will educate Members about how to appropriately access care from Ambulance, Emergency Rooms, and urgent care/walk-in clinics, and less intensive interventions other than their Primary Care home. Specifically, please discuss:

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

CHA's Member Handbook is distributed to all new members and posted on CHA's website. It contains information on the appropriate use of the Ambulance and ER. This information is also printed on customized magnets, which include the contact number of their assigned provider, for easy reference. New Members are contacted and coached by CHA's Customer Service Department regarding establishing care with their PCP/PCD to avoid unnecessary ED utilization.

Frequent ED utilizers are contacted by CHA's case management staff to identify barriers to accessing primary care, unmet BH needs, or SDOH resources to help mitigate the individual's use of the ED.

CHA monitors several data points to track members' inappropriate use of the ED:

- Time of day of access
- Day of week of access
- Age group of access
- Most frequent diagnosis of those triaged as accessing the ED for a non-emergent concern
- Access by member clinic/provider assignment
- Missed appointments by member by clinic/provider assignment

This information is filtered by member and frequency of use. Members who have utilized the ED for non-emergent issues, have consistently missed appointments, or who have consistently

accessed the ED during regular clinic business hours, are contacted by CHA CM staff to both assess barriers to accessing their assigned PCP during regular business hours, and to determine if the member contacted their provider and was offered a same-day appointment prior to their access of the ED. This information allows CHA to more accurately determine where to target its member education efforts.

CHA PCPCH providers offer same-day, or next day appointments to meet member needs and discourage utilization of the ED for non-emergent health concerns and urgent care. CHA will collaborate with providers who offer these services to ensure members are educated for appropriate venues for access other than the ED. The local hospital is in the process of constructing a new building which will bring all its clinics together under one roof as part of their primary care home. As part of this project, the local hospital will be opening a walk-in clinic to augment its current array of services.

CHA will also expand its analytics to include the inappropriate use of ambulance services to develop procedures for improving appropriate use.

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

The Quality Management Department is facilitating a Performance Improvement Project (PIP) specific to ER Utilization. Participation is robust and includes local providers, triage nurses, clinic administrative staff, local hospital staff, RTS, and CHA case management staff. We are exploring opportunities to involve our oral health community in this effort.

ER utilization is monitored through daily review of Collective Medical, ER reports received by case management staff, and review of claims data. ED utilization data is reviewed with providers monthly in both the monthly metrics meeting as well as during the monthly ED Utilization PIP meeting. As a community team, we seek solutions to identified trends. Data by presenting diagnosis, time of day and day of the week of ED use, age range of most frequent ED users, and ED use by clinic assignment is reviewed by the team. Following the completion of a root cause analysis and development of an impact-effort matrix, the team is piloting two projects to reduce the inappropriate use of the ED. Additionally, CHA Quality staff is participating in a Quality by Design project with the local hospital to reduce ED utilization by increasing the availability of same-day appointments. This project is still in its early stages and is designed to be piloted in conjunction with the opening of the new walk-in clinic.

REDACT

CHA will expand its analytics to include the inappropriate use of ambulance services to develop procedures for improving appropriate use.

07.12.g.3 Describe how the Applicant will monitor and adjudicate claims for Provider Preventable Conditions based on Medicare guidelines for the following:

- ***Adverse Events; and***
- ***Hospital Acquired Conditions (HACs)***

Claims are monitored monthly through a report generated using the Medicare HAC diagnosis and procedure code. CHA requires all facilities to submit Present on Admission (POA) indicators for each principal and secondary diagnosis codes. CHA reviews claim at the time of adjudication and requests notes if necessary. Notes can be submitted to the Medical Director for review. Incidents are reported to the Compliance Department for further investigation and communication with the hospital to improve the quality of care and outcomes for members. Any potential payment recovery will be pursued.

07.12.g.4 Describe the Applicant's hospital readmission policy, and how it will enforce and monitor this policy.

CHA CMs actively monitor readmission via daily hospital reports. When readmission is identified, CM will verify:

- The admitting diagnosis is similar or the same as previous diagnosis
- The discharge plan for the initial diagnosis
- The prescriptions were given and filled at discharge
- A primary care follow-up visit was established at discharge and member kept the appointment

The CM team will reach out to the appropriate care managers to ensure any identified gaps are not repeated in the current admission. If trends are identified with particular cohorts of members or providers, CM will discuss the identified trends with the Provider Network Department for review with the provider.

At the claim level, we will review each inpatient claim before adjudication to see if any other inpatient claims are in the member's history. If the claims should be bundled, it will be denied, and the provider will be required to combine the two claims into one. Also, Claims will run quarterly inpatient hospital reports as a second level of audit to assure there are no hospital readmission claims that need to be bundled. Both reviews are based on the CHA Hospital readmission policy and procedure guidelines.

CHA is currently reviewing in advance for readiness policies associated with hospital readmission.

07.12.g.5 Please describe innovative strategies that could be employed to decrease unnecessary Hospital utilization.

CHA's Case Management Department partners with RTS to target those members with chronic, complex diseases to be sure those members are getting to their appointments and have what they need to stay as healthy as possible. RTS reviews each chart before the member's appointment for care gaps to prompt the attending physician to address all care gaps during the member's visit.

Members with diabetes can come to CHA's office to pick up their supplies. While at the office, the member meets with a pharmacy staff member, all of whom hold a level 2 Associate Diabetes Career Path Certificate. A discussion on medication compliance and diet ensues between the member and CHA staff, and any concerns related to PCP appointments and medication adherence are addressed. Results from the member's glucose monitor are downloaded and forwarded to the member's provider. An offer to schedule an eye or oral exam (if one hasn't been done in the past year) is made. These interventions may lead to lower rates of unnecessary hospitalization.

The Quality Management Department provides gap lists on all incentive measures to each provider every month. Providers enlist their Medical Assistants for patient outreach to schedule necessary appointments and tests with a focus on preventative care and arresting disease progression. QM presents gap lists to providers in multiple formats, i.e., by measure, by month/date of last visit/test, etc.

QM has actively engaged multiple community partners in a Performance Improvement Project to focus on unnecessary ED utilization. The effort began in August 2018 and will result in system transformation within the Klamath County health system upon completion. As of this writing, the PIP group has agreed to pilot two groups. The focus of these groups is targeted case management. One group composed of CMs from multiple agencies to discuss best practices, successes, barriers, and problem solve obstacles to increased access to primary care as the preferred choice instead of an ED visit; the second group as a community-wide "system of care" for adults to focus on ED "super-utilizers" and problem solve needed resources, PCP appointments, transportation, and other SDOH that may be impeding the member's ability to see his or her PCP (i.e., member cannot miss work to see the PCP during regular business hours, etc.).

CHA created magnets specific to each clinic/provider that encourage members to contact their provider prior to going to the ED. The magnets include circumstances under which members should go directly to the ED. They also provide information on who to call when members or someone they know is experiencing a BH crisis. The magnets are included in all new member packets and are available in each clinic.

CHA will begin using predictive analytics and algorithms within our population health data analytics tool to proactively identify members at increased for unnecessary utilization including hospital utilization. This information can be used to more efficiently deploy our resources including PCPCH management, RTS outreach, ICM outreach, and TWH outreach.

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

CCC has a Medicare Advantage program through ATRIO Health Plans. CHA engages Medicare Providers and members in the same way that it engages its Medicaid providers and members. CCC is working to better identify which providers its Medicare Advantage members consider their primary care provider in order to engage those providers in the care of these members more

fully. The ED Utilization project is a community-wide effort to lower ED utilization rates and so applies to all patient populations and is not limited to strictly CHA members. “Precision engagement” efforts to identify members’ needs and barriers to seeking primary care is a key focus of CHA’s member outreach and education strategy.

CHA will begin using predictive analytics and algorithms within our population health data analytics tool to proactively identify members at increased for unnecessary utilization including hospital utilization. This information can be used to more efficiently deploy our resources including PCPCH management, RTS outreach, ICM outreach, and TWH outreach.

Attachment 8 – Value-Based Payments

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Page limits for this Value-Based Payment Questionnaire is 10 pages. Items that are excluded from the page limit will be noted in that requirement.

A. Value-Based Payment (VBP) Requirements

VBP Minimum Threshold

CCOs must begin CCO 2.0 – January 2020 – with at least 20% of their projected annual payments to their Providers in contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher. OHA will assess adherence retrospectively. The denominator in this calculation is the total dollars paid (claims and non-claims-based payments) for medical, behavioral, oral, prescription drugs and other health services. Administrative expenses, profit margin, and other non-service-related expenditures are excluded from the calculation. Expanding VBP Beyond Primary Care to Other Care Delivery Areas. CCOs must develop new, or expanded from an existing contract, VBPs in care delivery areas which include Hospital care, maternity care, children's health care, Behavioral Health care, and oral health care. The term "expanded from an existing contract" includes, but is not limited to, an expansion of a CCO's existing contract such that more Providers or Members are included in the arrangement, or higher-level VBP components are included. Required VBPs in care delivery areas must fall within LAN Category 2C (Pay for Performance) or higher through the duration of the CCO 2.0 period. Before the Contract is signed, successful Applicants will receive final specifications of care delivery area VBPs, including required reporting metrics, from OHA. 2020 VBP requirements are included in the Core Contract. CCOs must implement care delivery area VBPs according to the following schedule after 2020:

•By 2021, CCO shall implement two new or expanded VBPs. The two new or expanded VBPs must be in two of the listed care delivery areas, and one of the areas must be either Hospital care or maternity care. A CCO may design new VBPs in both Hospital care and maternity care. A VBP may encompass two care delivery areas; e.g. a hospital maternity care VBP that met specifications for both care delivery areas could count for both hospital care and maternity care delivery areas.

•By 2022, CCO shall implement a new VBP in one more care delivery area. By the end of 2022, new VBPs in both Hospital care and maternity care must be in place.

•By 2023 and 2024, CCO shall implement one new VBP each year in each of the remaining care delivery areas. By the end of 2024, new or expanded VBPs in all five care delivery areas must be implemented. CCO VBP targets that achieve 70% VBP by 2024

CCOs must annually increase the level of payments that are value-based through the duration of the CCO 2.0 period. CCOs must meet minimum annual thresholds, according to the following schedule:

•For services provided in 2021, no less than 35% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;

•For services provided in 2022, no less than 50% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher;

For services provided in 2023, no less than 60% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher; and it is expected that, beginning 2023, no less than 20% of the CCO's payments to Providers must fall within LAN Category 3B (Shared Savings and Downside Risk) or higher. Payments that fall within LAN Category 3B or higher will qualify for the overall VBP target of 60% because LAN Category 3B is higher than LAN Category 2C; and

•For services provided in 2024, no less than 70% of the CCO's payments to Providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher and it is expected that beginning 2024, no less than 25% of the CCO's payments to Providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher, also qualifying for the overall VBP target of 70% per statement above.

Patient-Centered Primary Care Home (PCPCH) VBP requirements

CCOs must provide per-Member-per-month (PMPM) payments to their PCPCH clinics as a supplement to any other payments made to PCPCHs, such as fee-for-service or VBPs. CCOs must also vary the PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs. The PMPMs must be appropriate, increase each year over the five-year contract and, although OHA is not defining a specific minimum dollar amount, the payments should be sufficient to aid in the development of infrastructure and operations needed to maintain or advance PCPCH tier level.

The PCPCH PMPM payment counts for this requirement at a LAN Category 2A level. Unless combined with a LAN category 2C or higher, it does not count toward the CCO VBP minimum threshold for 2020 or CCO VBP annual targets, which require a LAN Category 2C (Pay for Performance) or higher.

Risk adjustment within VBP arrangements

OHA may require CCOs to use risk adjustment models that consider social complexity within their VBP arrangements in later years (2022-2024).

B.VBP Reporting

CCO VBP Data Reporting for 2020 is specified in this RFA, below, and the Core Contract. Awarded Successful Applicants must report their VBP data and other details for future years as described below.

CCO Data Reporting: 2020

CCOs must comply with the following reporting requirements in Year 1:

1.Describe the specific quality metrics from the HPQMC Aligned Measures Menu, or HPQMC Core Measure Set, if developed in future years, that will be used, including the established benchmarks that will be used for performance-based payments to Providers and other relevant details; and /or a. If the aligned measure set does not include appropriate metric/s for planned VBP, Applicants may request approval from OHA to use other metrics. Preference will begiven to those metrics defined by the National Quality Forum (NQF).

b. Should OHA contract with one or more other CCOs serving Members in the same geographical area, the CCO shall participate in workgroups to select performance measures to be incorporated into each CCO's value-based purchasing Provider contracts for common Provider types and specialties. CCOs will be informed in advance of the Provider types and specialties under consideration for performance measures. Each CCO shall incorporate all selected measures into its Participating Provider contracts.

2.By September 30, 2020, CCOs must submit payment arrangement data via APAC's Appendices G and H. Please see APAC Reporting Guide for additional information.

3.Report PCPCH VBP details including:

- ***a. Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020);***
- ***b. Payment differential and/ or range by PCPCH tier levels over CY 2 (2021) through CY5(2024); and***
- ***c. Rationale for approach (including factors used to determine the rate such as Rural /Urban, social complexity).***

4. By Spring/Summer, CCO's executive leadership team must engage in interviews with OHA to:

- ***a. Describe how the first year of activities and VBP arrangements compare to that which was reported in the Application, including detailed information about VBP arrangements and LAN categories;***
- ***b. Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was reported in the Application; and***
- ***c. Report implementation plans for the two care delivery areas that will start in 2021; and***
- ***d. Any additional requested information on VBP development and implementation.***

Data Reporting: 2021

1. ***In the first quarter of 2021, CCOs must submit Year 1 VBP Data Template, which includes summary data stratified by LAN categories that describes 2020 payment arrangements. Although the CCO will likely be unable to report exactly all adjudicated payments made for 2020, OHA will require the reporting of fee-for-service payments that are associated with a VBP in order to assess the CCO's preliminary progress towards meeting the VBP targets. This will function as a rolled-up version of APAC's Appendix G (before Appendix G data are available) and will allow for more timely monitoring of the CCO's progress towards achieving the VBP targets. This report will also serve as a comparison for what the Applicant initially submitted. Note: Data submitted to Appendix G and H, which allows for***

a nine-month lag after the reported time period, will be the official assessment of a CCO's VBP target achievement.

2.By September 30, CCOs must submit VBP data via APAC's Appendix G and H for the previous calendar year.

3.Report PCPCH VBP details including:

- ***a. Payment differential and/or range across the PCPCH tier levels during year CY 2020;***
- ***b. Payment differential and/or range by PCPCH tier levels over CY 2021 through CY 2024; and***
- ***c. Rationale for approach (including factors used to determine the rate such as Rural/Urban, social complexity).***

4. By May 2021, CCO's executive leadership team must meet formally with OHA to:

- ***a. Describe the second year of VBP arrangements;***
- ***b. Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs on populations with complex care needs or at risk for health disparities, and compare and describe any modifications to the plan;***
- ***c. Report outcomes of the two care delivery areas implemented in January of 2021; and***
- ***d. Report implementation plans for the new care delivery area/s in January of 2022.***

Data Reporting: 2022-2024

1. By September 30, CCOs must submit VBP data via APAC's Appendix G and H for the previous calendar year.

2. Report PCPCH VBP details including:

a. Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020);

b. Payment differential and/ or range by PCPCH tier levels over CY 2 (2021) through CY 5 (2024); and

c. Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity).

3. By May of each year, CCO's executive leadership team must met formally with OHA to:

a. Describe the previous year of VBP arrangements;

b. Discuss the outcome of the CCO's plan for mitigating adverse effects of VBPs on populations with complex care needs and/or at risk for health disparities and compare and describe any modifications to the plan;

c. Report outcomes of the care delivery areas implemented in the previous year; and

d. Report implementation plans for the upcoming new care delivery areas.

4. Report complete Encounter Data with contract amounts and additional detail for VBP arrangements.

C. VBP Questions

For all questions below, describe VBP data using The Health Care Payment Learning and Action Network (LAN) categories and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations

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

See enclosed document RFA4690-CHA-ATT08-RFA VBP Data Template

08.C.2 Provide a detailed estimate of the percent of the Applicant's PMPM LAN category 2A investments in PCPCHs and the plan to grow those investments.
Applicants must submit the following details:

08.C.2.a Payment differential across the PCPCH tier levels and estimated annual increases to the payments

Cascade Health Alliance (CHA) currently contracts with PCPCH clinics in its service area on a capitated basis. We plan to add a component to that contract to pay additional funds based on their PCPCH tier level. This payment will be made every month to support the ongoing operations of the clinic and encourage the clinics to seek higher level tiers in the future.

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08.C.2.b Rationale for approach (including factors used to determine the rate such as Rural, Urban, or social complexity)

CHA performed analysis on its current contracted PCPCH clinics and member base to develop tiered rates. These rates were created to be meaningful and impactful with enough incentives between tiers to encourage clinics to move to higher tiers. CHA is developing new ways to measure social complexity, and currently, the distinction between rural and urban is a non-factor as all our clinics are in the same area.

08.C.3 Describe in detail the Applicant's plan for mitigating any adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; lesbian, Gay, Bisexual, transgender and queer (LGBTQ) people; persons with disabilities; people with limited English proficiency; immigrants or refugees and Members with complex health care needs as well as population at the intersections of these groups. Mitigation plans could include, but shall not be limited to:

CHA has a VBP structure that aligns incentives for most of our providers. As part of our review of our VBP program with our providers, CHA will proactively evaluate any adverse effects which may include racial, ethnic and culturally-based communities, Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) people, persons with disabilities, people with limited English proficiency, immigrants or refugees and Members with complex health care needs as well as population at the intersections of these groups.

We are committed to mitigating any adverse effects VBPs may have on health inequities, health disparities or specific populations. If we determine that there's any adverse impact, CHA intends to mitigate this by revising its VBP methodology and incorporate it as part of our Health Equity plan.

08.C.3.a Measuring contracted Provider performance against their own historical performance rather than national benchmarks when patient mix is more complex.

CHA has historical cost and quality performance information for our contracted providers. We plan to set the quality performance thresholds that trigger VBPs at either the CHA target or improvement from the contracted provider's prior year's performance using the Minnesota method. This decreases the likelihood that VBPs will adversely affect any of the specific populations listed above**.**

08.C.3.b Use of risk-adjustment models that consider social and medical complexity within the VBP; and

CHA is implementing a risk adjustment methodology that will calculate and report documented medical complexity for members assigned to PCPs and members treated by specialists. Providers that care for members with higher documented medical complexity have the potential to receive an increased share of VBPs. Medical complexity is a VBP balancing measure and will decrease the likelihood of VBP adversely affecting members with high medical complexity. CHA plans to develop the capacity to calculate and report social complexity for members and incorporate social complexity as a balancing measure in our VBP methodology. CHA is currently receiving social complexity data for children through its participation in the Oregon Pediatric Improvement Project and plans to use this data to test social complexity VBP balancing measures.

08.C.3.c Monitoring number of patients that are "fired" from Providers.

CHA tracks all PCP and oral health member assignment changes including changes initiated by the provider and the member. Member-initiated requests are valuable to look for more subtle methods which providers may use to deselect members. CHA also tracks all patient grievances related to all providers. Assignment changes and complaints will be tallied, and, in the case of primary care and oral health providers, rates will be calculated. Data feedback will be reported to providers. If CHA identifies a provider in an outlier status for assignment changes or grievances, CHA plans to pursue the following interventions as appropriate:

- Provider notification of outlier status
- Ongoing monitoring

- Request for provider assessment of the root cause
- Request for provider development of a Corrective Action Plan
- Eventual consideration of financial penalties, exclusion from VBP participation or possible network participation

08.C.4 Describe in detail the new or expanded, as previously defined, care delivery area VBPs the Applicant will develop in year one and implement in year two. The two new VBPs must be in two of the following care delivery areas: Hospital care, maternity care, children's health care, Behavioral Health care, and oral health care; noting which payment arrangement is either with a Hospital or focuses on maternity care, as required in 2021. The description will include the VBP LAN category 2C or higher, with which the arrangement aligns; details about what quality metrics the Applicant will use; and payment information such as the size of the performance incentive, withhold, and/or risk as a share of the total projected payment.

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08.C5 Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:

- ***The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)***
- ***The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)***

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Attachment 9 – Health Information Technology

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limit for this Health Information Technology Questionnaire is 36 pages, items that are excluded from the page limit will be noted in that requirement.

Introduction

As CCOs set out to deliver coordinated care that meets the Triple Aim, having the right health information technology (HIT) is crucial. This attachment is intended to gather information from Applicants on their HIT capabilities and plans for HIT to meet OHA's requirements. The responses included in this questionnaire will be used for both the RFA and for compliance and monitoring as follows:

RFA HIT Questionnaire: Responses will be used to evaluate whether Applicants meet minimum criteria as part of the RFA evaluation. In particular, Applicants will:

o Attest that they have or will have certain HIT capabilities as described in this document.

o Provide supporting detail about how they meet, or plan to meet each requirement, as well as projected plans for HIT activities related to the requirement, including milestones throughout the course of the 5 year contract. Supporting detail should include milestones and timelines for these activities. Please note: OHA will review supporting detail for completeness and applicability to the component, and will reject attestations that are not supported by complete, applicable detail. For example, a response in component 2 that does not address Behavioral Health Providers will not be considered complete.

o Certify or attest that they will meet monitoring and reporting requirements.

Draft HIT Roadmap: For Successful Applicants, responses will form the basis of a CCO's draft "HIT Roadmap". The draft HIT Roadmap will be subject to further OHA review during Readiness Review (see RFA, Section 5.6), which may include an interview and/or demonstration to show the CCO meets expectations and that future plans are credible. OHA may request further detail and negotiate milestones and targets, leading to an approved HIT Roadmap by December 31, 2019.

o Due to the critical nature of HIT to support CCO obligations, failure to complete an approved HIT Roadmap may delay completion of Readiness Review.

Contract, Monitoring and Reporting - Approved HIT Roadmap: CCOs will be required to maintain an approved HIT Roadmap, comply with the provisions of their Roadmap, provide an annual HIT Roadmap Update, and participate in an annual interview, including:

o An annual attestation that the CCO made progress on their roadmap, and provide supporting information on progress made, including any changes to the HIT Roadmap.

o Discuss the CCO's annual HIT Roadmap update.

Discussion of the HIT Roadmap update also be part of the annual VBP interview in addition to the annual HIT Roadmap interview. Each annual HIT Roadmap update must be approved by OHA.

Due to the critical nature of HIT to support CCO obligations, CCOs must continue to make progress on their HIT roadmaps to remain in good standing with OHA. OHA may offer technical assistance and reserves the right to require Corrective Action or other consequences including remedies authorized under the Contract (see Appendix B, Sample Contract, Exhibit D, Section 9).

Other HIT-related deliverables under the Contract:

o Annual attestation and reporting on progress on activities in the HIT Roadmap. Annual reporting on EHR adoption and HIE access and use information for CCO's physical, behavioral, and oral health Providers. Information will be reported to OHA in the form of:

Performance Expectations (see Appendix B, Sample Contract, Exhibit M) including:

• proportion of contracted physical, behavioral and oral health Providers who have adopted EHRs (including those with any EHR, Certified EHR, and 2015 Certified EHR);

• proportion of contracted physical, behavioral and oral health Providers who have access to HIE and proportion using HIE for Care Coordination; and

• proportion of contracted physical, behavioral and oral health Providers' who have access to, and proportion using, Hospital event notification; and

• EHR product and HIE tool(s) in use by each contracted Provider, in a format agreed to by OHA and the CCO during the draft HIT Roadmap review process.

o Signed HIT Commons Memorandum of Understanding (MOU) and annual payment of HIT Commons assessments

o Transformation Quality Strategy (TQS) – OHA encourages CCOs to reflect the HIT components of the transformation and quality initiatives in their TQS work plan and reporting (see Appendix B, Sample Contract, Exhibit B). HIT components will not be stand-alone requirements for TQS, but OHA would like to understand where HIT plays an important role in the transformation and quality work underway.

OHA's requirements are not intended to cause a proliferation of HIT systems. CCOs should have a good understanding of the HIT in place in their communities – with their network Providers and Hospitals – and incorporate Community partners in their HIT efforts. CCOs are encouraged to collaborate and leverage regional or statewide initiatives, where appropriate, as part of their HIT strategies. Further, OHA is supporting statewide HIT efforts that CCOs should consider leveraging. OHA can provide technical assistance related to HIT available to CCOs.

Section A. HIT Partnership - Informational Question

The HIT Commons is a shared public/private partnership designed to accelerate and advance HIT adoption and use across the state by coordinating, standardizing, governing, and supporting statewide HIT efforts. It is an independent body co-sponsored by OHA and the Oregon Health Leadership Council. The HIT Commons is meant to leverage and build on the success of collaborative HIT efforts to date, in particular the Emergency Department Information Exchange (EDIE) governance model. For more information, see HIT Commons website: http://www.orhealthleadershipcouncil.org/hit-commons/.

Contractors will be expected to participate in the HIT Commons beginning 2020, including all of the following: maintaining an active, signed HIT Commons MOU (see 2020 HIT Commons MOU) and adhering to its terms, paying annual HIT Commons assessments (see http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/12/2019-HIT-Commons-Assessments.pdf), and serving, if elected, on the HIT Commons Governance Board or one of its subcommittees.

OHA's HIT Advisory Group (HITAG) meets at least once a quarter and is an opportunity for CCOs to come together and share HIT best practices and advise OHA on its HIT efforts. All CCOs are invited to appoint a representative to HITAG. All CCOs will be required to send a representative to attend an annual HITAG meeting, regardless of whether that CCO has chosen to appoint a regular representative to HITAG. See the HITAG website for more information, including charter and current membership: https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx. Contractors will be required to participate in HITAG at least once annually.

09.A.1 Information Question

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

Cascade Health Alliance (CHA) is confident in our participation in the 2020 HIT Commons MOU and fulfilling its terms within. We are currently participating in the 2019 Commons MOU and are certain that the partnership requirements and responsibilities assigned to us as a CCO will also be satisfied. CHA is eager to continue working with OHA, OHLC, and other affiliates involved in a collaborative environment to engage in statewide solutions. CHA does not foresee any challenges or obstacles in signing the 2020 HIT Commons MOU at this time.

Section B. Support for EHR Adoption

Electronic Health Records (EHRs) are foundational to continued healthcare transformation allowing Providers to better participate in Care Coordination, contribute clinical data for population health efforts, and engage in Value-Based Payment arrangements. The new CCO Contracts will build on current CCOs' success in increasing EHR adoption rates for physical health Providers by increasing attention to EHR adoption by behavioral and oral health Providers. OHA does not require Providers to use any particular EHR product. Choosing an EHR product is a business decision for the Provider.

OHA expects CCO activities to lead to overall improvements in rates of EHR adoption. CCOs will set their own targets, choose where to focus their efforts, and decide how best to remove barriers to EHR adoption based on the needs in their communities. OHA expects that CCOs will set targets keeping in mind their Provider Networks. CCOs with more dispersed Provider Networks that may include many smaller Providers (who may face greater barriers to EHR adoption) may set more modest targets.

Please refer to the following link for information on related state programs:

• Medicaid EHR Incentive Program:
https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx

09.B.1 Evaluation Questions (recommended page limit 5 pages)

For each evaluation question, include information on Applicant's current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant's future plans. When answering the evaluation questions, please include in a narrative as well as a roadmap that includes activities, milestones and timelines.

09.B.1.a. How will Applicant support increased rates of EHR adoption among contracted physical health Providers?

The current rates of certified EHR adoption among in-network contracted physical health providers is greater than 70%. If CHA contracts with additional providers that have not yet adopted an EHR, we will advise the providers of the benefits of EHR adoption for individual patients, the practice, and the community. Benefits include (but are not limited to) increased practice efficiency, improved coordination of care, tools for population health, improved quality reporting and increased potential for HIE. CHA may explore partnering with an Aged, Blind or Disabled (ABP) EHR vendor to offer EHR services to providers that are unable to send data to the HIE. We will also connect providers with available resources (as needed), which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

For example, historically CHA has supported some of its providers with EHR incentives for clinical reporting.

09.B.1.b How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers?

Current rates of certified EHR adoption amongst in-network contracted Behavioral Health (BH) providers is higher than 50%. CHA will offer the same support we provide with physical and oral health providers. We may explore partnering with an ABP EHR vendor to offer EHR services to providers that are unable to send data to the HIE. We will also connect providers with available resources (as needed), which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

09.B.1.c How will Applicant support increased rates of EHR adoption among contracted oral health Providers?

CHA believes it is essential to explain to our providers that HIT, its tools, software, and EHR are designed to engage oral health and other healthcare providers in adopting and using HIT for electronic data capture and HIE in meaningful ways. Using EHR and HIE promises to expand and enhance quality, access to care, improve reporting and accountability, engage patients in their wellness, create virtual networks of providers, and develop oral health provider' roles in linking with primary healthcare and in the use of treatment guidelines and protocols.

One step to increasing HIT adoption by oral health providers is offering the ability to work with vendors that understand and use certified oral health systems. Encouraging our oral health providers to work with vendors to ensure the design and development of these products meet the needs of oral health providers will result in increased availability of certified oral health EHRs.

Current rates of certified EHR adoption amongst in-network contracted oral health providers is greater than 40%. CHA is looking forward to working with OHA and adopting innovative and creative strategies to expand EHR adoption among our provider network. These strategies may include exploring an EHR incentive payments model as an avenue to support increased rates of EHR adoption among contracted oral healthcare providers. CHA may also explore partnering with an ABP EHR vendor to offer EHR services to providers that are unable to send data to the HIE. We will also connect providers with available resources as needed which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

09.B.1.d. What barriers does Applicant expect that physical health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

The most commonly reported barriers to adoption are initial cost, technical support, technical concerns, resistance to changing work habits, maintenance/ongoing costs, and training[1]. If our providers are willing to adopt an EHR, we will assess their specific barriers and refer them for targeted assistance as appropriate.

[1] Kruse et al, Adoption Factors of the Electronic Health Record. PubMed.gov, 2019.

09.B.1.e. What barriers does Applicant expect that Behavioral Health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

The most commonly reported barriers to adoption are initial cost, technical support, technical concerns, resistance to changing work habits, maintenance/ongoing costs, and training[2]. If our providers are willing to adopt an EHR, we will assess their specific barriers and refer them for targeted assistance as appropriate. All in-network contracted BH providers are currently set up with an EHR system, and 50% are certified. CHA will also connect providers with available resources, as needed, which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

09B.1.f. What barriers does Applicant expect that oral health Providers will have to overcome to adopt EHRs? How do you plan to help address these barriers?

A significant barrier for oral health providers is the shortage of EHRs with diagnostic, therapeutic, or decision support applications appropriate for oral health. This lack of customized clinical support may dissuade many providers from acquiring and adopting HIT. A way to address this gap is to include oral health providers in discussions with our HIT vendors regarding the functionality and clinical applications that should be incorporated into oral health EHRs.

An additional barrier to HIT adoption that is unique to oral health providers is the lack of standardization and interoperability between systems. Many EHRs have proprietary interfaces that must be integrated using messaging or interface standards, such as Health Level Seven. Without this standardization and interoperability, it is difficult for EHRs to operate with other HIT systems.

A fundamental lack of integration between oral and physical health systems—a lack of interoperability represents a significant barrier to the adoption and implementation of HIT for oral health providers. Since oral health diagnoses and treatments are often closely associated with underlying medical issues in our member populations, the absence of integration and interoperability between oral and physical health systems impede oral health providers' and physicians' ability to coordinate care for their patients appropriately.

CHA believes the implementation of HIT will help oral health care providers overcome barriers they may face when treating CHA members, including but not limited to, Medicaid administrative issues and care-coordination; adoption of risk-based and evidence-based care; and physical and oral health collaboration and care coordination.

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[2] Kruse et al, Adoption Factors of the Electronic Health Record. PubMed.gov, 2019.

09.B.2 Informational Questions (recommended page limit 2 pages)

09.B.2.a What assistance you would like from OHA in collecting and reporting EHR use and setting targets for increased use?

CHA would like technical assistance from the OHA Transformation Center for collaborating and shaping our strategy for increasing and enhancing EHR adoption.

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

CHA will request medical record documentation systems and certification upon initial contracting with a physical health provider. We will consider incentives to encourage and assist providers and clinics that do not use certified EHR technology to obtain EHR based on the provider contract. The CHA Provider Network Department will communicate with each provider and practice for updates on EHR use and tools periodically.

CHA uses an internal document to track provider EHR use. The document's contents include provider/clinic name, type of care (Physical, Oral, or Behavioral), location (City, State), EHR use (Y/N), the name of EHR, certified EHR (Y/N), and the certified edition standards (Year). CHA's Compliance Department reviews this document during periodic quality audits.

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

CHA will request medical record documentation systems and certification upon initial contracting with a BH provider. Incentives are considered to encourage and assist providers and clinics that do not use certified EHR technology to obtain EHR based on the provider contract. The CHA Provider Network Department will communicate with each provider and practice for updates on EHR use and tools periodically.

CHA uses an internal document to track provider EHR use. The document's contents include provider/clinic name, type of care (Physical, Oral, or Behavioral), location (City, State), EHR use (Y/N), the name of EHR, certified EHR (Y/N), and the certified edition standards (Year). CHA's Compliance Department reviews this document during periodic quality audits.

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

CHA will request medical record documentation systems and certification upon initial contracting with an oral health provider. Incentives are considered to encourage and assist providers and clinics that do not use certified EHR technology to obtain EHR based on the provider contract. The CHA Provider Network Department will communicate with each provider and practice for updates on EHR use and tools periodically.

CHA uses an internal document to track provider EHR use. The document's contents include provider/clinic name, type of care (Physical, Oral, or Behavioral), location (City, State), EHR use (Y/N), the name of EHR, certified EHR (Y/N), and the certified edition standards (Year). CHA's Compliance Department reviews this document during periodic quality audits.

Section C. Support for Health Information Exchange (HIE)

In this document, HIE refers to the activity of sharing health information electronically (not a specific HIE tool or organization). Tools for health information exchange (HIE), are foundational to continued healthcare transformation, allowing Providers to better participate in Care Coordination, contribute clinical data for population health efforts, and engage in Value-Based Payment arrangements. The new CCO Contracts will build on current CCOs' success in increasing HIE access for physical health Providers by increasing attention to HIT access by behavioral and oral health Providers. OHA does not require Providers to use any particular HIE option or tool. Choosing an HIE option or tool is a business decision for the Provider.

CCOs must work to increase the number of physical, behavioral, and oral health Providers with access to HIE that supports Care Coordination. This could include exchanging care summaries, electronic Referrals, and other sharing that supports Care Coordination. Supporting the exchange of clinical information between physical, behavioral, and oral health is fundamental to the coordinated care model but can be challenging, especially given

restrictions around sharing substance use treatment data. CCOs may elect to focus on supporting HIE for specific use cases or users, such as electronic Referrals, or shared care plans for high-need patients. CCO support for access to HIE for Care Coordination could include such things as: providing a rubric to help Providers assess their HIE needs and select HIE tools, providing TA to Providers in selecting HIE tools, hosting a collaborative to bring Providers together to talk about their experiences with HIE tools, providing financial incentives for adoption of HIE tools, or paying for subscriptions to HIE tools.

In addition, CCOs must ensure their contracted Providers have access to timely Hospital event notifications. Hospital event notifications are electronic messages that notify a Provider or CCO that their patient or Member has been admitted to, discharged from, or transferred within a Hospital or Emergency Department. Unlike claims data, admit, discharge, and transfer data can be made available in near-real time. "Timeliness" refers to near-real time availability. CCOs must also use Hospital event notification tool(s) to inform their own Care Coordination and population health management activities. CCOs have the option to use, and provide Providers access to, Hospital event notifications via the subscription to the statewide EDIE/PreManage tool, or any other tool or resource that ensures contracted Providers have access to timely Hospital event notifications.

OHA expects CCO activities to lead to overall improvements in HIE access and, ultimately, HIE use. CCOs will set their own targets, choose where to focus their efforts, and decide how best to remove barriers to HIE access and use based on the needs in their communities. OHA expects that CCOs will set targets keeping in mind their Provider Networks. CCOs with more dispersed Provider Networks that may include many smaller Providers (who may face greater barriers to HIE access) may set more modest targets.

Please refer to the following links for information on related state programs:

• EDIE/PreManage: http://www.orhealthleadershipcouncil.org/edie/, https://www.oregon.gov/oha/HPA/OHIT/Pages/Programs.aspx

• HIE Onboarding Program: https://www.oregon.gov/oha/HPA/OHIT/Pages/HIE-onboarding.aspx

09.C.1 Evaluation Questions (recommended page limit 8 pages)

For each evaluation question, include information on Applicant's current operations, what Applicant intends to arrange by the Contract Effective Date, and Applicant's future plans.

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

CHA is one of the original partners of the HIE Reliance eHealth Collaborative. We continue our partnership with this dynamic HIE tool today and are currently one of only three current CCO's using the HIE Reliance eHealth Collaborative with a direct EHR connection to our case management system. CHA is also participating in the current OHA project for "HIE Onboarding

Program in Southern Oregon." The present data contributors and participants in Klamath County EHR within this system captures over 60% of our member population in Klamath Falls for physical and BH. A list of CHA's current contributing and participating facilities/providers will be available during the Readiness Review.

See CHA HIT Roadmap on page 30.

In 2019, for those that are not already participating in HIE, CHA will meet with participating providers and determine if current EHRs can send Continuity of Care Document information to the HIE. For those that are unable to send data to the HIE, CHA may explore partnering with an ASP EHR vendor to offer EHR. We will also connect providers with available resources (as needed), which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

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

CHA will explore any certified EHR incentive payments models as an avenue to support increased rates of EHR adoption among contracted physical, behavioral, and oral healthcare providers. Our strategy will also connect providers with available resources (as needed), which may include partners, peers, local, state, and national resources to support increased rates of certified EHR adoption.

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

It is essential to show all providers, including oral health, that HIT—its tools, software and, EHR—are designed to engage them in adopting HIT to capture electronic data and HIE. The information can improve access and quality of essential health services. These IT systems promise to expand and improve quality and access to care. They can boost reporting and accountability, engage patients in their wellness, create virtual networks of providers, expand oral health provider' roles in linking with primary healthcare and in the use of treatment guidelines and protocols. Our current challenge is with oral health providers without any representation in HIE.

One step to increasing HIT adoption by oral health providers is working with vendors that understand and use certified oral health systems; to encourage oral health provider to work with vendors to ensure that the design and development of these products meet the needs of oral health providers, with the result being the increased availability of certified oral health EHRs and potential participation in HIE.

REDACT

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

CHA is committed to delivering the best service and outcomes for Klamath County members. Our local hospital emails daily a comprehensive inpatient report for all CHA members with physical health coverage. The document is sent securely for HIPAA protection and delivered to our Case Management Department, which assigns it to a Transitions Case Manager (TCM). The TCM follows CHA internal Coordination of Care policies and procedures for communicating with Case Managers (CM) assigned to members within the hospital.

Our Case Management Department begins with an assessment of a physical health provider admission with current care and compares that data to member case management details within our case management system. This system is connected to our HIE partner, Reliance eHealth Collaborative. This staff also coordinates member details by accessing the hospital's EHR system data. They first identify if members listed in the daily notification are currently assigned to an Intensive Care Coordinator (ICC) or Physical Health-related provider staff and communicate with the appropriate assigned CM for proper quality of care coordination. The same day of the notification the TCM starts off communication with a warm hand-off via phone and follow-up with secure email communication with hospital staff. CHA assigned staff will continue coordinating throughout the members' inpatient's stay. Medical records are updated in our case/care management system, which then transfers daily to our contracted HIE for other provider and hospital care coordination updates.

Upon discharge, the TCM follows Transition of Care policies and procedures to ensure continued coordination of care and that the member is transitioned correctly. This transfer

includes, but is not limited to, transportation needs with our Non-Emergent Medical Transportation (NEMT), pharmacy coordination when a script is assigned, all authorizations, referrals, and expanded services and utilization necessary for appropriate care. CHA may initiate services from contracted vendors in cases in need of additional services and care.

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

We are committed to delivering the best service and outcomes for Klamath County members.

Our local hospital emails daily a comprehensive inpatient report for all CHA members with BH needs. The document is sent securely for HIPAA protection and delivered to the Case Management Department and assigned TCM. The TCM follows CHA internal Coordination of Care policies and procedures for communicating with CM who are assigned to members within the hospital.

Our Case Management Department begins with an assessment of a BH Provider admission with current care and compare that data to member case management details within our case/care management system. This system is connected to our HIE partner, Reliance eHealth Collaborative. This staff also coordinates member details by accessing the hospital's EHR system. They first identify if members listed in the daily notification are currently assigned to an ICC or BH-related Care Navigator and communicate with the appropriate assigned CM for proper quality of care coordination. The same day of the notification the TCM starts off communication with a warm hand-off via phone and follow-up with secure email communication with hospital staff. CHA assigned staff will continue to coordinate throughout the members' inpatient's stay. Medical records are updated in our case/care management system, which then transfers daily to our contracted HIE for other provider and hospital care coordination updates.

Upon discharge, the TCM follows Transition of Care policies and procedures to ensure continued coordination of care and that the member is transitioned correctly. This transfer includes but not limited to transportation needs with our NEMT, pharmacy coordination when a script is assigned, all authorizations, referrals, and expanded services and utilization necessary for appropriate care. Our Case Management Department may initiate services from contracted vendors in cases in need of additional services and care.

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

We are committed to delivering the best service and outcomes for Klamath County members. Our local hospital emails a daily comprehensive inpatient report for all CHA members with BH needs. The document is sent securely for HIPAA protection and delivered to the Case Management Department and assigned TCM. The TCM follows CHA internal Coordination of Care policies and procedures for communicating with CMs assigned to members within the hospital.

Our Case Management Department begins with an assessment of a BH Provider admission with current care and compares that data to member case management details within our case/care management system. This system is connected to our HIE partner, Reliance eHealth Collaborative. This staff also coordinates member details by accessing the hospital's EHR system. They first identify if members listed in the daily notification are currently assigned to an ICC or BH-related Care Navigator and communicate with the appropriate assigned CM for proper quality of care coordination. The same day of the notification the TCM starts off communication with a warm hand-off via phone and follow-up with secure email communication with hospital staff. CHA assigned staff will continue to coordinate throughout the members' inpatient's stay. Medical records are updated in our case/care management system, which then transfers daily to our contracted HIE for other provider and hospital care coordination updates.

Upon discharge, the TCM follows Transition of Care policies and procedures to ensure continued coordination of care and that the member transitions correctly. This transfer includes, but not limited to, transportation needs with our NEMT, pharmacy coordination when a script is assigned, all authorizations, referrals, and expanded services and utilization necessary for appropriate care. Our Case Management Department may initiate services from contracted vendors in cases in need of additional services and care.

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

Our local hospital emails a daily comprehensive inpatient report for all CHA members. The document is sent securely for HIPAA protection delivered to the Director of Case Management who then assigns the report to a TCM. The TCM follows CHA internal Coordination of Care policies and procedures for communicating with CMs assigned to members within the hospital.

CHA uses Collective Medical (formerly PreManage EDIE) for care coordination of emergency department alerts. These alerts allow assigned CMs to coordinate with hospitals in cases that transition to inpatient cases.

09.C.2 Informational Questions (recommended page limit 2 pages)

09.C.2.a What assistance you would like from OHA in collecting and reporting on HIE use and setting targets for increased use?

CHA would like technical assistance from the OHA Transformation Center for collaborating and shaping our strategy for increasing and enhancing HIE use and setting targets for increased.

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

CHA is one of the original partners with the HIE Reliance eHealth Collaborative. Today, we continue our partnership with this dynamic HIE tool and are currently one of only three CCOs partnering with the HIE Reliance eHealth Collaborative. CHA is also participating in OHA's directive of the HIE Onboarding Project for the Southern Oregon Region. The current data

contributors and participant providers in Klamath County for our HIE system captures over 70% of our member population in Klamath Falls for physical health. Reliance eHealth Collaborative supplies a monthly report of all contributing and participating providers and facilities.

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

CHA is one of the original partners with the HIE Reliance eHealth Collaborative. Today, we continue our partnership with this dynamic HIE tool and are currently one of only three CCOs partnering with the HIE Reliance eHealth Collaborative. CHA is also participating in OHA's directive of the HIE Onboarding Project for the Southern Oregon Region. CHA is confident that over 90% of our BH providers is participating in our HIE today. Reliance eHealth Collaborative supplies a monthly report of all contributing and participating providers and facilities.

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

CHA will request medical record documentation systems and certification upon initial contracting with an oral health provider. Incentives are considered to encourage and assist providers and clinics that do not use certified EHR technology and HIE participation.

CHA is one of the original partners with the HIE Reliance eHealth Collaborative. Today, we continue our partnership with this dynamic HIE tool and are currently one of only three CCOs partnering with the HIE Reliance eHealth Collaborative. CHA is also participating in OHA's directive of the HIE Onboarding Project for the Southern Oregon Region. The current data contributors and participant providers in Klamath County for our HIE system captures approximately 20% of our member population in Klamath Falls for oral health. Reliance eHealth Collaborative supplies a monthly report of all contributing and participating providers and facilities.

It is essential to educate providers the importance of HIT tools and EHRs designed to engage oral health providers with critical member health information. With HIT engagement, providers will be potentially incentivized to adopt HIE for collaborative care coordination. The information can improve access and quality of essential health services. These systems hold promise to expand and improve quality and access to care, enhance reporting and accountability, engage patients in their own wellness, create virtual networks of providers, and expand oral health providers' roles in linking with primary health care and in the use of treatment guidelines and protocols. Our current challenge is with our oral health providers with low participation in HIE.

One step to increasing HIE adoption by oral health providers is the ability to work with vendors that understand and use certified oral health systems. To encourage providers to work with vendors to ensure that the design and development of these products meet the needs of oral health providers, with the end result being the increased availability of certified EHRs and participation in HIE.

Section D. Health IT for VBP and Population Health Management

CCOs will scale their VBP arrangements rapidly over the course of 5 years and will spread VBP arrangements to different care settings. CCOs will rely on HIT to support these arrangements including administering payments under VBP arrangements, supporting Providers with data needed to manage their VBP arrangements, and managing population health effectively through insight into Member characteristics, utilization and risk. OHA expects that CCOs will have the HIT needed to support increased expectations for VBP arrangements as well as support for population health management. OHA will support CCOs' use of risk adjustment models that consider social and medical complexity within their VBP arrangements and plans to provide CCOs with technical assistance and collaborative learning opportunities.

09.D.1 Informational Questions

09.D.1.a If Applicant will need technical assistance or guidance from OHA on HIT for VBP, please describe what is needed and when.
CHA does not anticipate any need for technical assistance or guidance from OHA regarding HIT for VBP at this time.

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

CHA uses HIE Reliance eHealth Collaborative, along with information given by our providers through their EHRs, to report on SDOH that does not appear on claims data. This data is staged in our data warehouse. Once the information is in our warehouse, we can match it to SDOH-HE related data that appears on claims. Matching between claims and HIE data requires standardization through the data warehouse before matching can be effectively used.

CHA is currently working on due diligence for the potential implementation of an advanced analytics tool that assists in connecting with the clinic and provider EHR's. These analytic tool enhancements will allow a secure HIPAA compliant data flow of information between CHA and providers. This ebb and flow of info will support not only claims data, but clinical services data a through direct connection with multiple EHR connections with providers, clinics, and our local hospital. CHA believes this may resolve the challenges listed above related to VBP.

Through our community partnerships with the Klamath Falls Blue Zones Project, the Healthy Klamath Coalition, Klamath Health Partnership, South Central Early Learning Hub, Oregon Institute of Technology, as well as others, CHA has access to secondary community-level data that is collected for multiple assessments and reports, and other population health primary datasets. Utilization of community data, provided by our partners, allows for a higher understanding of disparities experienced by our community at large and better alignment of our initiatives and services with community priorities. Collaborating with community partners, aggregating SDOH-

HE data and applying it to inform our services and initiatives that address SDOH-HE, will support the Triple Aim of better health, better care, and lower costs.

Examples of secondary community data:

- Well-Being Index
- Community UpLift with Douglas, Klamath, and Lake Counties
- Community Health Assessment
- Blue Zones Sector data
- County Health Rankings
- County-level Behavioral Risk Factor Surveillance System data

Examples of primary datasets:

- Community Needs Assessments
- Community Food Assessment
- PRAPARE Assessments

09.D.1.c What are some key insights for population management that you can currently produce from your data and analysis?

CHA draws Medicaid member demographics from our claims-based system, which is populated from state EDI files and claims encounter data. Demographics include birth date, age, gender, benefit plan, address, zip code, ethnicity, race, special healthcare needs, and provider assignments. CHA's Business Intelligence and Decision Support Department validates this data and uploads to our data visualization tool. The information is also uploaded to our provider network mapping tool to analyze the geographic spread of members by specific location.

CHA pulls Medicaid member data from Reliance eHealth Collaborative (HIE) to supplement potential incorrect, missing details, and assist in validating details from our claims-based system data. This allows us to capture additional information from clinical services rather than solely relying on our claims-based system.

Through our community partnerships with the Klamath Falls Blue Zones Project, the Healthy Klamath Coalition, Klamath Health Partnership, South Central Early Learning Hub, Oregon Institute of Technology, as well as others, CHA has access to secondary community-level data that is collected for multiple assessments and reports, and other population health primary datasets. Utilization of community data, provided by our partners, will allow for a higher understanding of disparities experienced by our community at large and better alignment of our initiatives and services with community priorities. Collaborating with community partners, aggregating SDOH-HE data and applying it to inform our services and initiatives that address SDOH-HE, will support the triple aim of better health, better care, and lower costs.

CHA vigilantly analyzes surveys, demographics and population data to understand the community and its members. Data drives decisions at CHA, and our diligence equips our providers with the information they need to improve service outcomes and address healthcare disparities. CHA's Community Advisory Committee (CAC) meets every month to identify, discuss, and develop actions to address health care disparities in the Klamath County community. These tools and resources allow CHA to identify interdependencies between member demographics and SDOH-HE factors. Through analysis of these resources, CHA has identified demographic data insights that have resulted in positive change for our members and providers. Examples of these actions include assisting with language alternative communications and solving transportation needs for members.

09.D.2 Evaluation Questions

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

CHA provides member-level performance in relation to chart review and claims-based quality measures and member enrollment VBP performance. Our quality metrics management tool tracks and reports on claims-based measure performance. This HIT solution is used to report performance to clinics and to base quality incentive program payments. This tool provides a "self-service" portal that allows each clinic to produce their gap reports; however, no provider or clinic is enrolled in this service, so gaps lists are provided monthly via secure email.

CHA also analyzes data reports directly received from clinic EHRs to report metrics performance further. The combination of our quality metrics management tool and clinic supplied EHR data provides CHA's current ability to track and report metric performance. CHA uses MS SQL and data visualization tool to produce clinic dashboards to report additional VBP measures. In addition to monthly metrics performance and VBP dashboards, we also supply contracted providers with gaps in care reports for claims-based measures providers.

CHA currently utilizes VBP dashboard (populated via MS SQL and data visualization tool) to provide performance updates on percentages of member seen, clinic enrollment, and association of grievances, including member terminations and reassignments. Our current quality metrics management tool and other data analytics tools provide metrics performance to each clinic. These dashboards and reporting will be disseminated to all participating VBP providers at least quarterly. In these reports, CHA will include a clear identification of member gap lists to assist the provider with interventions to act in filling the care gaps associated with the VBP. Primary care and oral health providers will receive data for those members specifically attributed and assigned to them as their provider. For specialists and BH provider assignments are based on

member's seen. CHA currently has the data and the infrastructure to report on all VBPs for primary care, specialists, BH, and oral health through 2023. REDACT

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

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

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

(3) Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.

CHA plans to integrate multiple solutions in the next five years to address VBP administration. Solutions may include enhancements with Reliance eHealth Collaborative, member engagement technology, additional population health, and data analytics tools. As we move forward with VBP and quality improvement plans, CHA will continue reviewing solutions as HIT vendor contracts reach renewal dates, to ensure the platforms provide valid, consistently, actionable data for timely VBP and metrics performance tracking and reporting.

CHA currently utilizes VBP dashboard (populated via MS SQL and data visualization tool) to provide performance updates on percentages of member seen, clinic enrollment, and association of grievances, including member terminations and reassignments. Our current quality metrics management tool and other data analytics tools provide metrics performance to each clinic. These dashboards and reporting will be disseminated to all participating VBP providers at least quarterly. In these reports, CHA will include a clear identification of member gap lists to assist the provider with interventions to act in filling the care gaps associated with the VBP. Primary care and oral health providers will receive data for those members specifically attributed and assigned to them as their provider. For specialists and BH provider assignments are based on member's seen. CHA currently has the data and the infrastructure to report on all VBPs for primary care, specialists, BH, and oral health through 2023. REDACT

CHA delivers provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. Elements of these scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

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

In year one (currently), the VBP dashboard (populated via MS SQL and data visualization tool) will provide performance updates on percentages of member seen, clinic enrollment, and association of grievances, including member terminations and reassignments. Our current quality metrics management tool and other data analytics tools provide quality metrics performance to each clinic.

CHA is implementing provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. Elements of these scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

As illustrated in the Information Technology Roadmap, CHA will implement a clinical performance tool and a provider-facing scorecard to track clinical performance in the third quarter of 2019. In the second quarter of 2020, CHA will enhance the scorecards based on provider feedback. CHA will also implement an internal data visualization tool in the first quarter of 2020. This tool will allow users to create self-service reports on a mobile device to engage providers and provider groups.

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

CHA meets quarterly with providers, hospital staff, and clinic staff to share data and best practices of technology to support the improved health of our community. Training focuses on

managing patient-level information using problem lists and medication lists, as well as efficient documentation and chart review.

Training on HIT focuses on influencing providers' willingness and ability to use EHRs effectively. CHA's education helps providers understand how HIT and EHR systems can be leveraged in clinical practice and introduce features and functionality with which providers may not be familiar. CHA continually engages with providers and clinics to educate and train on available HIT tools.

09.D.2.e Describe the Applicant's plans for use of HIT for population health management, including supporting Providers with VBP arrangements. Include in the response any plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Describe how Applicant will do the following:

09.D.2.e.1 Use HIT to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes? Please include the tools and data sources that will be used (e.g., claims), and how often Applicant will re-stratify the population.

09.D.2.f What are your plans to provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in those arrangement(s)?

In year one, the VBP dashboard (populated via MS SQL and data visualization tool) will provide performance updates on percentages of member seen, clinic enrollment, and association of grievances, including member terminations and reassignments. Our current quality metrics management tool and other data analytics tools provide quality metrics performance to each clinic.

CHA utilizes a clinical performance tool to identify members' clinical performance. This tool will detect and prioritize undocumented clinical risk. Meaningful evaluation of documentation performance will be reported at both the program and provider level, measuring various KPIs, year-over-year performance trending, and percentage of undocumented clinical risk outstanding. These analytics will be continually updated on a secure portal to target interventions and improve outcomes throughout the calendar year.

This HIT clinical performance tool can ingest data from a wide variety of sources and provide actionable insights on key patterns and trends. These analytics and predictive models have been applied to a broad set of data assets to drive more informed results that go beyond the use of claims-based models.

Our provider scorecards will generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. Elements of these scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.

- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

CHA is working on due diligence for the potential implementation of an advanced analytics tool that assists in connecting with clinics and provider EHR's. These analytic tool enhancements will allow for a secure HIPAA compliant data flow of information between CHA and providers. This ebb and flow of info will support not only claims data, but clinical services data through a direct connection with multiple EHR connections with providers, clinics, and our local hospital. We believe increased EHR availability and system upgrades would reduce interoperability concerns with multiple systems with a more integrated systems approach for reporting, disseminating, and analyzing our member and provider data.

See CHA HIT Roadmap on page 30 for additional reference to plans for HIT activities, milestones, and timelines.

As illustrated in the Information Technology Roadmap, in the third quarter of 2019 CHA will implement a clinical performance tool, a provider-facing scorecard to track clinical performance. In the second quarter of 2020, CHA will enhance the provider scorecards based on provider and clinic feedback. In addition, in quarter one of 2020 CHA will implement an internal data visualization tool. This tool will allow users to create self-service reports on a mobile device to engage providers and provider groups. Furthermore, CHA plans to implement an advanced analytics tool that assists in connecting with clinics and provider EHR's by quarter three of 2021.

09.D.2.g Please describe any other ways that the Applicant will gather information on, and measure population health status and outcomes (e.g., claims, clinical metrics, etc.). Describe Applicant's HIT capabilities for the purposes of supporting VBP and population management. Again, please provide plans for start of Year 1 as well as plans over the 5-year contract, including activities, milestones, and timelines. Include information about the following items:

09.D.2.g.1 What data sources do you draw on – for example, if you incorporate clinical quality metrics, what data do you collect and how? How often do you update the data? How are new data sources added? How do you address data quality?

CHA strategically uses data to equip our providers with the information they need to improve outcomes of the lives of our members. As such, we draw from two main data sources, along with other supplemental sources, on an as-needed basis.

Our two primary data sources: our claims-based system (populated from state EDI files); and our utilization and authorization system (populated through the provider portal and HL7 messages). We pull member information, such as eligibility, and demographics are drawn from our claims system. As-needed data sources include code crosswalks (for specialties), one-time loads from historical systems, and data from our quality metrics management system for validation purposes. Information from these systems is placed in an internal data warehouse daily, along with our historical system's data from our previous claims system. The data is integrated and put

into flat file extracts and transferred through secure FTP to our quality metrics management system weekly, along with EDI files such as 837s and 820s, which are used for quality metrics.

Adding an as-needed datebook is simple. The data is usually a supplement to the other information in the data warehouse without requiring integration into existing datasets such as claims. If a data source needs to be added that requires integration into existing datasets, it is first staged in its original form, then integrated into the format that is used in existing datasets as needed, e.g., our quality metrics management system claim format. Incorporating new data sources requires extensive integrity checks before a transition to the production environment.

Once the data transitions to CHA's warehouse it undergoes thorough integrity checks. CHA looks for duplicate entries between the historical and current systems. If a new report is generated from our data warehouse, the report is also sent to a subject matter expert to determine if the data reported is quality and reasonable. If the data does not match with the expectations of the subject matter expert, more intelligence is gathered to either support or disprove the data reported.

Once the data is extracted and sent to our quality metrics management system it undergoes additional data integrity checks, such as identifying orphaned records, records that have foreign keys that do not tie to a primary key in another extract, and duplicate primary keys in a single extract. CHA also provides a monthly financial extract to include a month by month account for claim expenses. This is compared to what is reported in the claims extracts with an acceptable variance.

09.D.2.g.2 Data storage: Where do you store data (e.g., enterprise data warehouse)?

CHA's data is stored in three warehouse locations. One of these sites was built to move the functionality of previously used MS Access reports to MS SQL, which allows better data integrity and requires less manual work on the user's part.

A second data warehouse was built around the historical claims-based system and current case management system. This location allows for integrating and transferring data between these systems, such as moving authorizations from our case management system to our historical claims-based system. This site contains mostly historical reports and allows for testing as-needed among data sources.

The third data warehouse is where our extracts for quality metrics management and data analytics tools are created. This location also has a full claims-based system database backup that is restored daily. This allows us to reduce our risk to run reports that are resource intensive and do not rely on having live information run from this server.

In addition to our in-house data storage, we also send extracts to outside HIT vendors, each receiving member and claims information. Our quality metrics management tool receives weekly updates, data analytics receives monthly updates, and our EDI transaction management system receives daily updates as well as payment extracts after each check write is completed.

CHA invests in people, processes, technology, and infrastructure on a regular basis because we understand how critical it is to run an efficient business. We are committed to delivering the best

service and outcomes for Klamath County members. In general, our production databases are avoided when creating reports unless it is low impact or the data needs to a be live, such as claims examiner performance.

09.D.2.g.3 Tools:

(a) What HIT tool(s) do you use to manage the data and assess performance?

(b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?

CHA uses the following tools and reporting:

- MS SQL Server, (2008 R2, 2014)
- Database Engine
- Integration Services
- SQL Server Reporting Services (SSRS)
- SAP Crystal Reports
- Tableau Visualization tool
- PHTECH CCO Metrics Manager
- Milliman's PRM Analytics
- Health Scape's Pareto Intelligence
- HMS Essette Care Management
- MedImpact's MedOptimizer
- Caliper's Maptitude GIS

Standard reports include:

Daily Reports

- **Pharmacy Report:** This report identifies all claims and is used to narrow down members using pharmacies outside of Klamath County. The report is monitored for members who may have moved outside of coverage area.
- **Claims Analyst Performance:** The number of claims completed by each analyst by claim type.

Weekly Reports

- **Claims Processing, 30 Days Out:** Institutional and professional total claims by category and highest daily intake identified.
- **PCD Assignment List:** Identifies all members and their assigned oral health provider.

- **Unassigned List:** Members under 18 who are eligible but have not been assigned a PCP.
- **Quality Metrics Dashboard:** Dashboard for internal leadership and providers for all current overall quality metric performance.

Monthly Reports

- **Member Spend:** Annual spend and identification of claims per member.
- **Top % Member Spend Details:** The member spend report is filtered to display only the top 25 high utilizers.
- **Clinic Utilization:** This report highlights the number of members who have been assigned to a PCP and have been seen by said PCP throughout the year. The number of members assigned is based on an average over one year of how many members for which the provider was paid capitation. Members seen is a rolling total each month of members seen during the year.
- **Member Demographics:** The demographic report organizes members by zip code, address, age, gender, language, ethnicity, care plan, and provider assignments. Members are also mapped by location.
- **Capacity Report:** Our capacity report shows, per provider, how many members they currently have assigned, and how many members were added and dropped from the previous month (oral health, physical, and BH).
- **Member Retention:** Identifies members that have fallen off our plan and returned or have not returned.
- **Authorizations:** The amount of authorization per month, by status and if the authorization was denied the denial reason.
- **ED Utilization:** Total ED utilization is broken down by PCP assignment and member counts, ED inpatient readmissions, ED triage vs. full charge.
- **Oral Health Dashboards:** This report is per oral health provider and displays the number of members assigned, active, active seen, and by percent seen, complaints, sealants, and oral eval.
- **Medical Provider Complaints:** Number of medical complaints by prescribed state categories for all providers.
- **Claims Processing Trends:** Institutional and professional claims for New, remaining (by status), Completed total (paper, electronic, auto adjudicated) and by Team Member.
- **Claims Paid Previous Month**: All claims paid on checks issued in the previous month. Funds are validated using the general ledger.
- **Members Not Paid Oral Health Capitation:** The number of members eligible during the time period with providers that were not paid capitation.

- **Electronic Claims Percentage:** By claim type, the percentage of claims by month that are electronic vs. paper.
- **Auto-Adjudication Amount:** The number of claims that were auto adjudicated vs. those adjudicated manually.
- **EOP Checks:** An explanation of payment for physical checks that can be offered to a provider after checks are issued.
- **Provider Scorecards:** CHA provides medical and demographic information to providers and practices through a clinical performance tool. These documents include internal reporting on chronic conditions, CLAS, REAL+D data for our Provider Network, Quality, and Case Management Departments.
- **Specialty Utilization by Drug Within Disease:** Highlights the cost of fill count of paid claims classified as specialty medications, sorted by which disease they are used to treat.
- **Rx Greater Than $500:** Prescriptions paid at all pharmacies that cost more than $500.
- **Eligible Utilizing Member Claims Count:** Shows how many plan members are eligible to fill a prescription vs. how many members actually filled their prescriptions.
- **Key Indicators and Trends**: The Key Indicators and Trends dashboard provide an at-a-glance view of cost trends, the key influencers of that trend, and actionable links to the relevant detail about each measure. In this dashboard, you can select your own reporting period and comparison period used to calculate trend.
- **PA Volume Summary:** Total count of how many approved and denied prior authorizations were placed in pharmacy management system.
- **PA Data Log:** All identifiers of each prior authorization placed in pharmacy management system for patient, drug, quantity, refills authorized, rejection reason(s), date, who authorized, and comments.
- **Pharmacy Claims Report:** Shows claims summary broken down by member group division. This report is primarily used to look at how many members are in each group division, how many prescriptions were filled, and the total amount paid.
- **Utilization Analysis by Month:** Provides a rolling 12 months and year-to-date summary showing total, averages, and percentages related to various plan costs and volumes.
- **AG Reporting:** Pulls quarterly medical and oral health authorizations, including status and determination from our case management system.
- **AG Report Total Authorizations:** Identifies all medical and oral health authorizations completed quarterly, including denied, modified, and completed from our case management system.

- **Pharmacy Notice of Authorization (NOA) Summary:** Summarizes the total number of authorizations processed by pharmacy, broken down by completed, denied, canceled, etc.
- **Pharmacy NOA Log:** Provides member level authorization NOA details for all pharmacy denials quarterly.
- **AG NOA Log:** Identifies all medical and oral health modified and denied authorization at the member level, including auth class, subclass, and service type
- **Provider Network Adequacy Mapping:** Identifies location of all oral, physical, and BH providers in relation to member location.

Quarterly Reports

- **PCPCH Enrollment Mix:** This is a list of providers in tier buckets with the total number of members for each tier.
- **New Enrollee Utilization:** Provider gap reports with new member enrollments who have had no claim services in their first six months.
- **Top 15 Drugs:** Identifies the top 15 drugs plan paid with the highest spend.
- **Opioid POS Denied Claims Report:** Identifies all opioid claims with a claim status of "denied."
- **Overutilization and Safety:** Provides information relating to Acetaminophen Overuse and Opioid Cumulative Dosing. Detail includes submitted conflict, intervention, and outcome codes which may be used to override such denials. References by claim ID and detail of any subsequent approvals are also provided. Detail can be limited by selected report type to include all claims, denied claims, approved claims or only impacted claims.
- **Top-N-Prescriber:** Identifies primary care providers whose average prescription drug cost is greater than $50 and specialty care providers whose average prescription drug cost is greater than $700.
- **MED for statewide Opioid PIP:** Identifies all adjudicated opioid claims including medication dose, fill quantity, and day supply; calculates daily morphine equivalent dosing used by members.
- **Opioid Point of Sale Denied Claims Report:** Identifies all opioid claims with a claim status of "denied."
- **Smoking Cessation Report:** Identifies all members filling prescriptions for Nicotine Replacement/Tobacco Cessation Therapies.

Semi-Annual Reports

- **Provider Levels:** Providers by level, credential, accreditation/degree, and PCP's broken down by type.

- Population/**Eligibility Data:** OHP eligibility and federal populations by zip codes.

Annual Reports

- Randomized Provider Audit Report:

09.D.2.g.4 Workforce: Do you have staff (in-house, contractors or a combination) who can write and run reports and who can help other staff understand the data? What is your staffing model, including contracted staffing?

All members of our Business Intelligence and Decision Support can analyze data, articulate and communicate data to other department staff members and leadership, as well as make prescriptive action when necessary. This department is comprised of the following team roles:

- Business Intelligence and Decision Support Department
  - Director of Business Intelligence and Decision Support
  - Health Informatics Database Analyst
  - Health Informatics Database Analyst
  - Data Analyst
- Additional resources from Quality, Claims, IT, Finance and Pharmacy
  - Quality Management Analyst
  - Director of Claims and Member Services
  - Finance Department
  - Certified Pharmacy Technician
  - Certified Pharmacy Technician.
- Additional 3rd party resources as needed.
  - IT Consulting

09.D.2.g.5 Dissemination: After reports are run, how do you disseminate analysis to Providers or Care Coordinators in your network? How do you disseminate analysis within your organization?

We have four methods of disseminating internal analysis among team members and leadership.

- Business Intelligence & Decision Support department provides a monthly email communication with all the pertaining regular reporting and according to each department's requirements as defined in our dashboard/KPI reporting schedule. The email is followed up with department meetings to review analysis and identify any additional needs for requests of information as needed.
- Our clinical performance tool is available internally to those with access rights to obtain scorecard details as necessary.

- CHA utilizes our data visualization tool for disseminating report details internally and externally. Our self-service structure allows for the approved users to pull all generated reports. Many of the reports have a direct connection to our databases or claims-based system which allows for updated data.
- The Quality Department disseminates weekly to all in-network contracted providers on quality measure performance reporting weekly from our quality metrics management system.

CHA disseminates clinical data to providers or care coordinators in our provider and care coordination network. Each distribution method is summarized below.

- Scorecard Reports: The provider scorecards and all associated analytics are posted to our clinical performance tool portal to download and distribute to providers via secure encrypted email by the Provider Network or Quality Department.
- Quality Departments dissemination of analysis
  - Quality Management Department metrics performance information is provided internally to all directors and executive leadership staff every week and reviewed monthly during our Operations Council meeting. The dashboards and trendlines are provided to clinics and providers on a monthly basis during the monthly metrics meeting, which includes either provider or administrative representation from each local Primary Care Clinic. Analysis of the performance data is presented by the Quality Department for discussion and sharing of best practices and successes between clinics. Providers also discuss barriers to metric achievement or member engagement. This discussion often leads to the establishment of a Performance Improvement Project to innovate interventions to improve both performance and member health outcomes.

09.D.2.g.6 Effectiveness: How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

CHA is implementing a dedicated collaboration team site and a Project Management tracking tool to track our HIT Roadmap targets. These new tools will allow us to track all projects and progress. They will include capabilities to assign tasks and sub-tasks related to each project and use alerts to notify leadership of timing status. A monthly report will be extracted and presented to our Operation's Council for progress status updates, project reviews, decision making, and action assignments for escalation when necessary. All CHA team members associated or potentially affected by a HIT project on the Roadmap will have an opportunity to review and discuss any question or concerns during our regularly scheduled staff meetings.

Our Business Intelligence and Decision Support Department will partner with our Compliance Department to initiate an audit format that measures the quality and functionality of projects compared to their approved scope. The results will be reviewed and discussed in the Operations Council meeting with our leadership group.

09.D.2.g.7 Addressing challenges: What challenges do you anticipate related to HIT to support VBP arrangements with contracted Providers, including provider-side challenges? How do you plan to mitigate these challenges? Do you have any planned projects or IT upgrades or transitions that would affect your ability to have the appropriate HIT for VBP?

CHA is fully invested in expanding our VBP with providers in our community. We integrated the addition of an on-site Provider Network Department and a new clinical performance tool in 2018 to deliver actionable data to drive improved outcomes. We continue to use our Quality Department to disseminate our quality metrics management system reporting to providers and through other care coordinators in our community PIPs. And we are always researching potential solutions for continuous improvement to serve our members and providers better.

One of our challenges has been to obtain real-time clinical data from our providers. To help mitigate this we are providing an HIE solution with Reliance eHealth Collaborative as a source to upload real-time data.

CHA implemented our data visualization tool in Q4 of 2018 to enhance our internal and external communications with actionable data related to VBP. Our self-service structure allows for the approved internal CHA users to pull all auto-generated reports (with some filter capabilities) and prescribe action to our providers as necessary.

CHA is currently working on due diligence for the potential implementation of an advanced analytics tool that assists in connecting with the clinic and provider EHR's. These analytic tool enhancements will allow for a secure HIPAA compliant data flow of information between CHA and providers. This ebb and flow of info will support not only claims data, but clinical services data through a direct connection with multiple EHR connections with providers, clinics, and our local hospital. We believe this could potentially resolve the challenges listed above related to VBP.

Cascade Health Alliance, LLC

TECHNOLOGY ROADMAP

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Attachment 10 - Social Determinants of Health & Health Equity

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. For definitions related to SDOH-HE, please refer to the SDOH-HE Glossary. Page limits for this Social Determinants of Health and Health Equity is 10 pages, excluding the RFA Community Engagement Plan and the THW Integration and Utilization Plan. The RFA Community Engagement Plan must be limited to 4 pages, excluding required tables. The THW Integration and Utilization Plan must be limited to 5 pages.

Section A. Community Engagement

10.A.1 Evaluation Questions

10.A.1.a Did Applicant obtain Community involvement in the development of the Application?

Yes, Cascade Health Alliance (CHA) involved numerous groups in the development of our application, including Healthy Klamath Coalition, which is made up of four core partners: CHA, Klamath County Public Health, Klamath Health Partnerships – the local Federally Qualified Health Center (FQHC), and our only local hospital Sky Lakes Medical Center (SLMC). We also involve CHA's Community Advisory Council (CAC), Our County Mental Health Program (CMHP)/Local Mental Health Authority (LMHA), Klamath Basin Behavioral Health (KBBH), Primary care providers, Medical specialists, and Oral healthcare providers. Additionally, we include Behavioral Health providers, Board of County Commissioners, Blue Zones Project, Court Appointed Special Advocates (CASA), Lutheran Community Services (LCS), Oregon Institute of Technology (OIT), Klamath Community College, Sanford Children's Clinic and the Klamath Falls Downtown Association.

10.A.1.b Applicant will submit a plan via the RFA Community Engagement Plan for engaging key stakeholders, including OHP consumers, Community-based organizations that address disparities and the social determinants of health, providers, local public health authorities, Tribes, and others, in its work. The Plan will include strategies for engaging its Community Advisory Council and developing shared Community Health Assessments and Community Health Improvement Plan priorities and strategies.

See enclosed, *RFA4690-CHA-ATT10-Community Engagement Plan*

10.A.2 Requested Documents: Completed RFA Community Engagement Plan, including all required elements as described in RFA Community Engagement Plan Requirement Components and attaching required Tables in RFA Community Engagement Plan Required Tables.

See enclosed, *RFA4690-CHA-ATT10-Community Engagement Plan* and *RFA4690-CHA-ATT10-Community Engagement Plan Tables*.

Section B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership

CCOs will be expected to invest in services and initiatives to address the Social Determinants of Health and Health Equity in line with Community priorities, through a transparent decision-making process that involves the CCO's CAC, and involving meaningful partnership with SDOH-HE Partners. For the first two years of SDOH-HE spending, OHA has designated a statewide priority for spending on Housing-Related Services and Supports, including supported housing. OHA reserves the right to continue and/or establish a new statewide priority during the subsequent years of the Contract. Beginning CY 2020, CCOs will be required to spend a portion of end-of-year surplus, derived from annual net income or excess reserves, on Health Disparities and the social determinants of health. This statutory requirement – ORS 414.625(1)(b)(C) – will be operationalized through Oregon Administrative Rule, as described in the rule concepts accompanying this RFA. Further, OHA intends to establish a two-year incentive arrangement – the SDOH-HE Capacity-Building Bonus Fund ("SDOH-HE Bonus Fund") – to offer bonus payments above and beyond the capitation rate to CCOs that meet SDOH-HE-related performance milestones. Performance will be evaluated, and payments awarded to qualifying Contractors beginning CY 2021. The SDOH-HE Bonus Fund will be contingent on availability of funds under the Medicaid growth cap and any required CMS approval. CCOs will receive monetary bonus payments from the SDOH-HE Bonus Fund based on measured performance improvement according to key performance milestones throughout the calendar year. Total SDOH-HE Bonus Fund payments will be subject to a maximum percentage of the CCO's annual capitation rate. CCOs will be required to provide OHA with narrative and financial reporting of SDOH-HE Bonus Fund expenditures, including any funds distributed to SDOH-HE partners, in the manner and form required by the agency. OHA intends to develop the program structure, including performance milestones, Payment distribution methodology, and reporting requirements, between January 2019 and November 2020, with a targeted implementation during CY 2021. OHA additionally intends to establish a public advisory group, the SDOH-HE Measurement Workgroup, to recommend SDOH-HE related performance milestones, and outcome measures as relevant to OHA, and the Health Plan Quality Metrics Committee and Metrics and Scoring Committee. Metrics may include a combination of process and outcome metrics, where process metrics are designed to reward CCOs for successfully taking key steps to address SDOH-HE (for example, form necessary partnerships, build program infrastructure) and outcome metrics are designed to reward CCOs for performance in addressing SDOH-HE. Further, CCOs will be required to align spending of SDOH-HE bonus funds received with the CCO's SDOH-HE priorities, in order to continue growing and increasing impact in this critical area.

In the fall of 2020, OHA intends to issue to CCOs:
• The list of performance milestones, benchmarks, and specifications for CY2021
• Full program documentation, including SDOH-HE Bonus Fund structure, methodology and disbursement timeline for the subsequent year, published on the OHA website.
• The estimated maximum Payment each CCO could qualify to receive in 2021 if it meets all performance milestones under the program
• The estimated percentage of 2021 capitation rates CCOs could qualify to receive in 2022 under the SDOH-HE Bonus Fund (i.e. estimated percentage of 2022 Payments)

The SDOH-HE Bonus Fund is intended to be part of a coordinated strategy to incentivize and support increased spending on SDOH-HE over the course of the five-year contract. Additional elements of this strategy include:

• Performance-based reward: implement a variable profit margin to award CCOs according to efficiency and quality of care (evaluation beginning in 2020, incorporated into rates in 2022).

• Risk adjustment for social factors: risk adjust capitation rate based on social factors at the population and/or Member level (evaluation beginning in 2020, incorporated into rates in 2022). OHA intends to explore incentivizing collection of Member-level data through the SDOH-HE Bonus Fund starting in CY2020 to inform risk adjustment beginning in 2022.

• SDOH-HE Quality Pool metrics: Recommend SDOH-HE quality metrics to the Health Plan Quality Metrics and Metrics and Scoring Committees via the Health Equity Measurement and SDOH-HE Measurement Workgroups.

10.B.1 Informational Questions

10.B.1.a Does Applicant currently hold any agreements or MOUs with entities that meet the definition of SDOH-HE partners, including housing partners? If yes, please describe the agreement.

CHA maintains contracts with several community entities that meet the definition of SDOH-HE partners, but none of them are currently partners specific to housing. CHA contracts with the Klamath County Mental Health Authority (KBBH) to provide behavioral health services to our members. KBBH operates a rent subsidy program whereby individuals who are homeless or at risk of being homeless, and who have a Serious and Persistent Mental Illness (SPMI) diagnosis, receive case management services specific to obtaining and maintaining housing. Services include funds for deposits and on-going subsidized rent. KBBH also works closely with HUD to help individuals apply and eventually become eligible for Housing and Urban Development (HUD) housing so their "slot" can open for the next individual who needs this assistance. CHA is exploring opportunities to partner with housing providers as part of CCO 2.0.

We currently maintain contracts with the following SDOH-HE partners: **Klamath County Public Health (KCPH)-**In addition to partnering to provide covered services to members (i.e., communicable disease testing, pregnancy testing, immunizations, contraception, well-woman exams, etc.), CHA works closely with KCPH on the development of the Community Health Assessment and CHP. We also partner with KCPH on the Health Equity Coalition and Oral Health Coalition to bring necessary community supports and services to underserved and disadvantaged members in Klamath County; **Douglas County ESD/Early Learning Hub-** Klamath County partners with other area counties to comprise the Early Learning Hub serving Klamath County. CHA partners with the Hub on the Attendance for Life project focusing on ages 0 to 5 years old to ensure children who are immunized have regular developmental screenings, well child exams, and routine oral health exams as well as hygiene so that they are ready to start kindergarten and "show up for life";
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10.B.1.b Does Applicant currently have performance milestones and/or metrics in place related to SDOH-HE? These milestones/metrics may be at the plan level or Provider level. If yes, please describe.

CHA is a data-driven healthcare organization. We use data to make more educated decisions and equips our providers with the information they need to improve outcomes of the lives of our members. CHA collects member demographic information (race, ethnicity, preferred language, etc.,) at the time of enrollment and ongoing quarterly. The information is displayed in a "health equity" dashboard. While we do not currently have milestones/metrics related to SDOH-HE in place, CHA is working in partnership with other community stakeholders to obtain the necessary data to begin planning SDOH-HE priorities and milestones in preparation for 2020. SDOH-HE priorities and outcome metrics will be identified and included in the Health Equity Plan by August 1, 2019. Priorities will be chosen based on those identified by the community (CHP), the CAC (CHIP), and in alignment with the State Health Improvement Priorities (SHIP). CHA contracts with RTS, RTS and Klamath Health Partnership (KHP), each of which screens for and collects data on SDOH-HE.

CHA is also a member of Healthy Klamath Coalition – a collaboration between community members and organizations across sectors to improve the health of Klamath County. Healthy Klamath Coalition maintains the following SDOH-HE data: Access to Health Services (usual source of healthcare and health insurance status), Built environment (access to exercise opportunities, access to grocery stores, farmers market density, grocery store density, fast food density, liquor store density; recreation and fitness facilities), Cancer rates across the Community (breast, lung, prostate, colorectal, oral), Child abuse rates, Chronic diseases (Asthma, COPD, kidney disease, osteoporosis, rheumatoid and osteoarthritis), Death rates due to stroke, heart disease, heart failure; unintended injuries, motor vehicle collisions, alcohol-impaired driving deaths; and substance abuse. We maintain SDOH-HE data on Diabetes and associated risk factors (i.e., obesity, overweight), Disability status (physical, cognitive; ambulatory, hearing, vision, and self-care "difficulty"), Economics (living in poverty, social assistance receipts/revenue, business owners by gender, minority status, veteran status; households receiving public assistance, students eligible for free lunch).

CHA also maintains SDOH-HE data on Education (attainment level, student: teacher ratio, academic performance, drop-out, and graduation rates), Employment, Environment (including air quality and availability of safe drinking water), Exercise, nutrition, weight (including fruit

and vegetable consumption, engaging in physical activity, child, adult, and household food insecurity), Homeownership (including the number of housing units, median housing unit value, median rent, renters spending 30% or more of household income on rent), Household (average household size, foreign-born persons, single-parent households), Immunization and infectious diseases (including flu and pneumonia vaccination rates, death due to flu and pneumonia; incidence of chlamydia and gonorrhea; HIV diagnosed cases), Income (including median household income, per capita income; children, families living below the poverty level; households with children receiving SNAP), Maternal, fetal, infant health (low birthweight, infant mortality, mothers who received early prenatal care, mothers who smoked during pregnancy), Mental health and mental disorders (number attempts and completed suicides, depression rates, those frequently in psychological distress), Neighborhood and community attachment (i.e., linguistic isolation), Older adults and aging population (independent living difficulty, Alzheimer's related deaths, dementia), Oral Health, Prevalence of high blood pressure, high cholesterol among members of the community, Public safety and crime, Substance Abuse (smoking, alcohol, opioid use, drug overdose, drug poisoning; including death rates and hospital admissions), Teen pregnancy rate, Transportation/commute to work (mean travel time, solo drivers with a long commute, public transit availability; the number of community members who walk to work; households without a vehicle), Voter turnout rates, and Wellness and lifestyle (those community members who have frequent physical distress, insufficient sleep, life expectancy, self-reported general health assessment)

Data collected and aggregated by the Healthy Klamath Coalition is more indicative of the state of our community as it is not limited to strictly CHA members. The information is more useful in identifying opportunities for CHA to have a more significant impact on the health of our entire community. For example, the low level of preventative oral healthcare accessed by members of our community demonstrated the necessity of a formal performance improvement project to enhance community-wide education efforts to improve the oral health of our community, as well as to assure adequate access for our members. CHA also has access to community-wide SDOH data through its partnership with the Klamath Blue Zones Project. We have been an active partner with Blue Zones since its inception in Klamath County and have been a Blue Zones approved worksite since 2017. Blue Zones Project is helping transform communities across the United States into areas where the healthy choice is easy and promotes a higher quality of life.

10.B.1.c Does Applicant have a current policy in place defining the role of the CAC in tracking, reviewing and determining how SDOH-HE spending occurs? If yes, please attach current policy. If no, please describe how Applicant intends to define the role of the CAC in directing, tracking, and reviewing SDOH-HE spending.

The CAC currently tracks, reviews and determines SDOH-HE priorities and spending. CHA's SDOH-HE spending policy is in development and will define the CAC's continued involvement in directing the SDOH-HE priorities. However, the Community Projects Advisory Committee (CPAC) Charter does utilize the CAC's CHIP to prioritize SDOH-HE needs for Klamath County members. The CPAC reviews grant requests from the community and recommend impactful

projects to CHA's Board of Directors for SDOH-HE spending. In the new policy CHA is developing, the CAC will be much more involved with the CPAC in determining priorities, tracking and reviewing SDOH-HE spending that benefits our members and Klamath County.

10.B.1.d Please describe how Applicant intends to award funding for SDOH-HE projects, including:

10.B.1.d.1 How Applicant will guard against potential conflicts of interest;

CHA established the CPAC in 2016 to assist in determining which grant proposals submitted were in the best interest of our members and the community at large in alignment with our SDOH framework and our community improvement plan. The CAC gives input to these CPAC projects. CPAC has established a Charter, and number 6 of the Charter explains that each member will abide by CHA's Conflict of Interest Policy & Procedure. Additionally, all CPAC members – along with the Board of Directors, Executive Team, and CAC – sign a conflict of interest form when they are first appointed. The CPAC has recommendation authority and is not the ultimate decision-maker in what projects are funded—that ability is reserved for CHA's Board of Directors. In addition to our Board abiding by its fiduciary responsibilities, its members also sign a conflict of interest form and abide by CHA's Conflict of Interest Policy & Procedure. In addition to CPAC, some SDOH-HE projects are evaluated at the executive level while others require board approval. Regardless, all entities requesting a grant, whether providers of services or not, are also screened against the Office of Inspector General exclusion list and System of Award Management.

10.B.1.d.2 How Applicant will ensure a transparent and equitable process;

With CAC input on SDOH-HE priorities, the CPAC uses a scoring sheet with agreed upon scoring criteria for all requests. The CPAC meets as a committee, with a quorum present, to review and score all grant proposals. Once projects are tallied, they are recommended to CHA's Board of Directors at a formal meeting where the CPAC Chair presents the projects and answers questions from the Board. While exploring opportunities relevant to the community, the executive team may identify an SDOH-HE solution and execute accordingly below a certain threshold, seeking Board approval when necessary.

10.B.1.d.3 How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.

The CPAC presents progress reports to CHA's Board of Directors based on quarterly impact reports each grantee is required to provide. We publish a Benefit Corporation Report annually which describes each funded project, its outcome, and the impact to the community. In 2018, CHA hired an independent research company focused on improving the health of underserved populations. This company is currently measuring the social and economic impact of many of the grants awarded in the community. At CHA, we facilitate collaboration between our members and other influencing community partners for optimal performance. We are uniquely positioned to support our members and have shown our allegiance and commitment to investing in Klamath County for over 27 years.

10.B.1.e For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

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10.B.2 Evaluation Questions:
10.B.2.a Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

CHA applies the following criteria when determining with whom to partner to positively impact the SDOH affecting our members: Partner must be in Klamath County or have direct ties to the community, partner must demonstrate knowledge of health-related and social determinant issues having a direct impact on community members and aligned with our SDOH framework and community improvement plan, partner's mission must be in alignment with the intent of building a health community, partner must demonstrate cultural and linguistic competence and have policies setting the expectations of its staff to provide services in a culturally and linguistically appropriate manner, and partner must have a non-discrimination policy of its provision of services to members of the community in place.

10.B.2.b Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for project, how interested parties can apply for consideration, and the project selection process.

In order to broadly communicate our SDOH-HE spending priorities to the public and our network of partners, CHA publishes an annual Request for Grant Proposals (RFGP) on our website. The RFGP consists of the application packet which includes the spending priorities driven by the CHIP developed by the Community Advisory Council, the Oregon Health Authority metrics, and SDOH. The packet also includes all deadlines and contact
information for questions before the deadline for submission. CHA will use a digital engagement strategy to further communicate with our network of partners when funds are available for grants. Our future social media platform will assist CHA in communicating SDOH-HE spending to our members and the public. In addition to publishing RFGP on our website, CHA emails all information to our Healthy Klamath Coalition partners. We make sure our ecosystem of partners—anyone who has requested addition to our RFGP list—and anyone we believe may need funds based on community knowledge are notified.

10.B.2.c Please describe how Applicant will track and report SDOH-HE expenses and outcomes, including technological capacity and process for sharing and collecting data, financial systems, and methods for data collection.

CHA will track SDOH-HE outcomes and expenses. We will use an independent research company focused on improving the health of underserved populations to measure the social and economic impact of many of our programs. Our data analytics, business intelligence, and clinical performance tools can ingest data from a wide variety of sources. This information provides

actionable insights on critical patterns and trends. CHA's analytics and predictive models have been applied to a broad set of data assets to drive more informed results that go beyond the use of claims-based models. We are committed to delivering the best service and outcomes for Klamath County members. Regarding financial systems, CHA will track all actual expenditures paid with its financial accounting software or claims payment software, whichever is applicable. Expenditures will be reported in Exhibit L as required by contract.

The incorporation of additional data assets enables CHA's clinical performance system to develop a more comprehensive risk profile of every member, resulting in further refined targeting and improved outcomes. This tool can generate custom target reports specific to CHA's needs. Data analytics is one of the driving forces of CHA's ability to improve outcomes of its members. Our tool's functionality gives us the ability to analyze race, ethnicity, language, and disability data to identify high-risk members and proactively engage them to close gaps in care, as well as to ensure accurate and complete documentation of their conditions.

CHA uses Reliance eHealth Collaborative (HIE) along with information provided by our providers through their own EHRs to report on SDOH that do not appear on claims data. This data is staged in our data warehouse. Once the information is in our data warehouse, we can match it to SDOH-HE related data that appears on claims. Matching between claims and HIE or HIE data requires standardization through the data warehouse before matching can be used effectively.

Through community partnerships with the Klamath Falls Blue Zones Project, Healthy Klamath Coalition, Klamath Health Partnership, Oregon Institute of Technology, CHA has access to secondary community-level data for multiple assessments and reports, and other population health primary datasets. Using community data provided by our partners allows for a higher understanding of disparities experienced by our community at large. It also allows us to align our initiatives and services with community priorities better. Collaborating with community partners, aggregating SDOH-HE data and applying it to inform our services and initiatives that address SDOH-HE, will support the triple aim of better health, better care, and lower costs.

Examples of secondary community data: Well-being Index, Community Health Assessment, Blue Zones Sector data, County Health Rankings, and County-level Behavioral Risk Factor Surveillance System data. Examples of primary datasets: Community Needs Assessments, Community Food Assessment, and PRAPARE Assessments. CHA collaborates with community partners to gather and aggregate SDOH data to inform improvement opportunities toward improved health outcomes and identify the needs of the community and specific populations.

10.B.2.d Applicant will submit a plan for selecting Community SDOH-HE spending priorities in line with existing CHP priorities and the statewide priority on Housing-Related Services and Supports via the RFA Community Engagement Plan, as referenced in section A.

CHA's response to this question is included in the Community Engagement Plan, referenced in Section A. See enclosed, *RFA4690-CHA-ATT10-Community Engagement Plan*

Section C. Health-Related Services (HRS)

10.C.1 Information Questions

10.C.1.a Please describe how HRS Community benefit investment decisions will be made, including the types of entities eligible for funding, how entities may apply, the process for how funding will be awarded, the role of the CAC (and Tribes/tribal advisory committee if applicable) in determining how investment decisions are made, and how HRS spending will align with CHP priorities.

CHA's RFGP is open to all Klamath County local entities. CAC notifies members of when we are requesting grant proposals so they can have input and send to entities they believe have a project which could benefit from a grant that aligns with CHA's SDOH framework and community improvement plan. The RFGP is published on CHA's website, so anyone who visits will know we are accepting proposals. All entities are welcomed to submit a proposal via email, deliver in person, or mail to our office. We make the process simple and request that proposals be no more than five pages, including the budget and any letters of support. CHA asks that projects funded take place in local Klamath County entities that we serve.

In 2016 we formed CPAC, which reviews the proposals and scores them based on how closely the project matches our SDOH framework, the OHA metrics, and the CAC's community health improvement plan (CHIP). Grants are awarded for one year, with a provision for an extension if the grantee is not able to complete the project in one year. We continue to seek innovative partnerships to expand and explore new CPAC award opportunities that benefit the community at large and drive a healthy population for OHP members. For example, the School-Based Health Center (SBHC) at Mazama High School; CHA funded the remodeling of two buildings to make sure students have healthcare on site and do not need to leave campus to have their physical and behavioral health needs met. The SBHC serves over 2,500 students including the Mazama students, their siblings, and any of the feeder schools to the high school whether they are on OHP or not.

Section D. Community Advisory Council membership and role

10.D.1 Informational Questions

10.D.1.a Please identify the data source(s) Applicant proposes to use when defining the demographic composition of Medicaid Members in the Applicant's Service Area.

CHA draws Medicaid member demographics from our claims-based system, which is populated from state EDI files and claims encounter data. Demographics include birth date, age, gender, benefit plan, address, zip code, ethnicity, race, special healthcare needs, and provider assignments. The Business Intelligence (BI) & Decision Support Department staff validates this data and uploads to our BI visualization tool. The information is also uploaded to our provider network mapping tool to analyze the geographic spread of members by specific location. Medicaid member data is also pulled from Reliance eHealth Collaborative (HIE) to supplement potential incorrect, missing details, and assist in validating details from our claims-based system data. This allows us to capture additional details from clinical services rather than solely relying on our claims-based system.

10.D.2 Evaluation Questions

10.D.2.a Applicant will submit a plan via the RFA Community Engagement Plan, as referenced in Section A, for engaging CAC representatives that align with CHP priorities and membership demographics, how it will meaningfully engage OHP consumer(s) on the CCO board and describe how it will meaningfully engage Tribes and/or tribal advisory committee (if applicable). Applicant may refer to guidance document CAC Member Assessment Recruitment Matrix.

See enclosed, *RFA4690-CHA-ATT10-Community Engagement Plan*

Section E. Health Equity Assessment and Health Equity Plan

10.E.1 Informational Questions

10.E.1.a Please briefly describe the Applicant's current organizational capacity to develop, administer, and monitor completion of training material to organizational staff and contractors, including whether the Applicant currently requires its Providers or Subcontractors to complete training topics on health and Health Equity.

CHA facilitates training for all provider types annually based on the OHA's Office of Equity and Inclusion's Criteria for approval of Cultural Competence Continuing Education Training. All providers are expected to attend or send a delegate with the expectation that the information is brought back to their respective staff for dissemination and discussion. Providers "sign in" when attending the training for tracking and attestation purposes. The training agenda is determined in collaboration with the Provider Network Department, Quality Management Department, and Compliance to ensure inclusion of all required topics (i.e., Fraud, Waste, and Abuse; cultural competency), updates to provider-related policies (i.e., Credentialing policies), and topics related to quality of care concerns or common themes from member grievances. When topic experts do not exist within CHA to conduct provider and staff training, CHA seeks subject matter experts externally to provide training, especially as it pertains to cultural competency, SDOH-HE. CHA has access to a local Adverse Childhood Experiences (ACE) trainer as well as a local trainer for Implicit Bias, both of which have provided training to area providers and CHA staff. CHA has periodic staff meetings and provides staff training at that time.

10.E.1.b Please describe Applicant's capacity to collect and analyze REAL+D data.

CHA uses a third-party clinical adjustment tool to ingest data from a wide variety of sources and provide actionable insights on key patterns and trends. These analytics and predictive models have been applied to a broad set of data assets to drive more informed results that go beyond the use of claims-based models. For example, to ingest and analyze the following: Encounter (837s) and our internal claims data, Pharmacy data, Lab results, EMR data, Continuity of care document (CCD/CDA), HL7, Admission discharge & transfer (ADT), and Custom EMR extracts.

The incorporation of additional data assets enables CHA to have a more comprehensive risk profile of every member, resulting in further refined targeting and improved outcomes. Our clinical performance tool can apply diverse data sets and can generate custom target reports specific to our needs and develop action plans. Data analytics is one of the driving forces of CHA's ability to improve outcomes of its members. This tool's functionality gives us with the ability to analyze race, ethnicity, language, and disability data to identify high-risk members and

proactively engage them to close gaps in care, as well as to ensure accurate and complete documentation of their conditions.

Through community partnerships with the Klamath Falls Blue Zones Project, Healthy Klamath Coalition, Klamath Health Partnership, Oregon Institute of Technology, CHA has access to secondary community-level data for multiple assessments and reports, and other population health primary datasets. Using community data provided by our partners allows for a higher understanding of disparities experienced by our community at large. It also allows us to better align our initiatives and services with community priorities. Collaborating with community partners, aggregating SDOH-HE data and applying it to inform our services and initiatives that address SDOH-HE, will support the triple aim of better health, better care, and lower costs.

Examples of secondary community data: Well-being Index, Community Health Assessment, Blue Zones Sector data, County Health Rankings, and County-level Behavioral Risk Factor Surveillance System data. Examples of primary datasets: Community Needs Assessments, Community Food Assessment, and PRAPARE Assessments. CHA collaborates with community partners to gather and aggregate SDOH data to inform improvement opportunities toward improved health outcomes and identify the needs of the community and specific populations.

10.E.2 Evaluation Questions (Health Equity Assessment)

See Health Equity Assessment Guidance Document

10.E.2.a Please provide a general description of the Applicant's organizational practices, related to the provision of culturally and linguistically appropriate services. Include description of data collection procedures and how data informs the provision of such services, if applicable.

CHA monitors enrollment data from the state to understand our cultural and linguistical population. We are aware of our population's literacy barriers and make sure our member materials and educational documents are at a sixth-grade level. CHA's Member Handbook is provided to all new members and posted on our website. This handbook is available in audio version, Spanish and large print formats. CHA is exploring the implementation of text-to-speech capabilities to make it easier for members to receive the information spoken in their own language. We use member data to identify members' primary language because we understand that language barriers between providers and patients may also result in decreased care, lack of understanding of preventive care plans and medical care to our member. CHA offers a language service to all our provider offices as well as internal staff. We work to align our members care with a provider who can help with language barriers within their treatment.

CHA provides outreach to all new members to assure they have received their member ID card and new member packet. We assign them to a Primary Care Provider and oral health provider within 30 days of coming onto the plan. We go over their benefits and ask them if they have any cultural barriers hindering their access to care. If any concerns are identified, we notify the Case Management Department so the members' needs can be case managed. New CHA members often deal with financial barriers to healthcare. CHA meets members where they are and strives to engage them with our healthcare providers to establish care.

Data collection procedures: We use internal Report Request Form to pull the claims data information from our claims-based software program. This is included in our monthly standard reports that are available with our data visualization tool. Our BI and Decision Support staff completes mining, validation, and extract work before delivery to our Provider Network, Quality, and Case Management Departments. Details include birth date, where the member lives (full address of residence, or guardian), language, race, and ethnicity. Additional details not available in our claims-based system includes income, place of birth, and where the member was raised. These items may be included in our EHR connections or through our HIE with Reliance eHealth Collaborative. With our Blue Zone Project certified partnership, we can use other population health surveys and demographics from that partnership to help supplement our data.

10.E.2.b Please describe the strategies used to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the Service Area.

CHA is an Equal Employment Opportunity Employer. We do not discriminate in any of our hiring practices. Several of our member-facing positions include "Spanish speaking preferred" in our job recruiting efforts, and our employee demographics are representative of the community we serve. We post all positions internally and externally and use different posting locations, such as online employment sites, state employment department, recruiters, and local temporary agencies to recruit diverse personnel and leadership.

CHA provides annual training for all its employees on topics such as implicit biases and health equity. We are a culturally competent business that is committed to delivering the best service and outcomes for Klamath County members. Our Leadership Team receives instruction throughout the year on our hiring practices and our Employee Handbook includes nondiscrimination policies. All employees are provided a copy and acknowledge receipt as well as their responsibility to read and understand the policies. The Employee Handbook is updated annually or when necessary to comply with laws and regulations.

10.E.2.c Please describe how Applicant will ensure the provision of linguistically appropriate services to Members, including the use of bilingual personnel, qualified and certified interpreter services, translation of notices in languages other than English, including the use of alternate formats. Applicant should describe how services can be accessed by the Member, staff, and Provider, and how Applicant intends to measure and/or evaluate the quality of language services.

CHA contracts with a vendor to provide all our members, staff, and providers with certified interpreter services to ensure a smooth transition into communicating more efficiently with our limited English proficient and Deaf and Hard-of-Hearing members. The interpreters undergo rigorous screening, testing, and training. Training includes learning specialized medical terminology and procedures, to ensure that our members receive clear, concise, and accurate communication. We receive monthly utilization reports. Some providers have access to video-translation services at their facilities. CHA provides all network providers yearly training on how to access the vendor and a quick reference guide is provided for their staff. CHA contracts with a Spanish translator to translate member materials. We use multiple outside resources for member

material such as OHA approved forms. At CHA, we meet members where they are to consistently deliver high value member satisfaction experience.

Upon initial credentialing as well as re-credentialing, CHA requests providers to indicate if they speak any additional languages in addition to English. This information is also requested of facilities with whom CHA has credentialing delegation agreements. Updates are requested on an annual basis. The CHA Provider Directory identifies those providers who speak another language as well as clinics that have multilingual staff. CHA is updating its credentialing communications with providers to more clearly identify provider and clinic staff language capabilities as well as the use of language technology to ensure our members are receiving clear, concise and accurate communication. Grievances are also monitored to ensure that member complaints regarding translation services are addressed.

10.E.2.d Please describe how Applicant will ensure Members with disabilities will have access to auxiliary aids and services at no cost as required in 42 CFR 438.10, 42 CFR part 92, and Section 1557 of the Affordable Care Act. Response should include a description of how Applicant plans to monitor access for Members with disabilities with all contracted providers.

CHA's Member Handbook is provided to all new members and posted on our website. This handbook will include information regarding the availability of Auxiliary Aids and Services (AAS) for members with disabilities. CHA will refer members in need of AAS to providers and cover any costs. Examples include qualified interpreters, notetakers, computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, Telecommunications Devices for Deaf persons (TDD's), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments.

We will also cover the costs of qualified readers, taped texts, audio recordings, Brailled materials, large print documents, and other effective methods of making visually delivered materials available to people with visual impairments. CHA plans to acquire any needed devices to be compliant within our facility to include a video interpreting equipment. CHA will incorporate language into provider contracts or contract addenda stipulating that members with disabilities will have access to services free from physical barriers. CHA will monitor access for members at the time of annual audits.

10.E.3 Requested Documents: Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality, and Policies and procedures related to the provision of culturally and linguistically appropriate services.

See enclosed, *RFA4690-CHA-ATT10-Policies and Procedures*

Section F. Health Equity Assessment and Health Equity Plan

10.F.1 Informational Questions

10.F.1.a Does Applicant currently utilize THWs in any capacity? If yes, please describe how they are utilized, how performance is measured and evaluated, and identify the number of THWs (by THW type) in the Applicant's workforce.

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10.F.1.b If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

CHA contracts and pays THWs on a fixed fee basis with severe penalties for noncompliance with service level agreements

10.F.2 Evaluation Questions

10.F.2.a Please submit a THW Integration and Utilization Plan which describes: Applicant's proposed plan for integrating THWs into the delivery of services; How Applicant proposes to communicate to Members about the benefits and availability of THW services; How Applicant intends to increase THW utilization; How Applicant intends to implement THW Commission best practices; How Applicant proposes to measure baseline utilization and performance over time; How Applicant proposes to utilize the THW Liaison position to improve access to Members and increase recruitment and retention of THWs in its operations.

10.F.3 Requested Documents

Completed THW Integration and Utilization Plan (page limit: 5 pages)

See enclosed, RFA4690-CHA-ATT10-THW Integration and Utilization Plan.

Section G. Community Health Assessment and Community Health Improvement Plan

10.G.1 Evaluation Questions

10.G.1.a Applicant will submit a proposal via the RFA Community Engagement Plan, referenced in Section A, describing how it intends to engage key stakeholders, including OHP consumers, Providers, local public health authorities, including local health departments, Tribes, Community-based organizations that address disparities and the social determinants of health, and others, in its work. The Plan should detail the Applicant's strategies for engaging its Community Advisory Council, its process for developing and conducting a Community Health Assessment, and development of the resultant Community Health Improvement Plan priorities and strategies. The Plan should specify how the Applicant's strategy for health-

related services links to the CHP. Applicants should include information on approaches to coordinate care across the spectrum of services, as well as to encourage prevention and health promotion to create healthier communities.

See enclosed, *RFA4690-CHA-ATT10-Community Engagement Plan*

Attachment 11 - Behavioral Health Questionnaire

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response. Include reasons why your organization is able to effectively complete the CCO service delivery and program design requirements, and how this will be accomplished in time to meet the needs of Members on implementation.

Page limit for this Behavioral Health Questionnaire is 58 pages, items that are excluded from the page limit will be noted in that requirement.

Section A. Behavioral Health Benefit

Applicant must be fully accountable for the Behavioral Health benefit to ensure Members have access to an adequate Provider Network, receive timely access to the full continuum of care, and access effective treatment. Full accountability of the Behavioral Health benefit should result in integration of the benefit at the CCO level. Applicant may enter into Value-Based Payment arrangements; however, the arrangement does not eliminate the Applicant's responsibility to meet the contractual and individual Member need. Applicant must have sufficient oversight of the arrangement and intervene when a Member's need is not met or the network of services is not sufficient to meet Members' needs. How

11.A.1 How does Applicant plan to ensure that Behavioral Health, oral health and physical health services are seamlessly integrated so that Members are unaware of any differences in how the benefits are managed?

Cascade Health Alliance (CHA) eliminates silos to share information across case management areas to holistically meet each member's individual needs. Our healthcare processes, strategies, and evidentiary standards are equitable for behavioral health (BH), oral health and physical health services. CHA's BH, Oral Health and Registered Nurse (RN) Physical Case Managers (CM) as well as CHA's prior authorization staff, work closely together to coordinate care for members. Oregon Health Authority's (OHA) parity analysis verifies CHA already provides seamless integration of health services. We continue our commitment and explore opportunities to enhance CHA's integration practices to ensure our members experience no differences in how their benefits are managed.

11.A.2 How will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner meaning that Applicant will not identify a pre-defined cap on Behavioral Health spending, nor separate funding for Behavioral Health and physical health care by delegating the benefit coverage to separate entities that do not coordinate or integrate?

CHA has developed successful relationships and programs to support Klamath County's healthcare ecosystem and has changed the culture around healthcare to drive true integration of physical, behavioral, and oral health. CHA will continue managing the Global Budget in a fully integrated manner for the delivery, management, access, and quality of healthcare delivered to

our members. We will provide all services as defined in the benefit plan and funded by the prioritized list of the Oregon Health Plan (OHP). We do not delegate the benefit coverage to any separate entities. CHA manages its Global Budget by contracts with our provider network and coordinating care. We do not delegate benefit coverage to any other entity that does not coordinate or integrate. CHA maintains contracts with several patient-centered primary care homes and a BH home to assist with the integrated healthcare needs of our members.

11.A.3 How will Applicant fund Behavioral Health for its Service Area in compliance with the Mental Health Parity and Addiction Equity Act of 2008?

CHA funds BH for its members in compliance with the Mental Health Parity and Addiction Equity Act of 2018. According to OHA's Summary Analysis of Mental Health Parity in Oregon Medicaid dates September 2018 and December of 2018, "Cascade Health Alliance had no parity findings resulting from this analysis and did not require a parity action plan." CHA met and will continue to comply with the parity requirement that if a Non-Quantitative Treatment Limit is applied to Mental Health/ Substance Abuse Disorder (MH/SUD) benefits, it is applied in a comparable manner for Medical and Surgical benefits and is not applied more stringently to MH/SUD benefits. BH services are critically important to both member health and community financial outcomes. We consistently improve access and utilization of medically necessary BH services.

11.A.4 How will Applicant monitor the need for Behavioral Health services and fund Behavioral Health to address prevalence rather than historical regional spend? How will Applicant monitor cost and utilization of the Behavioral Health benefit?

CHA will monitor the need for BH services and fund in accordance with the Global Budget. CHA will utilize data from multiple sources to monitor cost and utilization. These include:

- Historical encounter data is useful for assessing prevalence. CHA recognizes it will underestimate prevalence due multiple factors including care provided without submission of encounter data, members not seeking care, and members seeking care who cannot access care.
- Publicly available behavioral health data including OHA vital statistics, the Behavioral Risk Factor Surveillance System, the Robert Wood Johnson Foundation county health rankings, Healthy Klamath Coalition data, and the Healthy Teens Survey.
- Assessment of unmet BH needs will also be estimated through discussion with local providers (including Oral Health, Physical Health and Behavioral health), law enforcement, and Klamath County Public Health.

11.A.5 How will Applicant contract for Behavioral Health services in primary care service delivery locations, contract for physical health services in Behavioral Health care service delivery locations, reimburse for the complete Behavioral Health Benefit Package, and ensure Providers integrate Behavioral Health services and physical health services?

CHA contracts with multiple primary care locations to provide both physical and BH services. These offices provide care for BH, Substance Use Disorders (SUD), health behaviors that contribute to chronic conditions, and physical symptoms related to stress. Treatment teams at these offices include physicians, counselors, and suboxone prescribers. The expectation of integration is reinforced by care coordination provided by CHA staff. Each morning, the ED census is reviewed for urgent/emergent member issues. PCPs are notified if their patients are seen in the ED for BH related issues. They are provided a rapid referral form to complete for BH treatment.

Additionally, Klamath County has an Oregon Health & Science University (OHSU) Family Residency Program where BH and physical services are integrated. The program has at least two behaviorists who train Primary Care Providers (PCPs) on how to handle BH issues and provide BH services to CHA members.

Klamath County's Federally Qualified Health Center (FQHC) and the Community Mental Health Provider (CMHP) also provide integrated physical and BH services. The FQHC integrates physical health, BH, and oral healthcare under one facility where CHA members receive a Warm Handoff from their PCP to a BH provider in a seamless manner.

CHA convened the necessary parties to facilitate the recent opening of a BH-SPMI clinic by our CMHP. The new clinic coordinates the needs of the SPMI population who are willing to visit their BH provider but have not established care with a PCP. The new clinic makes it convenient for SPMI members to visit with a physical healthcare provider without having to make separate trips to two different clinics.

These clinics contract for reimbursement with CHA to provide the complete BH benefit package. CHA's Case Management Department regularly audits treatment plans to ensure members receive all necessary physical and BH services.

11.A.6 How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area?

CHA ensures through provider network visualization tools and claims-based data that all members and BH providers comply with OHA's time and distance standards. When appropriate services are not available, or there is a delay in services, CHA contracts with Out of Area (OOA) providers to ensure our members can access BH services.

CHA's Member Handbook is provided to all new members and posted on our website. This handbook lists the benefits covered under OHP and refers explicitly to Chemical Dependency and BH services. CHA is working on the most recent update to the member handbook, which includes information related to a BH emergency and lists multiple resources with their phone numbers such as Klamath Basin Behavioral Health (KBBH), Oregon Warmline, and Oregon Youth Line.

11.A.7 How will Applicant ensure timely access to all Behavioral Health services for all Members?

CHA ensures through provider network visualization tools and claims-based data that all members and BH providers comply with OHA's time and distance standards. When appropriate services are not available, delayed, or for members outside our service area, CHA contracts with OOA providers to ensure all members have timely access to all BH services.

CHA partners with the County Mental Health Provider (CMHP), KBBH to provide 24/7 access to care through their crisis line and mobile crisis team. KBBH also offers walk-in hours Monday through Friday for members to receive drop-in therapy or medication management. Walk-in times are also provided by Lutheran Community Services (LCS).

CHA staff reviews the ED census daily to ensure that members seen for urgent/emergent BH needs to receive adequate and timely referrals and follow up. Members are also provided with timely access to SUD services. If members need detox or a residential bed, and there is not one available locally, services are arranged an OOA provider to receive appropriate services.

11.A.8 How will Applicant ensure that Members can receive Behavioral Health services out of the Service Area, due to lack of access within the Service Area, and that Applicant will remain responsible for arranging and paying for such out-of-service-area care?

If members need detox or residential bed and services are not available locally, an OOA provider may be arranged for needed services. If members need a Secure Residential Treatment Facility (SRTF), CHA coordinates care as needed with the receiving facility and the Exceptional Needs Care Coordinator (ENCC) through KBBH. This sharing of information ensures rapid access to treatment and appropriate discharge planning and follow up. For pediatric members, CHA coordinates a Certificate of Need with a contracted psychiatrist to demonstrate that residential treatment is the most appropriate option. CHA's Provider Network Department contracts with OOA providers as needed.

When members are out of the area for BH needs, care coordination extends to meeting their physical needs. No authorization is needed for medical care while receiving BH care OOA for pediatric and adolescent members. Care is coordinated with a residential treatment provider to locate a medical office when needed for adults. Once a medical provider is selected by the member and/or treatment provider, CHA's Provider Network Department contracts with them if needed.

11.A.9 How will Applicant ensure Applicant's physical, oral and Behavioral Health Providers are completing comprehensive screening of physical and Behavioral Health care using evidence-based screening tools?

CHA providers utilize evidence-based screening tools to assess patients for both physical and behavioral needs. These tools consist of but are not limited to:

- SBIRT- Screening, Brief Intervention, Referral to Treatment
- CANS- Child and Adolescent Needs and Strengths
- CASII- Child and Adolescent Service Intensity Instrument

- ASAM- American Society of Addiction Medication
- ACES- Adverse Childhood Experiences
- PHQ-9- Patient Health Questionnaire

CHA will incorporate this requirement in contract language beginning in calendar year 2020 and audit for compliance annually.

11.A.10 How will Applicant ensure access to Mobile Crisis Services for all Members to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute Care Psychiatric Hospital, in accordance with OAR 309-019-0105, 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320?

CHA partners with CMHP, KBBH to provide a 24/7 crisis line and a mobile crisis team. This team works with the Assertive Community Treatment (ACT) team to provide services wherever members are located including homeless shelters, libraries, correctional facilities, and schools. CHA initiated, and continues to facilitate, a Performance Improvement Project (PIP) in collaboration with community partners and providers from the hospital, Klamath County Public Health, BH, and pediatric healthcare. The goal of this PIP is to decrease inappropriate Emergency Department (ED) utilization by providing member education, better care coordination, and improved access to CHA members. KBBH has a team of providers including therapists, Certified Alcohol and Drug Counselors (CADC), and care navigators located at Klamath County's correctional facility. This allows them to provide stabilization services to members while they are incarcerated, and continued treatment when they are released. KBBH also maintains facilities for crisis and respite stays for adults and youth, which allows for stabilization with medication management and therapy for a short duration to prevent the need for a long-term acute stay.

11.A.11 Describe how Applicant will utilize Peers in the Behavioral Health system.

CHA works through our contracted providers and community partners to provide Peer services to our members. When members are referred to BH services, peer support is available and added to their treatment plan when appropriate. This service is an adjunct to individual therapy, groups, and medication management. Our community BH providers are continually training more peer support specialists to meet this growing need in our service area.

11.A.12 How will Applicant ensure access to a diversity of integrated community supports that mitigate SDOH-HE, increase individuals' integration into the community, and ensure all Members access to Peer services and networks?

CHA coordinates with KBBH, LCS, REDACTED (RTS), Klamath and Lake Community Action Services (KLCAS), and REDACTED (RTS) to ensure a diverse array of services is successfully integrated for our members. Each of these partners provides unique services to members, including housing, peer support, case management, care coordination, transportation, mobile crisis care, mobile hospital follow-up, medication

management, chronic pain groups, and food distribution. Availability of these services allows us to meet the diverse needs of our members. Access to these services allows our members to integrate into the community by addressing SDOH-HE issues and reducing barriers to receiving care.

Section B. Billing System and Policy Barriers to Integration

Applicant must identify and address billing system and policy barriers to integration that prevent Behavioral Health Provider billing from a physical health setting. Applicant will develop payment methodologies to reimburse for Warm Handoffs, impromptu consultations, integrated care management services and all services for evidence-based treatments (for example, Wraparound, ACT, PCIT, EASA, Peer Delivered Services). Applicant will examine equity in Behavioral Health and physical health reimbursement.

11.B.1 Please describe Applicant's process to provide Warm Handoffs, any potential barriers to ensuring Warm Handoffs occur and are documented, and how Applicant plans to address them.

CHA works with internal and external partners to ensure Warm Handoffs for members. Members in need of case management are identified in multiple ways: ED census, authorization requests, correctional facilities reports, community meetings, PCP visits, and self-referrals. Once identified, CHA's CM contacts the member to offer care planning, treatment referrals, and community resources. For example, a PCP submits a request for a member requiring surgery. While reviewing the records, the CM identifies the member is also experiencing BH issues. The member is referred to CHA's BH CM who contacts the member and coordinates additional treatment with the provider and member as needed.

For example, when a pregnant member has BH needs, the BH CM contacts the member to offer additional services and support. When external partners identify members with BH needs, CHA's BH CM convenes the member's treatment team to share information on the member's needs, and coordinate and align available resources to meet those needs.

Barriers to a Warm Handoff may arise when a member is outside the service area or when appropriate services are unavailable locally. When this occurs, CHA works with an OOA provider to ensure timely access to appropriate BH services.

11.B.2 How does Applicant plan to assess for need and utilization of in-home care services (Behavioral Health services delivered in the Member's home) for Members?

Member assessments are prompted by various sources such as the ED census report, correctional facilities reports, referrals from physical or oral health providers, missed appointments, and PCP or self-referrals. CHA CMs conduct member assessments to identify underlying SDOH-HE barriers to care or other healthcare needs which may require in-home services and ensure those needs are incorporated into the member's care plan.

CHA partners with KBBH to provide mobile crisis services to members. When members are in crisis and unable to access a provider, the crisis team responds to the member for intervention. This service is not only provided in homes, but also in schools, shelters, correctional facilities, and libraries.

If BH concerns arise, the local hospital's maternity nurses refer a family to KBBH's Health Families Program. This is a preventative program providing in-home visits for new parents to assess for BH needs.

CHA's pharmacy staff may also identify potential BH needs while conducting home visits for members with persistent and severe respiratory conditions. When concerns are raised, CHA staff contact the member's provider to close the referral loop. CHA's CM staff will also contact the member for further assessment.

If communication with a member ends abruptly (for example, there has been no contact with the member, phone calls have not been returned, appointments are missed), CHA utilizes RTS, RTS or local law enforcement to perform wellness checks to ensure the member is safe. At that time, the member is assessed and/or referred for immediate physical, BH or SDOH needs.

If a member requires BH care but is not in crisis, an appointment with a therapist, healthcare navigator, or peer support specialist is arranged telephonically. This reduces the number of missed appointments and provides care to members who avoid leaving their homes.

11.B.3 Please describe Applicant's process for discharge planning, noting that discharge planning begins at the beginning of an Episode of Care and must be included in the care plan. Discharge Planning involves the transition of a patient's care from one level of care to the next or Episode of Care. Treatment team and the patient and/or the patient's representative participate in discharge planning activities.

At CHA, discharge planning begins on the day of admission and is driven by the patient and/or the patient's representative as appropriate. We coordinate discharge planning in conjunction with local and statewide facilities to promote appropriate discharge planning when members are in residential treatment or hospitalized. From the date of admission, the facility notifies CHA of the admission and sends regular clinical updates to our BH CM who monitors their treatment plan. This information is used to medically justify their stay, coordinate care, and plan for discharge. CHA's BH CM works closely to coordinate care with contracted BH providers' post-acute behavioral provider staff to facilitate appropriate follow-up care. To transition from one level of care to the next, the follow-up care may include scheduled physical and oral healthcare appointments, prescriptions, addressing SDOH-HE needs, and transportation arrangements.

When the member is discharged, their treatment team is notified to ensure follow-up within seven days is achieved. The BH CM communicates with the member and/or treatment team to offer additional services as needed.

11.B.4 Please describe Applicant's plan to coordinate Behavioral Health care for Fully Dual Eligible Members with Medicare providers and Medicare plans, including ensuring proper

billing for Medicare covered services and addressing barriers to Fully Dual Eligibles accessing OHP Covered Services.

CHA has dedicated CMs to coordinate care for Medicare-eligible members which include our Fully Dual Eligible Members. The CM consistently delivers a high-value member satisfaction experience for the Fully Dual Eligible Members, which includes coordinating their BH care and ensuring access to OHP covered services.

CHA ensures that Fully Dual Eligible Members have Medicare as their primary billing and OHP as their secondary bill for covered services. We require Coordination of Benefits (COB) information on all claims for Medicare-covered services. CHA processes all secondary claims to pay the Medicare deductible or remaining coinsurance. CHA receives Medicare Advantage (MA) crossover claims as well as COB crossover claims. When members receive services not covered by Medicare but are covered by Medicaid, the provider bills CHA directly for payment of services. This process allows our dual members to access OHP covered services and avoid access to care issues without any delay in payment to the provider.

Section C. MOU with Community Mental Health Program (CMHP)

Applicant will enter a MOU with Local Mental Health Authority that will be enforced and honored. Improved health outcomes and increased access to services through coordination of safety net services and Medicaid services.

11.C.1 Describe how Applicant plans to develop a comprehensive Behavioral Health plan for Applicant's Service Area. Please include dates, milestones, and Community partners.

CHA will develop a comprehensive BH plan for our service area in collaboration with our key partners including KBBH, LCS, Klamath County Public Health, all primary care providers, our local hospital Sky Lakes Medical Center (SLMC), EMS, Mobile Crisis team, BestCare, Transformations Wellness Center, You Matter to Klamath, Local Public Safety Coordinating Council (LPSCC), Department of Human Services (DHS), Aging & People with Disabilities (APD), and Oregon Institute of Technology (OIT). We will develop partnerships with potential key partners including The Klamath Tribes.

Dates and milestones are as follows:

Date	Milestone
April 2019	Development of aim statement including the defining scope of the BHP
June 1, 2019	Assessment of current state, barriers and gaps. High level process mapping and review of available data
August 1, 2019	Articulation of 4-6 prioritized problem statements

September 1, 2019	Research and review of bright spots – best practices and successful examples of similar communities
October 1, 2019	Select measures of success with goal setting
November 1, 2019	Select interventions with sponsors and owners

11.C.2 Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP. Please include dates and milestones.

In Klamath County, the Community Health Assessment and the Community Health Improvement Plan (CHP) are developed by the Healthy Klamath Coalition's four founding partners: "Core Four", in collaboration with other local providers and agencies. The "Core Four" includes: CHA, Klamath Health Partnership (FQHC), Klamath County Public Health, and SLMC. Notable collaborators include: KBBH, Blue Zones Project of Klamath Falls, Klamath Falls APD, DHS, City of Klamath Falls, Klamath County School District, Klamath City Schools, Oregon Institute of Technology, Lutheran Community Services, Klamath Tribal Health and Family Services, Klamath Regional Health Equity Coalition, and Klamath-Lake Counties Food Bank.

KBBH is the Local Mental Health Authority (LMHA) in Klamath County and provides BH services as the CMHP. The Healthy Klamath Coalition has completed the Community Health Assessment which has been published for public review and comment.

Representatives from CHA and KBBH have attended and will continue to participate in all Healthy Klamath Coalition meetings throughout the development of both documents.

Dates and milestones are as follows:

Date	Milestone
February 25, 2019	Survey published and distribution began to community partners, stakeholders, and members of the public for input on top priorities for focus of the CHP
March 28, 2019	Survey results were tallied by Klamath County Public Health
April 12, 2019	The Coalition began work on the 2020 CHP
September 2019	Final 2020 CHP document completed.
September 2019	Select interventions with sponsors and owners

October 2019	Select measures of success with goal setting

11.C.3 Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the local plan. Please include dates and milestones.

CHA collaborates with the LMHA in the development of the local CHP plan initiatives. The LMHA, KBBH, participates in the development of the Community Health Assessment which drives the CHP. The dates and milestones are therefore similar (and in some cases identical) to the CHA and CHP dates and milestones. The priorities of our LMHA are embedded in the Community Health Improvement Plan (CHP). Improvement priorities are a standing agenda item at the CAC, of which the LMHA is a member.

Dates and milestones are as follows:

Date	Milestone
April 12, 2019	The Coalition began work on new 2020 CHP
September 2019	Final 2020 CHP document completed
September 2019	Determine initiatives in collaboration with the LMHA.
October 2019	Select measures of success and determine goals/targets in collaboration with the LMHA

11.C.4 Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority? If yes, please describe.

CHA does not foresee any barriers or challenges with the LMHA to executing the CHP due to the strong partnerships that exist between the "Core Four" and all contributors to both the County Health Assessment and the CHP.

Section D. Provision of Covered Services

Applicant must monitor its Provider Network to ensure mental health parity for their Members.

11.D.1 Please provide a report on the Behavioral Health needs in Applicant's Service Area.

Based on current (2018) county health rankings from the Robert Woods Johnson Foundation, Klamath County has higher than average rates of poverty, child abuse, substance abuse (methamphetamine, opioids and alcohol), high school drop-out, infant mortality and low birth weight, all of which indicate a higher than average ACEs scores for members of our community. A recent "no-show" project conducted in collaboration with the Oregon Institute of Technology's Population Health Management department revealed that of those members who fail, or "no

show", for their medical appointments, the average ACEs score was 6, indicating a high level of trauma among our members, which further informs the high level of need for BH services in our region. Housing, poverty, and unemployment continue to be focus areas of concern for social serving agencies in Klamath County. The high rate of suicide is another area of concern and will be a focus area in the CHP going forward.

CHA works closely with local government and community resources to identify BH needs in Klamath County. Organizations include the Klamath County District Attorney's office, Klamath Falls Police Department, local correctional facility, and Healthy Klamath. These resources assist with identifying interdependencies of SDOH and other social economic impacts in regard to BH related needs. Utilizing our claims-based system we've identified the BH provider workforce/network includes a total of seventy-eight (78) providers. BH providers offer services to include mental health, behavior analysis, social work, professional counseling, addiction counseling, marriage and family therapy, and child, adolescent, and adult psychiatry. Thirty-two (32) providers offer services in mental health which results in (1) behavioral health provider to every (579) members within the service area. At least 94.39% of CHA members are within the 60 miles drive distance or 60 minutes of drive time to a BH provider. The Severe and Persistent Mental Illness (SPMI) population includes 3,761 members resulting in (1) behavioral health provider to every (117) SPMI members.

11.D.2 Please provide an analysis of the capacity of Applicant's workforce to provide needed services that will lead to better health, based on existing Behavioral Health needs of the population in Applicant's Service Area.

CHA's Provider Network adequacy is analyzed by identifying all contracted BH providers. Members are analyzed in three ways: as a whole population, by members who utilize BH services, and members within the Severe and Persistent Mental Illness (SPMI) population. Once provider and member populations are identified, ratios are calculated to understand capacity. Extraction of provider and member data include capturing physical addresses to understand member's needs based on location. CHA's Provider Network mapping tool is then utilized to analyze OHA requirements of time and distance standards to ensure adequate access to BH needs. If the provider network is not meet the capacity needs for our members based on this analysis, corrective actions plans will be developed to increase adequacy for CHA members as necessary.

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CHA members can access services from multiple independent BH providers in the area. CHA maintains partnerships with other local agencies to either provide or coordinate services for our members, including DHS Child Welfare and APD, Adaptive Behavioral Services, and Intellectual/Developmental Disabilities (I/DD). Juvenile Justice and Community Corrections are key participants in cases that involve judicial intervention or monitoring.

The BH workforce in Klamath County is strong and diverse yet faces the same challenges as those faced by other communities in terms of recruitment and retention of qualified, certified and/or licensed BH providers. We are fortunate to have a local institute of higher education (Oregon Institute of Technology) which has BH degrees in its curriculum that allows local providers to provide internships to students. Klamath Community College (KCC) also has a course of study in substance use disorders that qualifies graduates to become Certified Alcohol and Drug Counselor I (CADC I) at the entry level. KBBH, the largest provider of BH services in the community, intentionally recruits staff out of state so as not to compete with other local or regional BH providers and partners for these scarce resources.

CHA's BH benefit allows members to see both local and out of area providers for treatment. CHA will continue to support these services and seek contracts with individual independent providers to increase access to BH services.

11.D.3 How does Applicant plan to work with Applicant's local communities and local and state educational resources to develop an action plan to ensure the workforce is prepared to provide Behavioral Health services to Applicant's Members?

CHA will continue to collaborate with key community stakeholders to expand our action plan to further develop workforce capacity in Klamath Falls.

Klamath Community College (KCC) provides an Addictions Studies curriculum for those seeking certification as a CADC I.

CHA has a strong partnership with the Oregon Institute of Technology (OIT), which is in Klamath County. OIT has several programs which prepare students to provide BH services. The Behavioral Improvement Group (BIG) Applied Behavior Analysis (ABA) Clinic through OIT, provides treatment for autism, schizophrenia, and challenges associated with intellectual disabilities. The program has both an undergraduate and graduate program in Applied Behavior Analysis. Students work with patients as they pursue training as certified behavior analysts.

OIT also provides an undergraduate program in Applied Psychology which qualifies students to be credentialed at the Qualified Mental Health Associate (QMHA) level and the ability to provide direct care services in a BH care facility. Bachelor's level students are referred to KBBH for their required internships for this program. A Masters in Marriage and Family Therapy is also offered which qualifies students to be credentialed at the QMHP (Qualified Mental Health Professional) level to provide therapy and counseling services and may lead to licensure as a Licensed Marriage and Family Therapist (LMFT) once all requirements for licensure have been met. The majority of these Masters level students fulfill their internships at KBBH as well.

OHSU nursing students are required to complete a rotation at KBBH as part of their education. OHSU's Rural Health Program is located at Cascades East Family Practice which trains new doctors through its residency program. Residents fulfill a rotation at KBBH during their residency.

Southern Oregon University (located 65 miles to the west of Klamath Falls in Ashland, Oregon) and Oregon State University's Cascade Campus (located 137 miles north of Klamath Falls in Bend, Oregon), both provide a Masters in Clinical Mental Health Counseling. These programs prepare students to become Licensed Professional Counselors (LPC) upon completion of the program and meeting all requirements for licensure. KBBH provides internship opportunities for these students upon request.

11.D.4 What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?

CHA partners with BH providers to develop capacity planning and review staff to patient ratio on a monthly basis, number of members seen, number of members seen 30 days after assessment, and appointment adherence rates to ensure workforce capacity that meets the BH needs of our members and potential members.

If the provider network does not meet the capacity needs for our members based on this analysis, internal corrective actions plans will be developed to identify areas of opportunity to increase adequacy for CHA members as necessary.

11.D.5 What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?

Although CHA services are in a rural and geographically challenged area, we have a robust bonus and incentive program to attract and retain BH Providers, Physician Assistants and Family Nurse Practitioners. These incentives can be used for moving costs and forgives the incentive where the practitioner agrees to provide healthcare access in the community for three years.

Moreover, SLMC residency retention rate over the past three years (55%, 50%, and 71%) for 2016, 2017 and the class of 2018 respectively make for a very attractive teaching and clinical residency program. Residents can practice, learn, teach and work with CHA to drive innovative programs that allow them to fuse medicine and technology. This is proof positive that our workforce is getting the support and incentives they need and results in progressive medicine and better healthcare for CHA members and the community at large.

11.D.6 How will Applicant utilize the data required to be collected and reported about Members with SPMI to improve the quality of services and outcomes for this population? What other data and processes will Applicant collect and utilize for this purpose?

SPMI members will be identified by data extracts from our claims system with specific DRG codes e.g., bipolar, major depression, schizophrenia, etc. (per OAR 309-036-0105). SPMI identification can also be made through high ED utilization, multiple arrests (secure email is received every day of everyone who was arrested the previous day), and through referrals from

community partners. CHA receives notification through daily secure email of in-patient care from the local hospital. A CHA Behavioral CM uses all data to determine the need for this population.

To improve the quality of services and outcomes, CHA will work with OHA and other agencies to identify areas for improvement. BH CMs will attend quarterly Southern Oregon Regional Acute Care Council (SORACC) meetings to address system-wide issues facing adults with SPMI, available resources, tools to stabilize transitions and Oregon State Hospital (OSH) placement and commitment updates. CHA's CMs also participate in monthly BH Director's meetings to discuss OHA updates, CCO policies, and procedures.

CMs also attend the monthly Older Adult Stakeholders meeting which allows CHA to interface with community members as well as agency representatives from DHS, DD Services, the Senior Center, KBBH and LCS to address the unmet needs of our older population, many of whom have SPMI. BH CMs use this new information gleaned from these meetings to appropriately enhance member care plans based on shared best practices.

CHA trains and educates community partners to ensure that members with SPMI receive care coordination related to housing to address SDOH. RTS receives referrals from providers and partners with members to explore all possible housing options through Klamath Housing Authority (KHA) the VA, the Klamath County Homeless Shelter (KCHS), and KLCAS. Recently the KCHS built a new shelter to accommodate women and children, and KLCAS can also connect members to energy assistance.

KBBH provides case management through its SPMI rental subsidy program to provide funding for members to move into appropriate housing. This includes care coordination, therapy, and support for members to remain in housing. Another way CHA ensures the quality of service and outcomes is collaborating with KBBH to provide ACT services to adult members with SPMI (once a member is identified as SPMI, they become eligible for ACT services). The ACT team uses a group of CMs, care navigators, and therapists to deliver the appropriate services in a timely manner in the community. Services are offered at libraries, homeless shelters, and the correctional facility to provide greater flexibility in treatment so that members do not need to come to an office. These services do not require a prior authorization, which increases access to this population.

CHA utilizes multiple internal data reporting and analysis to identify members with SPMI to improve the quality of services and outcomes for this population. Claims-based data extracts are generated through MS SQL queries to identify the relationship between ED claims, BH providers and PCPs. This data will provide us with information to address appropriate intervention efforts as needed e.g., if we see high ED usage within a specific combination of BH provider and PCP. Claims-based data is also extracted to identify SPMI members who are not assigned to a PCP and have high ED utilization. This data will allow CHA to assign SPMI, high ED utilizers to a PCP to ensure better care coordination and appropriate use of services. CMs will follow internal coordination of care policies and procedures to ensure appropriate services, quality care, and

access. Clinical data can be extracted from our HIE, Reliance eHealth Collaborative as well and ED data from Collective Medical.

11.D.7 What Outreach and/or collaboration has Applicant conducted with Tribes and/or other Indian Health Care Providers in Applicant's Service Area to establish plans for coordination of care, coordination of access to services (including crisis services), and coordination of patient release?

As recently as April 2019, CHA scheduled and facilitated meetings with the administration of the Klamath Tribes to discuss collaboration and their potential participation in CHA's CAC. CHA will continue to engage with the Klamath Tribes to strengthen our relationship and explore opportunities for coordination of care to improve health outcomes for the members in Klamath County.

Section E. Covered Services Components

11.E.1 Substance Use Disorder

How will Applicant support efforts to address opioid use disorder and dependency? This includes:

11.E.1.a How will Applicant provide, in a culturally responsive and linguistically appropriate manner, SUD services to Members, including outpatient, intensive outpatient, residential, detoxification and MAT services?

CHA is developing a Health Equity (HE) strategy to improve our providers holistic understanding of the care for our members in our community. We partner closely with local providers to offer SUD services to our members. KBBH offers outpatient SUD services as does LCS with the inclusion of MAT. BestCare offers intensive outpatient services, detoxification, and residential treatment. Transformations Wellness Center (TWC) provides residential services and is actively working on expanding its services to include an increased residential capacity as well as MAT services. CHA also contracts with two primary care offices that offer MAT as part of their wellness program.

Upon credentialing and re-credentialing, providers are asked to declare languages spoken other than English. Those who speak another language predominantly speak Spanish. KBBH can provide services in the following languages on site by employed staff members: Spanish, American Sign Language, Brazilian Portuguese, English, Gujrat, Mandarin, Portuguese, and multiple other languages through CHA's vendor for interpreter services.

11.E.1.b How will Applicant provide culturally responsive and linguistically appropriate alcohol, tobacco, and other drug abuse prevention and education services that reduce Substance Use Disorders risk to Members?

CHA ensures members are receiving culturally responsive and linguistically appropriate services to reduce SUD risk through utilization review and on-site audits. CHA's BH CM reviews supporting documentation submitted by SUD providers to decide on authorization requests. The

primary document that is reviewed is the American Society of Addiction Medicine (ASAM). The ASAM uses six dimensions to determine the intensity of treatment services. In dimension four, members are asked about spiritual beliefs, religious affiliation, and cultural background that will help or hinder recovery. In dimension six, members are asked about language skills, developmental disorders or disabilities and literacy skills other than English.

CHA conducts an annual site review of our BH providers which incorporates a 39-point screening tool. Question 20 asks if the clinical assessment addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, and socio-economic level. These questions support CHA's providers in fully understanding our members so they can develop treatment plans that best fit their cultural and linguistic needs.

11.E.1.c How will Applicant inform Members, in a culturally responsive and linguistically appropriate manner, of SUD services, which will include outpatient, intensive outpatient, residential, detoxification and MAT services?

CHA's Member Handbook is provided to all new members and posted on our website. This handbook is available in English, Spanish and large print formats. It lists all available services, including SUD services. CHA also maintains a list of SUD and BH specific providers that is given to each member whose case is managed through our BH program, and during care conferences and care coordination efforts. CHA is developing a digital engagement strategy to include social media and online education and resources for members.

***11.E.1.d* In collaboration with local providers and CMHPs, ensure that adequate workforce, Provider capacity, and recovery support services exist in Applicant's Service Area for individuals and families in need of opioid use disorder treatment and recovery services. This includes: sufficient up to date training of contracted Providers on the PDMP, prescribing guidelines, buprenorphine waiver eligibility, overdose reversal, and accurate data reporting on utilization and capacity.**

We have several local providers that have obtained a Drug Addiction Treatment Act (DATA) waiver to offer Medication Assisted Treatment (MAT) with Suboxone. Members engaged in MAT are supported via individual as well as group BH counseling sessions. Family counseling is also available to all members. Provider capacity is not a concern as we have at least three providers who currently do not engage in MAT due to a lack of demand for the service. CHA is well equipped to meet the need in the future.

Prescribing guidelines for MAT with Suboxone is provided to all practitioners engaged in treatment. CHA utilizes an internal policy supported by two full-time pharmacy technicians who manage the MAT protocol. Patients prescribed Suboxone are required (and encouraged) to attend counseling sessions to help with their recovery. With the patient's permission, family members are engaged in the recovery support process. Approvals of Suboxone are contingent upon the member's demonstrated attendance to the counseling. CHA is notified of any missed counseling appointments; at which time an outreach call is made to determine if the member may require additional support due to a relapse.

Patients requiring intensive treatment support are referred to one of two residential treatment centers available in our service area. Patients admitted to these facilities are not subject to CHA's counseling requirements.

The PDMP plays a vital role in curbing the over-prescribing of narcotics, and CHA encourages all providers to access the portal (link available on our website) before writing for narcotics for all patients, and especially those with whom they are not familiar. CHA also encourages the simultaneous prescribing of Narcan to aid in the event of an overdose.

CHA's Pharmacy Department runs a quarterly MAT Capacity and Utilization report to assess for adequacy. Each provider can treat up to a maximum of 30 patients at a time, but if the report indicates the need for a provider to take on additional patients, CHA will assist the provider in submitting a notification of the need and intent to treat up to 100 patients.

11.E.1.e Coordinate with providers to have as many eligible providers as possible be DATA Waived so they can prescribe MAT drugs.

CHA supports and encourages qualified providers to apply for a DATA waiver to facilitate opioid dependency treatment in settings other than an opioid treatment program. CHA will assist interested providers in completing the application when needed.

Information on the application process and a link to the Substance Abuse and Mental Health Services Administration (SAMHSA) web page is available on our website.

11.E.1.f Coordinate care with local Hospitals, Emergency Departments, law enforcement, EMS, DCOs, certified Peers, housing coordinators, and other local partners to facilitate continuum of care (prevention, treatment, recovery) for individuals and families struggling with opioid use disorder in their Community.

CHA currently participates in the Klamath County Local Public Safety Coordinating Council (LPSCC), which meets every other week and serves as the County Opioid Task Force. Task force members in addition to CHA include KBBH, DHS, Klamath County Juvenile Department, Oregon State Police, Klamath County School District, Klamath County Public Health, Circuit Court, Community Corrections, Klamath County District Attorney, LCS, and a citizen representative. Care coordination for individuals and families struggling with opioid use disorder is done primarily by CHA's BH case manager.

CHA will continue the above activities. CHA will also look for opportunities to strengthen its coordination work. The comprehensive BH plan that CHA develops with providers in Klamath County is an opportunity to identify strategies to strengthen coordination of care for members and families struggling with opioid use disorder.

11.E.1.g Additional efforts to address opioid use disorder and dependency shall also include:

- ***Implementation of comprehensive treatment and prevention strategies***
- ***Care coordination and transitions between levels of care, especially from high levels of care such has hospitalization, withdrawal management and residential***

- ***Adherence to Treatment Plans***
- ***Increase rates of identification, initiation and engagement***
- ***Reduction in overdoses and overdose related deaths***

CHA partners with the Statewide Opioid PIP. We have participated in the South West Oregon Regional Collaborative, a collaboration between Umpqua Health Alliance, AllCare, Primary Health, Jackson Care Connect, Western Oregon Advanced Health, and CHA, since April 2017. The Collaborative was initially formed in 2016 to establish consistent benefit practices throughout the region to prevent "doctor shopping" among users as well as to present a consistent message to members and the community regarding the opioid epidemic. CHA and Umpqua Health joined the collaborative in 2017 to strengthen the message and reach of the broadcast/coverage area of CAC-approved media campaigns (television spots on local NBC affiliate stations; establishment of the StaySafeOregon website). The team effort has maintained its strong partnership to continue efforts to lower the use of opioids in the region. The rates of opioid overdose and overdose deaths in Klamath County are very low, making it difficult to determine if intervention efforts in Klamath County were effective statistically. An additional confounding factor is the lack of data on non-CCO claims for opioid prescription fills which makes it difficult to determine if CCO policies to lower the MED prescription benefit had a direct impact on the opiate problem in this area. While Oregon is transitioning its state-wide PIP from reducing the prescribing of high morphine equivalent doses to acute to chronic use, CHA will continue its efforts to reduce the prescribing of high equivalent doses to help further reduce opioid overdoses and overdose deaths in Klamath County.

Efforts to address opioid use disorder and dependency including and in addition to those listed in section 11.E.1 will be determined with broad community input. CHA will convene key stakeholders in our service area to determine the best strategies to address the specific areas listed above. CHA is part of the Klamath County Local Public Safety Coordinating Council (LPSCC), which serves as the County Opioid Task Force. Task force members include KBBH, DHS, Klamath County Juvenile Department, Oregon State Police, Klamath County School District, Klamath County Public Health, Circuit Court, Community Corrections, Klamath County District Attorney, LCS, and a citizen representative. CHA will convene the LPSCC, with the addition of members and specialty SUD providers, to select effective interventions to address opioid use disorder and dependency in Klamath County during CCO 2.0.

11.E.2 Fewer readmissions to the same or higher level of care Prioritize Access for Pregnant Women and Children Ages Birth through Five Years (recommended page limit 6 pages) Applicant will prioritize access for pregnant women and children ages birth through five years to health services, development services, Early Intervention, targeted supportive services, and Behavioral Health treatment.

11.E.2.a How will Applicant ensure that periodic social-emotional screening for all children birth through five years is conducted in the primary care setting? What will take place if the screening reveals concerns?

Primary care providers will screen social and emotional issues during wellness visits through the Ages and Stages Questionnaire-Social and Emotional (ASQ-SE) at 36 months of age. Our community uses the ASQ Developmental screen reliably with 80% performance on the OHA ASQ quality metric and expect the same results with the use of the ASQ-SE. CHA currently works with the Early Learning Hub to decrease the amount of missed preventive visits for children ages 0-5 through the Attendance for Life program. Children who screen positive may be followed in primary care and referred to ESDPT BH providers, or OHSU CDRC depending on the results of the screening. Administration of this screening will be a contractual requirement for primary care providers and monitored through annual compliance audits.

11.E.2.b What screening tool(s) to assess for adverse childhood experiences (ACEs) and trauma will be used? How will Applicant assess for resiliency? How will Applicant evaluate the use of these screenings and their application to developing service and support plans?

CHA works with KBBH to assess the needs of our children. KBBH's Healthy Families Program is a preventative program providing in-home visits for parents with babies 0-3 years to assess for BH needs using the ACEs questionnaire. Families are referred to the program by the local hospital's maternity nurses upon discharge after the birth of a child. Pediatricians screen mothers for depression at the child's two-week postnatal visit using the Edinburgh Postnatal Depression Scale (EPDS). Referrals are made for women who screen positive for depression.

KBBH uses multiple assessment tools, including ACEs, Child and Adolescent Strengths and Needs (CANS) and Child and Adolescent Service Intensity Instrument (CASII) to expertly determine the needs of our youth population. These tools are used by trained BH specialist to ask children about their lives. The questions cover topics such as functioning, risk behaviors, trauma experiences, stress symptoms, resiliency, and strengths within the child and their environment. The results from these screenings help determine the level of service appropriate for each child.

Use of screening tools is monitored and evaluated by CHA's Compliance Department during routing compliance audits and chart review, and by quality management staff during annual delegation review audits. CHA's Case Management Department ensures the tools are used in the development of treatment plans through their participation in the member's care team and care coordination meetings.

11.E.2.c How will Applicant support Providers in screening all (universal screening) pregnant women for Behavioral Health needs, at least once during pregnancy and post-partum?

CHA employs a dedicated maternity team comprised of an RN CM and a case assistant. The maternity team works closely with members and providers to assess all member pregnancy, and post-partum health needs to include an existing or newly diagnosed BH need. The maternity team also collaborates with our BH CM for referrals and resources when required. Our maternity team works diligently to assure appropriate and timely prenatal, post-partum and well-baby care.

11.E.2.d How will Applicant ensure that clinical staff providing post-partum care is prepared to refer patients to appropriate Behavioral Health resources when indicated and that systems are in place to ensure follow-up for diagnosis and treatment?

CHA's maternity team works in collaboration with CHA's BH CM. Together, they partner with providers to monitor post-partum patients that have an existing or emerging BH diagnosis. The team also provides support to the providers with members with a new BH diagnosis and assures a Warm Handoff from physical to BH providers. Systems are in place to support post-partum members with community referrals and ongoing case management by maternity and BH CM working in collaboration. If needed, the maternity CM hands off to the BH CM who then follows the member through a resolution to ensure appropriate BH services are received.

11.E.2.e How will evidence based Dyadic Treatment and treatment allowing children to remain living with their primary parent or guardian be defined and made available to families who need these treatments?

CHA contracts with KBBH and LCS to serve the needs of children on our plan. KBBH provides Parent-Child Interactive Therapy (PCIT) to families assessed to need this Dyadic Treatment. KBBH also has a staff member on site at the local child welfare office to provide screenings for children to determine the need for these services. LCS also works closely with child welfare to ensure that CHA members who need these services are referred and receive treatment. Both facilities provide family therapy. KBBH also assesses for the need of BH services through its Healthy Families Program.

These providers, along with CHA, deliver Wraparound in Klamath County. The goal of this program is to develop a youth-driven treatment plan using natural supports so that youth members with high needs can remain in this community. If a child has left the community to receive a higher level of care, the goal of the Wraparound program is to return him or her to our community as soon as possible. Wraparound referrals often come from school staff, therapists, mentors, and DHS workers who attend the weekly Community Resource Team (CRT) meetings. CHA's BH CM attends these meetings to monitor these members. This allows CHA to be proactive when providing rapid referral and approval to local resources when the youth member's needs are manageable locally, rather than waiting until those needs can no longer be served in the community.

In addition to Wraparound, KBBH also offers crisis respite services and a day treatment program. When children are struggling at home or school, these services allow them to be treated safely in another environment. If a youth member needs a higher level of care (for example, PRTS), the member would need to be placed into a residential program out of the area.

11.E.2.f How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

CHA contracts with RTS to conduct in-home visits and assess for SDOH including housing adequacy, nutrition and food, diaper needs, transportation, safety, and welfare checks. RTS will enroll the member in their program and monitor the member's needs, reporting back to CHA case management on progress and obstacles if encountered. CHA contracted with RTS and to conduct in-home visits, wellness checks, and medication reconciliation and other services.

Additionally, CHA's maternity CM engages with high risk pregnant and post-partum mothers to ensure that they have the necessary supports to make a successful transition into motherhood.

CHA's maternity CM or the local hospital's maternity nurses may place referrals to KBBH's Healthy Families program. Those families who opt into the program are assessed for social service support and BH needs during in-home visits.

Referrals to community agencies are made based on need.

11.E.2.g Describe how Applicant will meet the additional Complex Care Management and evidence-based Behavioral Health intervention needs of children 0-5, and their caregivers, with indications of ACEs and high complexity.

CHA attended the most recent OPIP meeting to gain a better understanding of the complex needs of our pediatric members. Our goal is to identify children on our plan who face both medical and social complexity. Once the children have been identified, the new case management staff will work closely with those members and their families to remove barriers to their care and to provide access to community resources. This process will be done with the support of community partners currently serving the population which includes DHS, pediatricians, and BH therapists. The BH CM will connect the family to additional resources such as the Wraparound program, day treatment, or crisis respite as needed. CHA is leveraging technical assistance provided by OPIP through OHA to ensure that we fully understand this population and develop our pediatric case management program to successfully meet the needs of our members with a high level of health complexity.

11.E.2.h How will Applicant ensure children referred to the highest levels of care (day treatment, subacute or PRTS) are able to continue Dyadic Treatment with their parents or primary caregivers whenever possible?

CHA recognizes the importance of attachment-focused therapy. As such, it is necessary to allow continuity of these attachments for youth member requiring higher levels of care. KBBH offers a day treatment program. This allows youth members who are struggling in a mainstream school to receive a higher level of care without leaving the area. Members in subacute or PRTS attend regular team meetings to review the treatment plan and seek input from family and providers. The member's previous therapist, current therapist, DHS worker, parent, attorney, tribal representative and KBBH care coordinator are members of the treatment team. This allows the continued involvement of people with whom the youth member is attached to and loved by, to remain part of their lives. This allows for an easier transition back to the community as the needed supports have remained in place throughout their course of treatment. CHA will explore

options for providing transportation, hotel accommodations, or teletherapy options for parents who are unable to travel to the child's out of area placement to continue participation in Dyadic Treatment options.

11.E.2.i Describe Applicant's annual training plan for Applicant's staff and Providers that addresses ACEs, trauma informed approaches and practices, tools and interventions that promote healing from trauma and the creation/support of resiliency for families.

CHA is developing a comprehensive training plan for staff and providers to address the following areas:

- Implicit Bias
- Social/Cultural Diversity
- Language Access/Use of Interpreters/Health Literacy
- Adverse Childhood Experiences (ACEs)
- Trauma Informed Care
- Meaningful Community Engagement
- Use of data to advance Health Equity
- Civil Rights and Non-Discrimination Laws
- Universal Access or Accessibility (in addition to ADA requirements)
- Addressing structural barriers and systemic oppression
- Social Determinants of Health
- CLAS Standards
- ACA 1557

CHA is enhancing its annual training for staff and providers by using certified trainers. Where internal or local expertise does not exist, CHA will utilize external resources to bring this information to its staff and providers. CHA currently has a relationship with the Lieberman Group as well as the Trauma Healing Project to provide training to its staff team and provider community.

Some of the training that CHA has provided staff and providers over the last twelve months include:

- Motivational Interviewing Seminar
- Adverse Childhood Experiences Training through OHP's Transformation program
- ACEs include Physical Abuse; Sexual Abuse; Emotional Abuse; Physical Neglect; Emotional Neglect; Intimate Partner Violence; Mother Treated Violently; Substance

Misuse Within Household; Household Mental Illness; Parental Separation or Divorce and Incarcerated Household Member

- Engaging People Who Use Drugs: Harm Reduction in Southern Oregon
- The Trauma Healing Project, Promoting Individual and Community Health through Healing
- Culturally Responsive Practices

11.E.3 Care Coordination

Applicant is required to ensure a Care Coordinator is identified for individuals with severe and persistent mental illness (SPMI), children with serious emotional disorders (SED), individuals in medication assisted treatment for substance use disorder (SUD), and Members of a Prioritized Populations. Applicant must develop standards for Care Coordination that reflect principles that are trauma informed, linguistically appropriate and Culturally Responsive. Applicant must ensure Care Coordination is provided for all children in Child Welfare and state custody and for other prioritized populations (e.g., intellectual/ developmental disabilities). Applicant must establish outcome measure tools for Care Coordination.

11.E.3.a.1 How will Applicant determine which enrollees receive Care Coordination services?

CHA is enhancing our current processes and developing our screening and stratification tools to focus on improving care coordination for our members with the highest needs such as SPMI, SUD, and children with serious emotional disorders.

CHA will deliver care coordination to members according to need and by request. The members with the highest needs will come to CHA's attention through multiple ED visits, multiple arrests, and missing healthcare appointments. They will also be identified through PCP referrals, BH referrals, oral health referrals, self-referral or needs identified by CHA CM.

11.E.3.a.2 How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

CHA will continue to collaborate with internal and external partners to ensure care coordination is available for the members who need it. Members with a need for care coordination are identified in multiple ways: ED census, authorizations, correctional facilities reports, community meetings, PCP/BH/oral health visits, and self-referrals. When these members are identified, a CHA CM offers care planning and treatment referrals.

CHA is receiving technical assistance from OHA in coordination with its ED PIP. As of April 2019, the group (composed of local providers, clinic administrators, triage nurses, community health workers, and BH providers) is moving forward with two distinct pilot projects to focus on care coordination. The first project will be composed of care and/or CMs and will focus on sharing best practices across the service delivery spectrum. The second project will be composed of clinic administrators or those with authority from their respective organizations to make

decisions on behalf of their clinic, that will impact the provision of services for the patient to improve health outcomes. The goal of these two pilot projects is to ensure that those patients who need a more intensive level of care coordination receive it. ED utilization is tracked monthly to determine if these two pilot projects, along with an increase in member education regarding ED use, are having an impact on the overall utilization rate in the community.

11.E.3.a.3 How will Applicant identify enrollees who have had no utilization within the first six months of Enrollment, and what strategies will Applicant use to contact and assess these enrollees?

CHA extracts data from our claims-based system to generate a monthly report to identify members that have zero utilization and have had no service on the plan for 180 days after enrollment. These members will be monitored and prioritized for outreach and assessment. CHA exhausts all resources to attain member contact information, such as Reliance HIE, EHR, and other sources to ensure outreach occurs.

As a follow-up, CHA may use RTS to assess SDOH barriers, such as transportation, housing adequacy, nutrition and food, transportation needs, etc., is provided to members in this category.

11.E.3.b How does Applicant plan to complete initial screening and Assessment of Intensive Care Coordination (ICC) within the designated timeline? (May submit work flow chart if desirable).

CHA Member Services sends a welcome packet to all new members which includes a health assessment form. If the member does not respond, CHA follows up with a phone contact. All completed health assessments are reviewed by the CM department to identify members that may benefit from ICC. A CM attempts to contact those members within one business day of identifying member's needs for ICC services. If unsuccessful, the CM staff attempts a minimum of three phone contacts over three separate days. If these attempts are unsuccessful, a letter is mailed to the member. An assessment and care plan are developed for each member from the information in the initial screening and follow up conversation. Medical, BH and SODH are assessed.

11.E.3.c Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

CHA currently has an ICC policy and procedure in place. CHA meets the ICC needs of adult members by collaborating with partners and providers, both locally and OOA, as needed to facilitate appropriate care. CHA contract with KBBH to provide the ACT program. This program provides therapy, skills training, supported employment, and supported housing assistance to members with SPMI. ICC is also provided for high needs members when they are out of the area. CHA's BH CM works with KBBH staff to ensure appropriate treatment planning and follow up for members who are released from a correctional facility or discharged from an inpatient stay.

CHA uses the Wraparound program to meet the ICC needs of youth members. A Wraparound Care Coordinator is assigned by LCS or KBBH. This assignment occurs when the community has submitted a referral and when the referral is approved through the Wraparound Review Committee. The Wraparound Care Coordinator will develop, implement, and monitor the care plan at the direction of the youth member and family. CHA's BH CM reviews and updates these care plans throughout the youth member's participation in the program to ensure they reflect the culture, attitudes, and beliefs of the youth member and family.

Young adult members (ages 16-25) are served through the Early Assessment and Support Alliance (EASA) program at KBBH. The purpose of EASA is to identify the symptoms of psychosis as early as possible in order to provide successful support and treatment. The EASA team at KBBH extends ICC services to these members through outreach efforts, ongoing advocacy, supported employment and supported housing assistance. These members are encouraged to transition into the ACT program as they move toward adulthood.

We are currently enhancing our ICC policy to include monitoring for all members ICC needs.

***11.E.3.d* How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?**

CHA will provide cost-effective integrated Care Coordination by leveraging existing resources for our members. We will manage the process within our service area through focused resources, data-driven tools, and proven methods. The focus will remain on members with high acuity that has been shown by multiple ED visits, numerous arrests, several chronic conditions, and missed healthcare appointments. Some of our partners will include KLCAS, RTS, and RTS to address SDOH and isolation. This coordination and proactivity include connecting members to resources for housing, food, transportation, and medication management needs.

***11.E.3.e* What is Applicant's policy for ensuring Applicant is operating in a way guided by person centered, Culturally Responsive and trauma informed principles?**

CHA will explore HIT solutions to further enhance care coordination and SDOH HE to maximize cost effectiveness. CHA's Case Management model is member centric, driven by members and or legal appointees. Inclusion of the member lends insight for CHA into any cultural or linguistic needs which will then be addressed by the CM, to provide optimal care. CHA uses Spanish speaking staff and the language line for translation services. CHA seeks to enhance our services by hiring bilingual CMs when possible.

CHA CMs have had Trauma Informed Care training and we plan future trainings to stay current on best practices. To monitor effectiveness of training, a random sampling of care plans is assessed for Trauma Informed Care practices. This is used for coaching opportunities and as case studies for ongoing team training.

***11.E.3.f* Does Applicant plan to delegate Care Coordination outside of Applicant's organization? How does Applicant plan to enforce the Contract requirement if Care Coordination delegation is chosen?**

CHA does not delegate care coordination outside of the organization.

11.E.3.g For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

CHA is proactive in our management of dually eligible members. We work closely with MA health plans and have a dedicated CM. Member receiving services not covered by Medicare, but covered by Medicaid, the provider can bill CHA directly for payment of services. This allows our dual members to have access to OHP covered services and avoid access to care issues. We coordinate care for Fully Dual Eligible members with BH needs using the same processes for all members with BH needs.

11.E.3.h What is Applicant's strategy for engaging specialized and ICC populations? What is Applicant's plan for addressing engagement barriers with ICC populations?

CHA is exploring opportunities to leverage digital technology to engage the ICC population through SMS text messaging, website and other digital platforms to engage members and drive healthy behavior.

Barriers will be addressed through RTS, RTS and Wraparound to engage members with specialized ICC needs. They provide gap care to members with chronic illnesses to maintain healthy lifestyles. This care becomes essential in the period after hospital discharge and before the PCP follow-up appointment. RTS receives referrals from CHA CMs to serve members who are facing multiple chronic conditions, BH and SUD issues. They also connect members to SDOH resources for housing, food, transportation, and medication management needs.

11.E.3.i Please describe Applicant's process of notifying a Member if they are discharged from Care Coordination/ICC services. Please include additional processes in place for Members who are being discharged due to lack of engagement.

Members remain in the Care Coordination/ICC and case management programs until they have met their goals, terminated from the plan, or no longer request the support. Our CMs and care coordinators attempt contact with members regularly to ensure they have been referred to and are receiving the appropriate services, are engaging with their providers, and are working toward their health goals. Once the member meets the treatment plan goals and has completed the program, the member is discharged from CM services followed with a phone discussion involving preventative and wellness goals. A letter will also be sent as a written follow up with contact information for their CHA CM if future services are required,

Members are closed at their request, if their eligibility terms, or if they are unable to be reached after three attempts (not returning calls, disconnected number, etc.). CHA CMs makes every effort to engage members that require ICC. A minimum of three call attempts are made to the member. For members with no working phone listed CHA reaches out to community providers and leverages other resources to secure a working phone number. CHA CMs utilize RTS and RTS to make home visits when needed to engage members. When no contact can be made,

CHA sends an informational letter to offer services. The member will then be scheduled for a 180-day follow-up attempt to offer services.

11.E.3.j Describe Applicant's plans to ensure continuity of care for Members while in different levels of care and/or episodes of care, including those outside of Applicant's Service Area. How will Applicant coordinate with Providers across levels of care?

CHA will continue to work with local and out of area agencies statewide to ensure continuity of care. When members are in residential treatment or are hospitalized out of the area, the BH CM monitors their care by reviewing regular clinical updates received from the respective facility. This information is used to coordinate care and plan for follow up care post discharge. The BH CM works closely with BH providers to facilitate appropriate follow-up care. When the member returns to the community, their local treatment team is notified to ensure follow-up within seven days. The BH CM contacts the member and/or treatment team to offer additional services as needed.

If a youth member has left the community to receive a higher level of care, intensive coordination (often through Wraparound) allows the child to return to their community and reengage as soon as possible.

11.E.3.k How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?

CHA's discharge planning begins the moment a member enters services, and we work with local, statewide and out of area agencies to promote appropriate discharge planning. When members are in residential treatment or hospitalized out of the area, the BH CM monitors their care from the date of admission forward. The facility notifies CHA of admission and sends regular clinical updates to the BH CM. This information is used to medically justify their stay as well as to coordinate care and plan discharge. The BH CM works closely with KBBH staff to facilitate appropriate follow-up care. When the member is discharged, their local treatment team is notified so that follow-up within seven days can be achieved. The BH CM contacts the member and treatment team to offer additional services as needed. At CHA, discharge planning begins on the day of admission and is driven by the patient and/or the patient's representative as appropriate. The BH CM is notified of the admission and participates in the care planning process, along with the member's local treatment team, through the member's course of treatment.

The facility sends regular clinical updates to CHA and the local team. Our BH CM works closely with the provider staff to coordinate the member's care and to ensure the appropriate resources, services, and supports (including any SDOH needs) are in place at the time of discharge. Members must be medically stable and have met the goals of their treatment plan upon transition to a lower level of care. The ensures follow-up within seven and the BH CM contacts the member and treatment team to offer additional services as needed.

11.E.3.l What steps will Applicant take to ensure Care Coordination involvement for ICC Members while they are in other systems (e.g., Hospital, subacute, criminal justice facility)?

CHA partners with local BH providers to ensure appropriate care coordination for members. We use Collective Medical to alert CHA staff to member's hospitalization both locally and out of the area. The BH CM contacts the admitting facility to request written notification of admission and weekly clinical updates. This allows CHA to plan for member's ongoing care post discharge. The member's treatment team is notified of the discharge and contacts the member to begin service provision as needed. Members in residential or subacute setting, the BH CM participates in team meetings to initiate an appropriate step-down plan. When members are incarcerated locally, KBBH provides services through the corrections department. This allows members to participate in a BH assessment, SUD assessment, and group or individual therapy while they are in a criminal justice facility.

11.E.3.m Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

CHA works closely with local BH providers and state agencies to assess and coordinate care for members who meet the ICC level of care. This collaboration amongst agencies helps to prevent duplication of services among the care partners. Together with local providers, CHA strives to maintain the 15:1 caseload requirement and adjusts staffing as needed. We will continue to monitor the need for staffing to assure the goal of 15:1 is met and maintained.

11.E.3.n Which outcome measure tool for Care Coordination services will Applicant use? What other general ways will Applicant use to measure for Care Coordination?

CHA currently has care coordination tools that measure, monitor and tracks outcomes. CHA's CM Director runs multiple reports to measure quality and outcomes of the care management process. Current reports reviewed include but not limited to ED utilization, hospital readmissions, missed primary care and/or specialist appointments, and timeliness of outreach and follow-up by CHA. CM uses the analysis of the reports to identify improvement opportunities, train staff, and improve health outcomes for our members. We are exploring ways to measure improvement in or stabilization of the disease process. We also seek evidence of improved self-management and/or knowledge of the disease process by the member.

11.E.3.o How will Applicant ensure that Member information is available to Primary Care Providers, specialists, Behavioral Health Providers, care managers and other appropriate parties (e.g., caregivers, Family) who need the information to ensure the Member is receiving needed services and Care Coordination?

CHA generates and distributes member CM assignment notifications to CHA staff. We also create and distribute member assignment lists to all PCPs and Primary Dental Providers (PDP). BH providers and specialists have access to MMIS to verify a member's eligibility and contact CHA's CM for care coordination. CHA's online provider portal allows registered providers to verify a member's PCP and PDP for care coordination purposes. Our online portal also allows

providers to see authorizations on file for a member, submit new authorization, and track the status of submitted authorizations.

CHA completes outreach to all new enrollees within 30 days of enrollment to verify receipt of their new member packet and confirm if the member is currently seeing a PCP or PDP. If the member does not have a provider, we assign them an established PCP or PDP. If we are unable to contact the member, we will assign them a PCP or PDP and notify them by mail. When the member is not under existing care, CHA reiterates the benefits of becoming established with a PCP or PDP and making a new patient appointment.

11.E.4 Severe and Persistent Mental Illness (SPMI) (recommended page limit 6 pages)

11.E.4.a How will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

CHA receives and analyzes reports from APD, DHS, and our BH providers. These reports assist us in identifying areas where treatment and services can be improved in collaboration with these organizations.

CHA will continue to partner with KBBH and Klamath Health Partnership to support the newly created physical health/SPMI clinic.

11.E.4.b How will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services, Personal Care Services and Habilitation Services, in licensed and non-licensed home and Community-based settings, to ensure individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

CHA's goal is for members to receive care in the least restrictive environment possible, and preferably at an integrated community setting. All members in these settings will be case managed to assure that they are in an appropriate level of care and that their transitions are well coordinated. CHA will actively manage members in the above settings through collaborative relationships with the member's placement and/or as a direct participant on the member's care team. Discharge planning begins on the day of admission. CHA aims to have all necessary community resources, services, and supports arranged for and in place on the day of discharge to ensure a smooth transition.

In addition to managing members' individual care plans, CHA also works with community and regional partners to alleviate barriers to care. CHA's BH CM and Director of Quality Management attend quarterly Southern Oregon Regional Acute Care Council (SORACC) meetings, which address system-wide issues facing adults with SPMI, available resources, tools to stabilize transitions in addition to OSH placement and commitment updates. The BH CM also participates in the monthly BH Director's meetings. This meeting provides a venue for

discussion regarding OHA updates, CCO policies and procedures, BH integration and mental health parity.

CHA CMs attend multiple BH meetings within the community. This allows CHA to interface with multiple community partners, as well as agency representatives from DHS, DD Services, the Senior Center, KBBH, and LCS to address the unmet needs of the SPMI population. CHA CM uses the information from these meeting to update and modify members' care plan as needed with the goal being the best possible outcome for the member. CHA collaborates with local BH providers to provide oversight of care coordination for the mutual SPMI population served by both entities.

While attendance at meetings in and of themselves are not "effective" interventions, they do provide the opportunity for community stakeholders to share best practices, information, and problem solve system barriers that may be contributing to a member's unsuccessful achievement of their treatment goals. They also provide an opportunity for stakeholders to identify opportunities for improvement and work toward their resolution.

Through its ED Performance Improvement Project, CHA has convened a group of clinic administrators, providers, triage nurses, and ED personnel to pilot a project for monthly meetings of a "community care network" to review cases of the most challenging members. These meetings are designed to review the most difficult cases, resources needed against those available, and to address the barriers to care, including SDOH concerns, to problem-solve issues to prevent further ED utilization.

11.E.4.c How will Applicant ensure Members with SPMI receive ICC support in finding appropriate housing and receive coordination in addressing Member's housing needs?

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11.E.4.d How will Applicant assist Members with SPMI to obtain housing, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

CHA collaborates with community partners through the care planning process to ensure that members with SPMI who need housing receive the resources they need consistent with their treatment goals and choice. The member is actively involved with the care team to drive clinical decisions. The team strives to honor the member's housing choice to the extent possible based on availability as well as the member's clinical needs. As noted above, RTS and KBBH are key partners that assist both CHA and the member in exploring all possible housing options.

11.E.4.e How will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

All members identified as SPMI are eligible for ACT services. CHA collaborates with KBBH to provide ACT services to adult members with SPMI. These members are identified through their high ED utilization, multiple interactions with law enforcement, and through referrals from community partners. The ACT team is composed of CMs, care navigators, and therapists who deliver the appropriate services in the community. Services are provided in multiple locations including libraries, homeless shelters, and correctional facilities. We meet the members where they are to provide flexibility in treatment. ACT services do not require prior authorization which allows for timely access to the program.

11.E.4.f *How will Applicant determine (and report) whether ACT team denials are appropriate and responsible for inappropriate denials. If denial is appropriate for that particular team, but Member is still eligible for ACT, how will Applicant find or create another team to serve Member?*

No eligible member is denied ACT services. If a member declines ACT services, the treatment team will work with the member to create an alternative plan. CHA's BH CM collaborates with community providers to facilitate appropriate treatment planning for members who decline or do not meet qualifications for ACT.

11.E.4.g How will Applicant engage all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation as required by the Contract?

CHA partners with KBBH and LCS to engage all members who are eligible for the ACT program. As ACT is a voluntary program, members have the option to opt out. With the member's permission, the ACT team performs periodic outreach to those who decline services. Members mandated by the court to participate in ACT due to being civilly committed, on probation, involved in behavioral intervention court, or otherwise ordered to participate in assisted outpatient treatment cannot decline services.

***11.E.4.h How will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include Care* Coordination?**

CHA, in cooperation with KBBH and LCS CM teams, work with members who decline ACT services to assure their needs are met. KBBH is a Choice Model Agency; the care team works with members to facilitate a plan that best fits the member's unique needs and expectations. KBBH programs are evidence-based, innovative and their services are consumer driven. CHA will continue to collaborate with our BH providers to ensure the best possible services for our members.

11.E.4.i How will Applicant work with Secure Residential Treatment Facilities (SRTFs) to expeditiously move a civilly committed Member with SPMI, who no longer needs placement in an SRTF, to a placement in the most integrated Community setting appropriate for that person?

CHA partners with the treatment teams at SRTFs to ensure that placement is appropriate for the member. We do this through the utilization review process. SRTF staff provides the CHA BH CM with clinical updates every seven days. The BH CM reviews this information to ensure this treatment option is still the most appropriate and least restrictive. The BH CM coordinates discharge planning and ongoing care with the Exceptional Needs Care Coordinator (ENCC) at KBBH. The ENCC is kept up to date on member's medication changes and progress with stabilization. When the BH CM or the SRTF treatment team believes the member is appropriate for community placement, the ENCC will visit the member to assess their status. The ENCC, CHA staff, and SRTF staff work together to determine when it is safe for the member to discharge to a lower level of care.

11.E.4.j How will Applicant work with housing providers and housing authorities to assure sufficient supportive and Supported Housing and housing support services are available to Members with SPMI?

While we currently have several local resources to assist in locating housing for members with SPMI (KBBH, KLCAS, and RTS), CHA will be conducting a formal, community-wide Health Equity Assessment to better identify and define gaps in care, including housing. Through this assessment, community partners specific to housing will be identified, and CHA will cultivate those partnerships and develop strategies for improvement, to better meet the needs of our members, as well as the community at large. Safe, adequate and affordable housing is a County-wide concern identified through the process of developing the Community Health Assessment and will be addressed in either the CHP or the CAC CHIP.

11.E.4.k Provide details on how Applicant will ensure appropriate coverage of and service delivery for Members with SPMI in acute psychiatric care, an emergency department, and peer-directed services, in alignment with requirements in the Contract.

CHA provides for acute psychiatric care, typically out of the area, for those members with SPMI who meet the criteria for this level of services. Discharge planning begins on the day of

admission. The BH CM is notified of the admission and participates in the care planning process, along with the member's local treatment team, through the member's course of treatment. Acute care facilities send regular clinical updates to CHA and the local team. Our BH CM works closely with the facility to coordinate the member's care and to ensure the appropriate resources, services, and supports (including any SDOH needs) are in place prior to discharge. Members must be medically stable and have met the goals of their treatment plan upon transition to a lower level of care.

While the use of the ED is a covered benefit, CHA diligently educates its members on its appropriate use. CHA identifies members who have 2 or more ED visits in a six-month time frame through regular review of ED census reports as well as a daily review of Collective Medical by both the Quality Management Department and the BH CM. The BH CM reaches out to these members to triage and identify any unmet healthcare or SDOH needs leading to the frequent use of the ED. CHA will develop a more formal ED Management Plan in response to the new contract outlining specific intervention strategies for this population.

Members with SPMI can freely access covered ED services through our local community hospital or any other hospital. While the use of the ED is a covered benefit, CHA recognizes that ED use can indicate a failure to meet member's needs. CHA identifies members who have 2 or more ED visits in a six-month time frame through regular review of ED census reports as well as a daily review of Collective Medical by both the Quality Management Department and the BH CM. The BH CM reaches out to these SPMI members to identify any unmet healthcare or SDOH needs leading to use of the ED. CHA will develop a more formal ED Management Plan in response to the new contract outlining specific intervention strategies for this population.

Peer Delivered Services are provided through contracts with area providers and written into members' care plans based on a referral, need, and request by the member. CHA will continue to support and build this important service in our community.

11.E.5 Emergency Department (recommended page limit 2 pages)

11.E.5.a How will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an Emergency Department in a six-month period? The management plan must show how the Contractor plans to reduce admissions to Emergency Departments, reduce readmissions to Emergency Departments, reduce the length of time Members spend in Emergency Departments, and ensure adults with SPMI have appropriate connection to Community-based services after leaving an Emergency Department and will have a follow-up visit within three days.

CHA is currently conducting a formal PIP, along with technical assistance through OHA, on the reduction of inappropriate ED utilization by all populations, including members with SPMI. Participants in this project include local providers, triage nurses, clinic administrators, BH direct care staff (Mobile Crisis Team staff), SUD providers, CHA CMs, and BH program administrators. At this time, the ED notifies CHA via direct contact as well as through Collective

Medical when members have utilized the ED. The CHA BH CM receives notification daily of ED utilization of all populations, reviews use, and follows up as necessary.

At this writing, the ED PIP is piloting two key projects, identified through an Impact Effort Matrix, both of which are in their infant stages. The first project is to convene a group comprised of all area case/care managers which will be dedicated to sharing best practices in case management, success stories, and seeking technical assistance from participants on difficult cases. The second project comprises stakeholder leaders who hold the authority to commit their respective agencies to supplying additional resources to solve over-utilization challenges on a case by case basis.

From this PIP, the community will be identifying and developing its management plan and subsequent policies and procedures for managing members with two or more ED visits in a six-month time-frame. Our local hospital recently conducted its own Quality by Design project to lower the "door to doc" time in the ED. The wait time in the ED is below an average of 20 minutes. KBBH provides emergency BH services to the community through a crisis line and mobile crisis team which allows members to speak with a therapist 24/7. The round-the-clock access prevents members from utilizing the ED if their BH concern can be successfully addressed. The mobile crisis team reaches members at the homeless shelter, library, correctional facility, or school. Additionally, RTS routinely collaborates with outlying areas' emergency responders in proactively triaging calls to prevent unnecessary transport to the ED.

At this time, Collective Medical is not in wide-spread use in the community, but is supported by CHA, and is being widely encouraged through the ED PIP as well as other provider engagement venues. Through the ED PIP, CHA is problem-solving barriers to its widespread use to further identify frequent ED utilizers and proactively address treatment concerns to prevent further ED non-emergent ED utilization.

11.E.6 Oregon State Hospital (recommended page limit 1 page)

11.E.6.a How will Applicant coordinate with system partners as needed regarding OSH discharges for all adult Members with SPMI?

CHA collaborates with local and statewide agencies to promote appropriate discharge planning for adults with SPMI. When members are hospitalized, the BH CM monitors their care by direct contact with provider care teams. At CHA, discharge planning begins at the time of admission, and members are followed from the date of admission to discharge. The facility notifies CHA of admission and CHA requires regular clinical updates to the BH CM. The BH CM works closely with KBBH staff to facilitate appropriate follow-up care. When the member is discharged, their local treatment team is notified to ensure follow-up within seven days can be achieved. The BH CM reaches out to the member and/or treatment team to offer additional services as needed. CHA also coordinates with community-based organizations to address SDOH needs.

11.E.6.b How will Applicant coordinate care for Members receiving Behavioral Health treatment while admitted to the State Hospital during discharge planning for the return to Applicant's Service Area when the Member has been deemed ready to transition?

At CHA, discharge planning begins on the day of admission and is driven by the patient and/or the patient's representative as appropriate. The BH CM is notified of the admission and participates in the care planning process, along with the member's local treatment team, through the member's course of treatment. OSH sends regular clinical updates to CHA and the local team. Our BH CM works closely with OSH to coordinate the member's care and to ensure the appropriate resources, services, and supports (including any SDOH needs) are in place at the time of discharge. Members must be medically stable and have met the goals of their treatment plan upon transition to a lower level of care.

11.E.7 Supported Employment Services (recommended page limit 1 page)

11.E.7.a How will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295?

CHA supports our BH providers who offer supported employment services for members to remove barriers and find a sense of purpose through meaningful work. Members with a BH diagnosis and a desire to work are eligible for this service. Members are not excluded or disqualified due to missed appointments or positive drug screens. Providers work closely with local employers who hire members involved in the supported employment program by building opportunities to accommodate many different interests and skill sets.

11.E.8 Children's System of Care (recommended page limit 2 pages)
Applicant will fully implement System of Care (SOC) for the children's system. Child-serving systems and agencies collaborating in the SOC are working together for the benefit of children and families.
11.E.8.a What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?

CHA will capitalize on its partnerships with community stakeholders to support the development of a fully implemented System of Care in Klamath County. The System will be designed to ensure that the needs of youth and families who are involved in or at risk of becoming involved in multiple systems can access the resources they need to prevent further system involvement, preserve the family and prevent out-of-home placement, and promote emotional, social and physical well-being. Partnerships with the key "system builders" currently exist, but will be formally systematized through charters, by-laws, and meeting minutes. CHA will look to other CCOs and/or Counties who have successfully implemented the full System of Care model for technical assistance and best practice. The "Core Four" entities of the Community Health Assessment (Klamath County Public Health, SLMC, CHA, and Klamath Health Partnership) will be instrumental to the success and sustainability of the System of Care in Klamath County and are committed to this process.

11.E.8.b Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

Klamath County has a successful practice level workgroup which meets following the weekly Wraparound review meetings and addresses concerns that surface during Wrap meetings. Concerns and/or barriers to services that cannot be resolved at the practice level will be referred to the Advisory Council using the process outlined in the Council's charter. The Committee is comprised of those in attendance at weekly Community Resource Team (CRT) meetings to problem-solve the needs of our most vulnerable youth and families. Membership includes CHA, Intellectual/ Developmental Disabilities (I/DD) Services, Juvenile Justice, BH providers, Child Welfare (DHS), and public schools.

The newly formed Advisory Council consists of supervisors and/or managers of the agencies represented on the CRT and therefore has the same collection of diverse perspectives and resources. The Advisory Council will review and allocate agency resources to resolve concerns or remove barriers to care that could not be solved at the practice level. The Council will determine its processes and procedures for resource allocation as it develops its charter and by-laws.

An Executive Council will be created in collaboration with executive level leadership from community stakeholders and tasked with effecting system change in Klamath County. CHA will facilitate its formation, including the development of a charter and by-laws.

11.E.8.c How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?

CHA is part of the steering committee of the SOC. Each level of the System of Care will be expected to keep minutes of its meetings to include resources requested, issues discussed, and actions taken. Currently, the Site Lead for Klamath County Wraparound maintains a list of issues discussed at the practice level workgroup including action taken. Items that cannot be resolved are referred to the Advisory Council for consideration. Issues that involve system change or the allocation of resources outside the established budget of a System partner will be referred to the Executive Council.

11.E.8.d What strategies will Applicant employ to ensure that the above governance groups are comprised of youth, families, DHS (Child Welfare, I/DD), special education, juvenile justice, Oregon Youth Authority, Behavioral Health, and youth and Family voice representation at a level of at least 51 percent?

CHA is fortunate to be in Klamath County where strong partnerships exist between multiple agencies and organizations that support youth and families and are committed to their success. The agencies listed above are already invested in this work. CHA fosters these relationships and their continued participation. CHA will leverage its CAC in recruiting youth and family representation on all levels of the System of Care, as well as publicize this opportunity on its website and through communications with members. We will explore utilizing the provision of transportation, gift cards, meals, and other avenues to encourage youth and family engagement. CHA will support other committee participants in their efforts to enlist youth and family participation to reach the 51% threshold.

11.E.9 Wraparound Services (recommended page limit 4 pages)
Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

11.E.9.a Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

When a youth has been in Wraparound for at least six months, they are offered the WFI-EZ survey which allows them to review their progress in Wrap and assess their provider's fidelity in administering Wraparound. The youths' ongoing feedback regarding the program's principles and strategies is important to the success of the individual, the family, and the program. These surveys will inform the SOC Advisory Council as to barriers that exist in community partnerships, collaboration efforts, access to care, and continued support. CHA's BH CM will ensure the surveys use during routine provider audits.

11.E.9.b *How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?*

The WFI-EZ data and analysis will be presented as a standing agenda item to the SOC Advisory Council on a regular basis.

11.E.9.c How does Applicant plan to receive a minimum of 35 percent response rate from youth?

CHA partners with KBBH and LCS to complete the WFI-EZ survey. The Wrap team has found that youth are not comfortable answering questions about this service when asked by the provider delivering the services. This has led to a low response rate. The Wrap team has developed a strategy moving forward whereby the supervisors at KBBH and LCS will contact the youth to complete the surveys. We anticipate this will improve the response rate to at least 35 percent. CHA will monitor the response rate and adjust our strategy as necessary.

11.E.9.d How will Applicant's Wraparound policy address:
11.E.9.d.1 How Wraparound services are implemented and monitored by Providers?

CHA currently collaborates with KBBH and LCS to implement Wraparound in Klamath County. As part of this collaboration, the Wrap Review Committee monitors the implementation of services by providers.

11.E.9.d.2 How Applicant will ensure Wraparound services are provided to Members in need, through Applicant's Providers?

Once we identify members who need Wraparound services, CHA collaborates with KBBH and LCS to implement Wraparound services. As part of our provider training, CHA educates local providers about Wraparound Services.

11.E.9.e Describe Applicant's plan for serving all eligible youth in Wraparound services so that no youth is placed on a waitlist. Describe Applicant's strategy to ensure there is no waitlist for youth who meet criteria.

Youth meeting the eligibility requirements will not be denied this service. The team does not maintain a waitlist. Should the need for a waitlist occur, CHA will develop a strategy to increase access.

***11.E.9.f* Describe Applicant's strategy to ensure that Applicant has the ability to implement Wraparound services to fidelity. This includes ensuring access to Family and youth Peer support and that designated roles are held by separate professionals as indicated (for example: Wraparound coaches and Wraparound supervisors are filled by two different individuals).**

Implementation to fidelity has been achieved already. CHA will ensure this continues through review and analysis of WFI-EZ data, member interviews, participation at Wrap review committees, participation in the practice level workgroup, and by facilitating the SOC Advisory Council. These meetings, interviews, and surveys provide information for an ongoing conversation around expectations for service delivery. Team roles are individually defined in our Wraparound policy.

CASCADE COMPREHENSIVE CARE, INC. & SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS

DECEMBER 31, 2015 AND 2014

MSP CERTIFIED PUBLIC ACCOUNTANTS

Cascade Comprehensive Care, Inc. & Subsidiary
Index to Consolidated Financial Statements
December 31, 2015

MSP CERTIFIED PUBLIC ACCOUNTANTS

A1214-21655-6

Independent Auditors' Report

The Board of Directors
Cascade Comprehensive Care, Inc. & Subsidiary

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Cascade Comprehensive Care, Inc. and its subsidiary which comprise the consolidated balance sheets as of December 31, 2015 and 2014 and the related consolidated statements of income, changes in stockholders' equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Cascade Comprehensive Care, Inc. and its subsidiary as of December 31, 2015 and 2014, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

MSP CERTIFIED PUBLIC ACCOUNTANTS

Other Matter

Our audits were conducted for the purpose of forming an opinion on the basic financial statements as a whole. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the basic financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

Molatore, Scroggin, Peterson & Co LLP
Certified Public Accountants

Klamath Falls, Oregon
June 22, 2016

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Balance Sheets
December 31, 2015

Assets

	2015	2014
Current Assets		
Cash and cash equivalents	$ 25,255,176	$ 15,396,727
Short term investments	1,937,438	2,048,125
Receivables	2,054,246	2,782,671
Inventory	11,950	23,413
Prepaid expenses	200,935	42,788
Total Current Assets	29,459,745	20,293,724
Fixed Assets		
Property and equipment, net	283,935	155,114
Other Assets		
Investments	9,632,220	8,227,137
Restricted statutory reserve	2,817,866	1,412,857
Deferred tax asset-long term	40,000	16,020
Organizational fees, net	1,494	1,494
Fees not amortized	68,412	68,412
Goodwill	126,328	126,328
Total Other Assets	12,686,320	9,852,248
Total Assets	$ 42,430,000	$ 30,301,086

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Balance Sheets
December 31, 2015

Liabilities and Stockholder's Equity

	2015	2014
Current Liabilities		
Accounts payable	1,421,223	36,979
Income taxes payable	328,000	864,611
Accrued expenses	1,640,774	1,342,340
Withheld payable	2,856,508	2,214,092
Claims payable	10,378,422	5,592,994
Risk pool payable	12,639,495	10,030,348
Total Current Liabilities	29,264,422	20,081,364
Long-term Liabilities		
Deferred tax liability	29,000	47,000
Total Long-term Liabilities	29,000	47,000
Total Liabilities	29,293,422	20,128,364
Stockholder's Equity		
Class A common stock, $1,000 par value, 500 shares authorized, 16 shares issued and outstanding	16,000	4,104
Class B common stock, $1,000 par value, 500 shares authorized, 29 shares issued and outstanding	29,000	30,000
Class C common stock, $1,000 par value, 500 shares authorized, 1 share issued and outstanding	1,000	1,000
Class D non-voting common stock, no par value, 9,954 shares authorized, 9,954 shares issued and outstanding	1,333,298	92,430
Additional paid in capital	429,638	448,246
Retained earnings	11,327,642	9,596,942
Total Stockholder's Equity	13,136,578	10,172,722
Total Liabilities and Stockholder's Equity	$ 42,430,000	$ 30,301,086

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Income
For the Years Ended December 31, 2015

	2015	2014
Revenue		
Contract revenue	$ 91,695,177	$ 56,719,155
HRA plan	(13,342,175)	(9,108,217)
Stoploss recoveries	238,761	168,867
Transformation grant revenue	-	927,465
Total Revenue	78,591,763	48,707,270
Operating Expenses		
Claim and capitation expense	69,673,997	41,081,077
ATRIO medical pool surplus and provider bonus	-	731
Stoploss Insurance	969,850	689,435
Salaries and benefits	3,496,971	2,492,667
Administrative expenses	1,918,473	2,360,296
Total Operating Expenses	76,059,291	46,624,206
Total Operating Income	2,532,472	2,083,064
Other Income (Expense)		
Net Equity Gain/(Loss) in ATRIO Health Plans and Klamath Medical Business Center	1,405,083	762,238
ATRIO Income	730,135	705,087
ATRIO Medical Incentive Pool	281,136	209,642
Realized Gain/(Loss) on sale of bonds	(7,920)	(832)
Unrealized Gain/(Loss) on bonds	(270,290)	(64,305)
Lease and other income	9,045	72,700
Investment income	100,000	60,000
Investment expense	(10,902)	(14,682)
Interest Income	156,885	60,625
Interest expense	(365)	(91)
Total Other Income (Expense)	2,392,807	1,790,382
Net Income Before Income Tax Provision	4,925,279	3,873,446
Income Tax Provision	(1,546,884)	(1,293,800)
Net Income	$ 3,378,395	$ 2,579,646

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Changes in Stockholders' Equity
For the Years Ended December 31, 2015

	Common Stock		Additional Paid-In	Retained	
	Shares	Amount	Capital	Earnings	Total
Beginning Balance January 1, 2014	10,159	$ 130,671	$ 445,664	$ 7,217,322	$ 7,793,657
					-
					-
Stock issuance	336	5,000	251,708	-	256,708
Stock redemption	(345)	(8,137)	(249,126)	-	(257,263)
Dividends	-	-	-	(200,026)	(200,026)
Net income	-	-	-	2,579,646	2,579,646
Ending Balance December 31, 2014 as orginally stated	10,150	127,534	448,246	9,596,942	10,172,722
Ending Balance December 31, 2014 as restated (See Note 15)	10,150	1,388,178	429,638	8,354,906	10,172,722
Stock issuance	12	9,120	-	-	9,120
Stock Redemption	(162)	(18,000)	-	(105,600)	(123,600)
Dividends	-	-	-	(300,059)	(300,059)
Net income	-	-	-	3,378,395	3,378,395
Ending Balance December 31, 2015	10,000	$ 1,379,298	$ 429,638	$ 11,327,642	$ 13,136,578

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Cash Flows
For the Years Ended December 31, 2015

	2015	2014
Cash Flows From Operating Activities		
Net income	$ 3,378,395	$ 2,579,646
Adjustments to reconcile net income (loss)		
to net cash provided (used) by operating activities		
Depreciation and amortization	74,567	83,936
Net equity income in ATRIO Health Plans and		
Klamath Medical Business Center	(1,405,083)	(762,238)
(Increase) decrease in:		
Accounts receivable	728,425	(828,121)
Prepaid assets	(158,147)	29,233
Inventory	11,463	(16,590)
Deferred tax asset	(23,980)	30,980
Restricted reserve	(1,405,009)	2,780
Increase (decrease) in:		
Accounts payable	1,384,244	(221,812)
Income taxes payable	(536,611)	864,611
Accrued liabilities	298,434	1,861,375
Withheld payables	642,416	40,181
Claims and risk payables	7,394,575	6,905,375
Deferred tax liability	(18,000)	(13,000)
Net Cash Provided/(Used) by Operating Activities	10,365,689	10,556,356
Cash Flows From Investing Activities		
Purchase of short term investments	110,687	(390,810)
Purchases of fixed assets	(203,388)	(23,627)
Net Cash (Used) by Investing Activities	(92,701)	(414,437)
Cash Flows From Financing Activities		
Dividends paid	(300,059)	(200,026)
Retirement of common stock	(123,600)	(257,263)
Issuance of common stock	9,120	256,708
Net Cash (Used) by Financing Activities	(414,539)	(200,581)
Net increase/(decrease) in cash and cash equivalents	9,858,449	9,941,338
Cash and cash equivalents at beginning of year	15,396,727	5,455,389
Cash and cash equivalents at end of year	$ 25,255,176	$ 15,396,727

The notes to the financial statements are an integral part of these financial statements

Note 1 – Nature of Activities and Summary of Significant Accounting Policies

Nature of Activities

Cascade Comprehensive Care, Inc. (the Company), successor to Klamath Comprehensive, Inc., was organized under the State of Oregon and started operations January, 1996. The Company is currently under contract (the Contract) with the State of Oregon, Oregon Health Athority, and the Division of Medical Assistance Programs (DMAP) to provide prepaid health services to Klamath County, Oregon as a fully capitated health plan. The Contract is funded by the State of Oregon and is reviewed and renewed annually. If the contract were not renewed or discontinued, it would materially affect the financial position of the Company. As of December 31, 2015, the Contract has been renewed for an additional year.

Cascade Health Alliance, LLC was formed in 2012 as a wholly own subsidiary by Cascade Comprehensive Care as a Coordinated Care Organization (CCO) for most Klamath County Medicaid residents and is certified by the State of Oregon.

On May 19, 2013 a memorandum of understanding was signed between Klamath County and Cascade Health Alliance regarding the provision of the mental health safety net. The Oregon Health Authority approved a CCO start date of September 1, 2013. With the announcement by the county in June 2013 that they would be closing the County Mental Health Department on June 30, 2013, CCC obtained contracts with the private mental health providers in order to have a sufficient mental health provider panel.

Principles of Consolidation

The accompanying financial statements include the accounts of Cascade Comprehensive Care and its wholly-owned subsidiary, Cascade Health Alliance, LLC.

All significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Material estimates that are particularly susceptible to significant change in the near term are related to the determination of withheld payables and claims payable. In connection with the determination of the incurred but not reported claims, the Company obtains an independent actuarial review of historical claim expenses.

Fair Value of Financial Instruments

Fair value guidance (GAAP) requires the reporting of fair value for assets and liabilities. For financial instruments, including cash, short term investments, receivables, payables, and accruals, the carrying amount approximates fair value because of their short maturity.

Cash

Cash and cash equivalents include cash on hand, cash in banks, and cash in a brokerage account. The Company regularly maintains cash balances in financial institutions in excess of the Federal Deposit Insurance Corporation's limit. These cash balances are subject to credit loss in the event of nonperformance by the bank. The Company has not incurred any losses in any of these accounts to date.

Short Term Investments

The Company maintains a brokerage account which invests in various short term debt securities. These securities are carried at fair value which approximates cost.

Equity Investments

Investments in which the Company has a 20% to 50% interest or otherwise exercises significant influence are carried at cost adjusted for the Company’s proportionate share of their undistributed earnings or losses.

Capitation Income

Capitation payments received under the Contract are recognized in the month in which the Company is obligated to provide care. During 2015 and 2014, approximately 95% and 99%, respectively, of operating revenues were generated from the Contract. As part of a risk-sharing incentive program, the Company also retains up to 15% of the interim payments of certain contractual providers

Note 1 – Nature of Activities and Summary of Significant Accounting Policies *(continued)*

against a risk-sharing fund. In the event of utilization in excess of budget, those providers bear the risk to the extent of the 15% of the fee-for-service fees.

Accounts Receivable
Accounts receivable consist primarily of the Maternity Case Rate Receivable, stop-loss recoveries receivable, and amounts due from ATRIO Health Plans, a related party. Risk of credit loss is negligible, therefore no allowance for doubtful accounts is provided. Due to the nature of the accounts receivable, the Company requires no collateral, has no policy for writing off bad debts, and does not charge interest on accounts receivable.

Inventory
Inventory is valued at the lower of cost or market.

Fixed Assets
Fixed assets are recorded at cost. Depreciation of fixed assets is provided using straight line methods over the estimated useful lives of the assets, ranging from five to twenty years. Depreciation expense for December 31, 2015 and 2014 was $74,567 and $83,936, respectively.

Maintenance and repairs of property and equipment are charged to operations, and major improvements are capitalized. Upon retirement, sale or other disposition of property and equipment, the cost and accumulated depreciation are eliminated from the accounts, and a gain or loss is included in operations.

Goodwill and Intangible Assets
The Company assesses goodwill for impairment annually. Impairment loss on goodwill is not recognized unless there is evidence of impairment based on the cash flows of the Company.

Health Care Service Cost Recognition
The Company contracts with various health care providers for the provision of certain health care services to its members. The Company compensates some of its providers on a capitation basis while other providers share the risk as outlined under Capitation Income. Operating expenses include all amounts incurred by the Company under the aforementioned contracts.

The cost of other health care services provided or contracted for includes losses paid during the period and the changes in the liability for unpaid losses and loss adjustment expenses. The reserves for losses and loss adjustment expenses include amounts estimated to settle individual claims that have been reported to the Company and additional amounts, determined based on actuarial assumptions, for losses incurred but not reported. The Company does not discount these reserves. Such liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate cost to settle the incurred losses may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed as the history of the Company grows, and any adjustments are reflected in earnings currently.

Accrued Medical Incentive Pool
Accrued medical incentive pool represents certain health care claims payables, which were withheld from providers during 2015 and 2014 and the provider incentive accrual. Payments from the incentive pool reserve may be limited by payment of health care costs to providers in excess of the agreed-upon medical target loss ratio as stipulated in the participating provider's contract. As part of a risk-sharing incentive program, the Company retains up to 15% of the interim payments of certain contractual providers against a risk-sharing fund. In the event of utilization in excess of budget, those providers bear the risk to the extent of the 15% of the fee-for-service fees.

Income Taxes
The income tax returns are based on calculations and assumptions that are subject to examination by various tax authorities. As reflected in the accompanying financial statements, the Company is recognizing its portion of deferred tax assets and liabilities. In accordance with FASB guidance, the Company records income taxes using an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been recognized in the Company's financial statements or tax returns. A valuation allowance is established when it is more likely than not that a deferred tax asset is not realizable in the foreseeable future. Tax assets are reviewed regularly for recoverability. Current income taxes are based upon the Company's current income and the current tax rate.

Note 1 – Nature of Activities and Summary of Significant Accounting Policies *(continued)*

Deferred income taxes result from temporary differences between the tax basis of assets and liabilities and their reported amounts in the financial statements. The principal difference arises primarily from compensated absences, amortization of intangibles, and depreciation methods. The change in the amount of deferred income taxes is recorded as a credit or debit to income currently. The Company's policy for accounting for interest and penalties is to include interest in interest expense and penalties under non-deductible expenses, both as an integral part of the income statement presentation. The Company believes that it has appropriate support for any tax positions taken, and as such, does not have any uncertain positions that are material to the financial statements. The Company's income tax returns are subject to examination by federal and state taxing authorities, generally for three years after they are filed.

Advertising
All costs of advertising of the Company's services are charged to expense as incurred and totaled $5,621 and $11,810 for 2015 and 2014, respectively.

Compensated Absences
The Company accrues vacation, holiday, and sick leave benefits. Accrued leave was $69,322 and $50,804 for the years ended December 31, 2015 and 2014, respectively. These amounts are included in accrued expenses on the balance sheet. The Company also has a long-term sick leave policy. This policy allows full-time employees to earn up to five days a year for personal illness, or to tend to a serious illness suffered by a family member. The total maximum number of days that can be accrued is 46 to 66 based on years of employment.

Note 2 – Investments

KMBC, LLC
In 2004, the Company acquired one-half interest in KMBC, LLC for $656,197. The other half is owned by Sky Lakes Medical Center. The equity method of accounting was adopted for this investment. Equity investment income (loss) of $(18,173) and $29,575 was recognized in 2015 and 2014, respectively.

ATRIO Health Plans, Inc.
ATRIO Health Plans, Inc. (ATRIO) is a Medicare Advantage Plan provider, which has also contracted with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare claims service in various counties in Oregon. The Company has owned an equity investment in ATRIO since its inception in 2004.

In 2011, the Company recapitalized its investment in ATRIO and purchased additional common stock in the amount of $2,001,000. In 2015 and 2014, a net increase in equity was recognized of $1,423,256 and $875,850, respectively.

The total cost of the Company's investment at December 31, 2015 and 2014 was $3,703,384.

There is no market for the common stock of ATRIO Health Plans, Inc. or any reasonable method for estimating the value of KMBC, LLC, and, accordingly, no quoted market prices are available. ATRIO Health Plans, Inc. is presented on the statutory basis of accounting which differs from generally accepted accounting principles. The impact of on the following table has not been determined. Following is a summary of financial position and results of operations of ATRIO Health Plans, Inc. and KMBC, LLC:

	2015	2014
Other assets	$ 46,261,299	$ 40,350,892
Property and equipment, net	1,341,384	1,121,731
Total assets	$ 47,602,683	$ 41,472,623
Liabilities	18,363,219	16,980,752
Stockholders' equity	29,239,464	24,491,871
Total liabilities and stockholders' equity	$ 47,602,683	$ 41,472,623
Sales	$ 148,365,651	$ 148,388,721
Net income	$ 2,692,750	$ 2,706,484

Note 2 – Investments *(continued)*

Statutory Reserve
Under the OMAP contract, the Company must establish restricted reserve funds to cover fee-for-service liabilities that would need to be covered in the event of insolvency. The reserve fund is required to be held by a third party. The Company maintained a primary restricted reserve in the amount of $396,139 for 2015 and $397,094 for 2014.

The Company is required to establish a secondary restricted reserve to cover additional State reserve requirements. This fund is held by a third party. This reserve is adjusted quarterly by an amount equal to 50 percent of the difference between the Company's average monthly fee-for-service liabilities and $250,000. At December 31, 2015 and 2014, the secondary reserve was $2,421,727 and $1,015,762, respectively.

Investment income from cash, cash equivalents, and short term investments was $17,259 for 2015 and $19,434 for 2014.

Note 3 – Accounts Receivable

Accounts receivable at December 31 consist of the following:

	2015	2014
Maternity case rate receivable	$ 409,606	$ 456,030
Stop-loss recoveries receivable	226,857	39,323
Notes Receivable	163,476	169,201
ATRIO risk settlement receivable	1,102,067	1,970,183
ATRIO receivable	119,094	110,727
Purchased Int Receivable - Bonds	33,269	27,357
Miscellaneous receivables	(124)	9,850
Total	$ 2,054,245	$ 2,782,671

Note 4 – Fixed Assets

Fixed assets at December 31 consist of the following:

	2015	2014
Office equipment	$ 475,511	$ 541,100
EZ Cap software and equipment	206,150	206,150
Electronic claims inload	115,903	48,130
Leasehold improvements	169,086	169,086
Less accumulated depreciation	(682,715)	(809,352)
Total	$ 283,935	$ 155,114

Note 5 – Withhold Payables

The Company and providers have entered into risk/incentive sharing agreements. Generally, under the terms of the agreement, 15% of fee-for-service payments are withheld. Based upon actual medical expenses compared to predetermined criteria, the amount withheld is either increased or decreased and paid annually to the provider. The amounts are as follows:

	2015	2014
Withhold payable	$ 2,856,508	$ 2,214,092
Risk pool payable	12,639,495	10,030,348
Total	$ 15,496,003	$ 12,244,440

Note 6 – Claims Payable and IBNR

Claims incurred represent capitation and non-capitation payments to providers for services rendered during the year. The claims payable liability is based on actuarial estimates related to the nature and volume of work performed by non-capitated providers. This estimated liability is evaluated annually by management in order to maintain it at a level that is sufficient to absorb probable incurred but not reported claims. Management's evaluation of the adequacy of the estimate is based on an annual actuarial review of historical claim experience.

Note 7 – Stop-Loss Insurance

The Company has a stop-loss insurance agreement with an insurance company to limit its losses on hospital inpatient and outpatient service claims and professional services. For hospital inpatient and outpatient services and for professional services, the terms of this agreement state the Company's retention per member per policy year for 2015 and 2014 is $225,000 and $200,000, respectively. The maximum amount payable by the insurance company per member per policy year for hospital and professional services combined is $2,000,000. There is no annual lifetime maximum. The coinsurance is 90% based on 100% of contract provider rates, subject to limitations.

Stop-loss insurance expense was as follows at December 31,

	2015	2014
Stoploss insurance premium expense	$ 969,850	$ 689,435
Stoploss recovery revenue	(238,761)	(168,867)
Net (Income) Expense	$ 731,089	$ 520,568

Note 8 – Profit Sharing Plan

The Company has a 401(k) profit sharing plan. All employees who are at least 21 years of age and have completed one year of employment are eligible to participate in the Company's plan. The 401(k) plan provides for contributions by the Company in such amounts as management may determine. In 2015 and 2014, the Company had 46 and 34, respectively, eligible employees participating in the plan. For years 2015 and 2014, the employer contribution was 5% of qualified compensation. The expenses charged to operations for December 31, 2015 and 2014, were $71,256 and $61,168, respectively.

Note 9 – Income Taxes

The provision (benefit) for income taxes consists of the following at December 31:

	2015	2014
Current tax expense		
Federal	$ 1,244,000	$ 1,040,000
State	285,300	242,800
Total current tax expense	1,529,300	1,282,800
Deferred tax expense (benefit)		
Federal	16,160	21,000
State	1,424	3,000
Total deferred tax expense	17,584	24,000
Total provision for income taxes	$ 1,546,884	$ 1,306,800

Deferred income taxes are provided for the temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities. The major differences that give rise to the deferred tax liabilities and assets are depreciation, amortization, and unpaid compensated absences. It is reasonably certain that all deductible temporary differences will reverse in future years; therefore, no valuation allowance is needed.

Note 9 – Income Taxes *(contined)*

These amounts have been presented in the Company's financial statements at December 31, as follows:

	2015	2014
Noncurrent deferred tax asset	40,000	16,020
Noncurrent deferred tax liability	(29,000)	(47,000)

Note 10 – Stockholders' Equity

The four classes of common stock are differentiated by ownership. Class A shares are owned by primary care physicians. Class B shares are owned by specialists. Class C shares are hospital-owned. Class D share ownership is at the discretion of the Board of Directors.

On February 23, 2012, the Company's board of directors declared a five-for-one stock split on the shares of the Company's class D, no par value, common stock. Each shareholder of record on February 23, 2012, received four additional shares of class D common stock for each share of class D common stock then held. The stock was issued June 29, 2012. All references in the financial statements to the number of shares outstanding of the Company's Class D common stock have been restated to reflect the effect of the stock split for all periods presented.

Entities under contract with the Oregon Department of Human Resources, Division of Medical Assistance Programs (DMAP), are required to maintain a level of net worth that will provide for minimum adequate operating capital. The minimum level of net worth is a calculation of Discounted Premium Revenue to Net Worth. This ratio must be less than or equal to 20:1.

At December 31, 2015, the Company met the requirement, as calculated by DMAP, of $2,872,054.

Note 11 – Supplemental Cash Flow Disclosures

Cash paid for income taxes, (net of refunds) in 2015 and 2014 amounted to $1,206,543 and $411,209 respectively.

Cash paid for interest in 2015 and 2014 amounted to $365 and $92, respectively.

Note 12 – Related Party Transactions

The Company has stockholders who are also providers who receive payments for services rendered. Compensation to board members consisted of $264,700 in 2015 and $306,000 in 2014. Members of management of Sky Lakes Medical Center (SLMC) are on the board of the Company. SLMC is the primary hospital in the Company's service area and owns approximately 35% of the Company. The following summarizes amounts paid to SLMC:

	2015	2014
Claims	$ 14,926,644	$ 8,966,381
Capitation	2,506,761	1,299,360
Other provider payments	311,131	219,251
Total	$ 17,744,536	$ 10,484,992

Claims payable to SLMC were $2,001,885 for 2015 and $613,781 for 2014.

The building occupied by the Company is owned by KMBC, LLC and the Company owns a one half interest in the LLC. The base rent is calculated on the fair market value of the square footage occupied by the Company, plus additional rent (utilities, etc.) and other common expenses incurred. Rental expenses for the years ended December 31, 2015 and 2014 are $175,479 and $172,256, respectively. The lease terminated in November 2009 and turned into month-to-month rent through December 2015.

Note 13 – Concentration of Risks

Substantially all of the Company's business activities are with members in Klamath County.

As stated in Note 1, the Company is under contract with DMAP. Premium revenue represented 98% of total revenues for 2015 and 98% for 2014.

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash deposits. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to certain limits. At December 31, 2015 and 2014, the Company had approximately $24,505,176 and $14,196,272 in excess of FDIC insured limits, respectively. The Company has experienced no losses on those accounts.

Note 14 – Commitments and Contingencies

The Company is party to legal proceedings incidental to its business. Although such litigation sometimes includes substantial demands for compensatory and punitive damages, in addition to contract liability, it is management's opinion that damages arising from such demands will not be material to the Company's financial position.

Note 15 – Error Correction

The par value and retained earnings were misstated due an error in a prior period. Retained earnings decreased by $1,354,636 and par value increased by $1,354,636. The error had no effect on net income for 2015.

Note 16 – Subsequent Events

The Company evaluated other subsequent events through June 22, 2016, the date these financial statements were available to be issued.

OTHER SUPPLEMENTARY INFORMATION

Cascade Health Alliance, LLC
Schedule of Assets, Liabilities and Equity
For the Year Ended December 31, 2015

Assets

	2015	2014
Current Assets		
Cash and cash equivalents	$ 26,052,117	12,574,713
Receivables	636,463	495,352
Inventory	11,950	23,413
Recevable from affiliate	3,801,315	5,758,857
Total Current Assets	30,501,845	18,852,335
Other Assets		
Restricted statutory reserve	2,817,866	1,412,857
Total Other Assets	2,817,866	1,412,857
Total Assets	$ 33,319,711	$ 20,265,192

Liabilities and Members' Equity

	2015	2014
Current Liabilities		
Accounts payable	1,599,679	-
Accrued expenses	1,284,757	875,727
Withheld payable	2,856,508	2,214,092
Claims payable	10,378,422	5,592,994
Risk pool payable	11,680,697	8,174,971
Total Current Liabilities	27,800,063	16,857,784
Total Liabilities	27,800,063	16,857,784
Members' Equity		
Members' Equity	5,519,648	3,407,408
Total Members' Equity	5,519,648	3,407,408
Total Liabilities and Members' Equity	$ 33,319,711	$ 20,265,192

Cascade Health Alliance, LLC
Schedule of Operations
For the Year Ended December 31, 2015

	2015	2014
Revenue		
Contract revenue	91,695,177	56,719,155
HRA plan	(13,342,175)	(9,108,217)
Stoploss recoveries	238,761	168,867
Transformation grant revenue	-	927,465
Total Revenue	78,591,763	48,707,270
Operating Expenses		
Claim and capitation expense	69,668,797	41,087,512
Stoploss Insurance	969,850	689,435
Administrative expenses	4,399,881	4,862,034
Total Operating Expenses	75,038,528	46,638,981
Total Operating Income	3,553,235	2,068,289
Other Income (Expense)		
Lease and other income	4,528	10,487
Total Other Income (Expense)	4,528	10,487
Net Income Before Income Tax Provision	3,557,763	2,078,776
Income Tax Provision	(1,445,524)	(832,007)
Net Income	$ 2,112,239	$ 1,246,769

Cascade Health Alliance, LLC
Schedule of Cash Flows
For the Year Ended December 31, 2015

	2015	2014
Cash Flows From Operating Activities		
Net income	$ 2,112,239	$ 1,246,769
Adjustments to reconcile net income (loss)		
to net cash provided (used) by operating activities		
(Increase) decrease in:		
Accounts receivable	(141,110)	548,024
Due from Affiliates	1,957,542	(4,756,733)
Prepaid assets	-	189,302
Inventory	11,463	(16,590)
Restricted reserve	(1,405,009)	2,780
Increase (decrease) in:		
Accounts payable	1,599,679	345,501
Accrued liabilities	1,051,446	8,720,166
Claims and risk payables	8,291,154	1,488,816
Net Cash Provided/(Used) by Operating Activities	13,477,404	7,768,035
Net increase/(decrease) in cash and cash equivalents	13,477,404	7,768,035
Cash and cash equivalents at beginning of year	12,574,713	4,806,678
Cash and cash equivalents at end of year	$ 26,052,117	$ 12,574,713

CASCADE COMPREHENSIVE CARE, INC. & SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS

DECEMBER 31, 2016 AND 2015

MSP CERTIFIED PUBLIC ACCOUNTANTS

Cascade Comprehensive Care, Inc. & Subsidiary
Index to Consolidated Financial Statements
December 31, 2016

MSP CERTIFIED PUBLIC ACCOUNTANTS

A1216-21655-10

Independent Auditors' Report

The Board of Directors
Cascade Comprehensive Care, Inc. & Subsidiary

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Cascade Comprehensive Care, Inc. and its subsidiary which comprise the consolidated balance sheets as of December 31, 2016 and 2015 and the related consolidated statements of income, changes in stockholders' equity, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Cascade Comprehensive Care, Inc. and its subsidiary as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the basic financial statements as a whole. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the basic financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

Molatore, Scroggin, Peterson & Co LLP
Certified Public Accountants

Klamath Falls, Oregon
June 22, 2017

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Balance Sheets
December 31, 2016

Assets

	2016	2015
Current Assets		
Cash and cash equivalents	$ 12,340,063	$ 25,255,176
Short term investments	2,051,598	1,937,438
Receivables	840,698	2,054,246
Inventory	6,752	11,950
Prepaid expenses	219,352	200,935
Total Current Assets	15,458,463	29,459,745
Fixed Assets		
Property and equipment, net	635,041	283,935
Other Assets		
Investments	10,288,826	9,632,220
Restricted statutory reserve	3,318,026	2,817,866
Deferred tax asset-long term	-	40,000
Organizational fees, net	1,494	1,494
Fees not amortized	68,412	68,412
Goodwill	126,328	126,328
Total Other Assets	13,803,086	12,686,320
Total Assets	$ 29,896,590	$ 42,430,000

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Balance Sheets
December 31, 2016

Liabilities and Stockholder's Equity

	2016	2015
Current Liabilities		
Accounts payable	$ 170,484	$ 1,421,223
Income taxes payable	56,518	328,000
Accrued expenses	2,154,132	1,640,774
Withheld payable	5,217,670	2,856,508
Claims payable	8,863,920	10,378,422
Risk pool payable	2,423,660	12,639,495
Stock redemption payable	1,883,471	-
Total Current Liabilities	20,769,855	29,264,422
Long-term Liabilities		
Deferred tax liability	210,000	29,000
Total Long-term Liabilities	210,000	29,000
Total Liabilities	20,979,855	29,293,422
Stockholder's Equity		
Class A common stock, $1,000 par value, 500 shares authorized, 25 shares issued and outstanding	25,000	16,000
Class B common stock, $1,000 par value, 500 shares authorized, 34 shares issued and outstanding	34,000	29,000
Class C common stock, $1,000 par value, 500 shares authorized, 1 share issued and outstanding	1,000	1,000
Class D non-voting common stock, no par value, 100,000 shares authorized, 35,977 shares issued and outstanding	1,200,015	1,333,298
Additional paid in capital	429,638	429,638
Retained earnings	7,227,082	11,327,642
Total Stockholder's Equity	8,916,735	13,136,578
Total Liabilities and Stockholder's Equity	$ 29,896,590	$ 42,430,000

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Income
For the Years Ended December 31, 2016

	2016	2015
Revenue		
Contract revenue	$ 94,091,194	$ 91,695,177
HRA plan	(12,395,051)	(13,342,175)
Stoploss recoveries	293,804	238,761
Total Revenue	81,989,947	78,591,763
Operating Expenses		
Claim and capitation expense	71,331,774	69,673,997
Stoploss Insurance	819,541	969,850
Salaries and benefits	3,860,813	3,496,971
Administrative expenses	2,461,355	1,918,473
Total Operating Expenses	78,473,483	76,059,291
Total Operating Income	3,516,464	2,532,472
Other Income (Expense)		
Net Equity Gain/(Loss) in ATRIO Health Plans and Klamath Medical Business Center	(707,591)	1,505,083
ATRIO Income	828,253	730,135
ATRIO Medical Incentive Pool	(742,505)	281,136
Realized Gain/(Loss) on sale of bonds	(38,375)	(7,920)
Gain (Loss) on sale of property and equipment	(8,737)	-
Unrealized Gain/(Loss) on bonds	369,599	(270,290)
Lease and other income	98,653	9,045
Investment expense	(11,184)	(10,902)
Interest Income	143,348	156,885
Interest expense	-	(365)
Total Other Income (Expense)	(68,539)	2,392,807
Net Income Before Income Tax Provision	3,447,925	4,925,279
Income Tax Provision	(1,644,428)	(1,546,884)
Net Income	$ 1,803,497	$ 3,378,395

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Changes in Stockholders' Equity
For the Years Ended December 31, 2016

	Common Stock		Additional Paid-In	Retained	
	Shares	Amount	Capital	Earnings	Total
Beginning Balance January 1, 2015	10,150	$ 1,388,178	$ 429,638	$ 8,354,906	$ 10,172,722
Stock issuance	12	9,120	-	-	9,120
Stock redemption	(162)	(18,000)	-	(105,600)	(123,600)
Dividends	-	-	-	(300,059)	(300,059)
Net income	-	-	-	3,378,395	3,378,395
Ending Balance December 31, 2015	10,000	1,379,298	429,638	11,327,642	13,136,578
Stock issuance	358	216,237	-	-	216,237
Stock Split	29,417				
Stock Redemption	(3,738)	(335,520)	-	(5,904,057)	(6,239,577)
Net income	-	-	-	1,803,497	1,803,497
Ending Balance December 31, 2016	36,037	$ 1,260,015	$ 429,638	$ 7,227,082	$ 8,916,735

The notes to the financial statements are an integral part of these financial statements

Cascade Comprehensive Care, Inc. & Subsidiary
Consolidated Statements of Cash Flows
For the Years Ended December 31, 2016

	2016	2015
Cash Flows From Operating Activities		
Net income	$ 1,803,497	$ 3,378,395
Adjustments to reconcile net income (loss)		
to net cash provided (used) by operating activities		
Depreciation and amortization	119,330	74,567
Net equity income in ATRIO Health Plans and		
Klamath Medical Business Center	(656,606)	(1,405,083)
(Increase) decrease in:		
Accounts receivable	1,213,548	728,425
Prepaid assets	(18,417)	(158,147)
Inventory	5,198	11,463
Deferred tax asset	40,000	(23,980)
Restricted reserve	(500,160)	(1,405,009)
Increase (decrease) in:		
Accounts payable	632,732	1,384,244
Income taxes payable	(271,482)	(536,611)
Accrued liabilities	513,358	298,434
Withheld payables	2,361,162	642,416
Claims and risk payables	(11,730,337)	7,394,575
Deferred tax liability	181,000	(18,000)
Net Cash Provided/(Used) by Operating Activities	(6,307,177)	10,365,689
Cash Flows From Investing Activities		
Purchase of short term investments	(114,160)	110,687
Purchases of fixed assets	(470,436)	(203,388)
Net Cash (Used) by Investing Activities	(584,596)	(92,701)
Cash Flows From Financing Activities		
Dividends paid	-	(300,059)
Retirement of common stock	(6,239,577)	(123,600)
Issuance of common stock	216,237	9,120
Net Cash (Used) by Financing Activities	(6,023,340)	(414,539)
Net increase/(decrease) in cash and cash equivalents	(12,915,113)	9,858,449
Cash and cash equivalents at beginning of year	25,255,176	15,396,727
Cash and cash equivalents at end of year	$ 12,340,063	$ 25,255,176

The notes to the financial statements are an integral part of these financial statements

Note 1 – Nature of Activities and Summary of Significant Accounting Policies

Nature of Activities

Cascade Comprehensive Care, Inc. (the Company), successor to Klamath Comprehensive, Inc., was organized under the State of Oregon and started operations January, 1996. The Company is currently under contract (the Contract) with the State of Oregon, Oregon Health Authority, and the Division of Medical Assistance Programs (DMAP) to provide prepaid health services to Klamath County, Oregon as a fully capitated health plan. The Contract is funded by the State of Oregon and is reviewed and renewed annually. If the contract were not renewed or discontinued, it would materially affect the financial position of the Company. As of December 31, 2016, the Contract has been renewed for an additional year.

Cascade Health Alliance, LLC was formed in 2012 as a wholly own subsidiary by Cascade Comprehensive Care as a Coordinated Care Organization (CCO) for most Klamath County Medicaid residents and is certified by the State of Oregon.

On May 19, 2013 a memorandum of understanding was signed between Klamath County and Cascade Health Alliance regarding the provision of the mental health safety net. The Oregon Health Authority approved a CCO start date of September 1, 2013. With the announcement by the county in June 2013 that they would be closing the County Mental Health Department on June 30, 2013, CCC obtained contracts with the private mental health providers in order to have a sufficient mental health provider panel.

Principles of Consolidation

The accompanying financial statements include the accounts of Cascade Comprehensive Care and its wholly-owned subsidiary, Cascade Health Alliance, LLC.

All significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Material estimates that are particularly susceptible to significant change in the near term are related to the determination of withheld payables and claims payable. In connection with the determination of the incurred but not reported claims, the Company obtains an independent actuarial review of historical claim expenses.

Fair Value of Financial Instruments

Fair value guidance (GAAP) requires the reporting of fair value for assets and liabilities. For financial instruments, including cash, short term investments, receivables, payables, and accruals, the carrying amount approximates fair value because of their short maturity.

Cash

Cash and cash equivalents include cash on hand, cash in banks, and cash in a brokerage account. The Company regularly maintains cash balances in financial institutions in excess of the Federal Deposit Insurance Corporation's limit. These cash balances are subject to credit loss in the event of nonperformance by the bank. The Company has not incurred any losses in any of these accounts to date.

Short Term Investments

The Company maintains a brokerage account which invests in various short term debt securities. These securities are carried at fair value which approximates cost.

Equity Investments

Investments in which the Company has a 20% to 50% interest or otherwise exercises significant influence are carried at cost adjusted for the Company’s proportionate share of their undistributed earnings or losses.

Capitation Income

Capitation payments received under the Contract are recognized in the month in which the Company is obligated to provide care. During 2016 and 2015, 100%, of operating revenues were generated from the Contract. As part of a risk-sharing incentive program, the Company also retains up to 20% of the interim payments of certain contractual providers against a risk-sharing fund.

Note 1 – Nature of Activities and Summary of Significant Accounting Policies *(continued)*

In the event of utilization in excess of budget, those providers bear the risk to the extent of the 20% of the fee-for-service fees.

Accounts Receivable
Accounts receivable consist primarily of the Maternity Case Rate Receivable, stop-loss recoveries receivable, and amounts due from ATRIO Health Plans, a related party. Risk of credit loss is negligible, therefore no allowance for doubtful accounts is provided. Due to the nature of the accounts receivable, the Company requires no collateral, has no policy for writing off bad debts, and does not charge interest on accounts receivable.

Inventory
Inventory is valued at the lower of cost or market.

Fixed Assets
Fixed assets are recorded at cost. Depreciation of fixed assets is provided using straight line methods over the estimated useful lives of the assets, ranging from five to twenty years. Depreciation expense for December 31, 2016 and 2015 was $119,330 and $74,567, respectively.

Maintenance and repairs of property and equipment are charged to operations, and major improvements are capitalized. Upon retirement, sale or other disposition of property and equipment, the cost and accumulated depreciation are eliminated from the accounts, and a gain or loss is included in operations.

Goodwill and Intangible Assets
The Company assesses goodwill for impairment annually. Impairment loss on goodwill is not recognized unless there is evidence of impairment based on the cash flows of the Company.

Health Care Service Cost Recognition
The Company contracts with various health care providers for the provision of certain health care services to its members. The Company compensates some of its providers on a capitation basis while other providers share the risk as outlined under Capitation Income. Operating expenses include all amounts incurred by the Company under the aforementioned contracts.

The cost of other health care services provided or contracted for includes losses paid during the period and the changes in the liability for unpaid losses and loss adjustment expenses. The reserves for losses and loss adjustment expenses include amounts estimated to settle individual claims that have been reported to the Company and additional amounts, determined based on actuarial assumptions, for losses incurred but not reported. The Company does not discount these reserves. Such liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate cost to settle the incurred losses may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed as the history of the Company grows, and any adjustments are reflected in earnings currently.

Accrued Medical Incentive Pool
Accrued medical incentive pool represents certain health care claims payables, which were withheld from providers during 2016 and 2015 and the provider incentive accrual. Payments from the incentive pool reserve may be limited by payment of health care costs to providers in excess of the agreed-upon medical target loss ratio as stipulated in the participating provider's contract. As part of a risk-sharing incentive program, the Company retains up to 20% of the interim payments of certain contractual providers against a risk-sharing fund. In the event of utilization in excess of budget, those providers bear the risk to the extent of the 20% of the fee-for-service fees.

Income Taxes
The income tax returns are based on calculations and assumptions that are subject to examination by various tax authorities. As reflected in the accompanying financial statements, the Company is recognizing its portion of deferred tax assets and liabilities. In accordance with FASB guidance, the Company records income taxes using an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been recognized in the Company's financial statements or tax returns. A valuation allowance is established when it is more likely than not that a deferred tax asset is not realizable in the foreseeable future. Tax assets are reviewed regularly for recoverability. Current income taxes are based upon the Company's current income and the current tax rate.

Note 1 – Nature of Activities and Summary of Significant Accounting Policies *(continued)*

Deferred income taxes result from temporary differences between the tax basis of assets and liabilities and their reported amounts in the financial statements. The principal difference arises primarily from compensated absences, amortization of intangibles, and depreciation methods. The change in the amount of deferred income taxes is recorded as a credit or debit to income currently. The Company's policy for accounting for interest and penalties is to include interest in interest expense and penalties under non-deductible expenses, both as an integral part of the income statement presentation. The Company believes that it has appropriate support for any tax positions taken, and as such, does not have any uncertain positions that are material to the financial statements. The Company's income tax returns are subject to examination by federal and state taxing authorities, generally for three years after they are filed.

Advertising
All costs of advertising of the Company's services are charged to expense as incurred and totaled $930 and $5,621 for 2016 and 2015, respectively.

Compensated Absences
The Company accrues vacation, holiday, and sick leave benefits. Accrued leave was $85,990 and $69,322 for the years ended December 31, 2016 and 2015, respectively. These amounts are included in accrued expenses on the balance sheet. The total maximum number of days that can be accrued is 34 to 54 based on years of employment.

Note 2 – Investments

KMBC, LLC
In 2004, the Company acquired one-half interest in KMBC, LLC for $656,197. The other half is owned by Sky Lakes Medical Center. The equity method of accounting was adopted for this investment. Equity investment income (loss) of $(137,716) and $(18,173) was recognized in 2016 and 2015, respectively.

ATRIO Health Plans, Inc.
ATRIO Health Plans, Inc. (ATRIO) is a Medicare Advantage Plan provider, which has also contracted with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare claims service in various counties in Oregon. The Company has owned an equity investment in ATRIO since its inception in 2004.

The Company purchased additional ATRIO common stock in the amount of $2,001,000 in 2011, and in 2016 bought $1,564,197. In 2016 and 2015, a net (decrease) increase in equity was recognized of $(769,876) and $1,423,256, respectively.

The total cost of the Company's investment at December 31, 2016 and 2015 was $5,267,581 and $3,703,384, respectively.

There is no market for the common stock of ATRIO Health Plans, Inc. or any reasonable method for estimating the value of KMBC, LLC, and, accordingly, no quoted market prices are available. ATRIO Health Plans, Inc. is presented on the statutory basis of accounting which differs from generally accepted accounting principles. Following is a summary of financial position and results of operations of ATRIO Health Plans, Inc. and KMBC, LLC:

	2016	2015
Other assets	$ 50,257,429	$ 46,261,299
Property and equipment, net	960,137	1,341,384
Total assets	$ 51,217,566	$ 47,602,683
Liabilities	24,877,048	18,363,219
Stockholders' equity	26,340,518	29,239,464
Total liabilities and stockholders' equity	$ 51,217,566	$ 47,602,683
Sales	$ 203,587,457	$ 148,365,651
Net income	$ (4,072,238)	$ 2,692,750

Note 2 – Investments *(continued)*

Statutory Reserve
Under the OMAP contract, the Company must establish restricted reserve funds to cover fee-for-service liabilities that would need to be covered in the event of insolvency. The reserve fund is required to be held by a third party. The Company maintained a primary restricted reserve in the amount of $395,850 for 2016 and $396,139 for 2015.

The Company is required to establish a secondary restricted reserve to cover additional State reserve requirements. This fund is held by a third party. This reserve is adjusted quarterly by an amount equal to 50 percent of the difference between the Company's average monthly fee-for-service liabilities and $250,000. At December 31, 2016 and 2015, the secondary reserve was $2,922,176 and $2,421,727, respectively.

Investment income from cash, cash equivalents, and short term investments was $19,216 for 2016 and $17,259 for 2015.

Note 3 – Accounts Receivable

Accounts receivable at December 31 consist of the following:

	2016	2015
Maternity case rate receivable	$ 241,520	$ 409,606
Stop-loss recoveries receivable	59,890	226,857
Notes Receivable	141,497	163,476
ATRIO risk settlement receivable	-	1,102,067
ATRIO receivable	124,890	119,094
Purchased Int Receivable - Bonds	22,986	33,269
Receivable - State of Oregon	249,009	-
Miscellaneous receivables	906	(124)
Total	$ 840,698	$ 2,054,245

Note 4 – Fixed Assets

Fixed assets at December 31 consist of the following:

	2016	2015
Office equipment	$ 720,881	$ 475,511
EZ Cap software and equipment	206,150	206,150
Electronic claims inload	172,002	115,903
Leasehold improvements	288,421	169,086
Less accumulated depreciation	(752,413)	(682,715)
Total	$ 635,041	$ 283,935

Note 5 – Withhold Payables

The Company and providers have entered into risk/incentive sharing agreements. Generally, under the terms of the agreement, 20% of fee-for-service payments are withheld. Based upon actual medical expenses compared to predetermined criteria, the amount withheld is either increased or decreased and paid annually to the provider. The amounts are as follows:

	2016	2015
Withhold payable	$ 5,217,670	$ 2,856,508
Risk pool payable	2,423,660	12,639,495
Total	$ 7,641,330	$ 15,496,003

Note 6 – Claims Payable and IBNR

Claims incurred represent capitation and non-capitation payments to providers for services rendered during the year. The claims payable liability is based on actuarial estimates related to the nature and volume of work performed by non-capitated providers. This estimated liability is evaluated annually by management in order to maintain it at a level that is sufficient to absorb probable incurred but not reported claims. Management's evaluation of the adequacy of the estimate is based on an annual actuarial review of historical claim experience.

Note 7 – Stop-Loss Insurance

The Company has a stop-loss insurance agreement with an insurance company to limit its losses on hospital inpatient and outpatient service claims and professional services. For hospital inpatient and outpatient services and for professional services, the terms of this agreement state the Company's retention per member per policy year for 2015 and 2014 is $225,000 each year.. The maximum amount payable by the insurance company per member per policy year for hospital and professional services combined is $2,000,000. There is no annual lifetime maximum. The coinsurance is 90% based on 100% of contract provider rates, subject to limitations.

Stop-loss insurance expense was as follows at December 31,

	2016	2015
Stoploss insurance premium expense	$ 819,541	$ 969,850
Stoploss recovery revenue	(293,804)	(238,761)
Net (Income) Expense	$ 525,737	$ 731,089

Note 8 – Profit Sharing Plan

The Company has a 401(k) profit sharing plan. All employees who are at least 21 years of age are eligible to participate in the Company's plan. The 401(k) plan provides for contributions by the Company in such amounts as management may determine. In 2016 and 2015, the Company had 53 and 46, respectively, eligible employees participating in the plan. For 2016, the employer 401(k) matching contribution was 1.5 times the employee contribution up to 3% of qualified compensation. For 2016 and 2015, the employer discretionary contribution was 2% and 5% of qualified compensation, respectively. The expenses charged to operations for December 31, 2016 and 2015, were $137,254 and $71,256, respectively.

Note 9 – Income Taxes

The provision (benefit) for income taxes consists of the following at December 31:

	2016	2015
Current tax expense		
Federal	$ 1,155,000	$ 1,244,000
State	268,800	285,300
Total current tax expense	1,423,800	1,529,300
Deferred tax expense (benefit)		
Federal	184,628	16,160
State	36,000	1,424
Total deferred tax expense	220,628	17,584
Total provision for income taxes	$ 1,644,428	$ 1,546,884

Deferred income taxes are provided for the temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities. The major differences that give rise to the deferred tax liabilities and assets are depreciation, amortization, and unpaid compensated absences. It is reasonably certain that all deductible temporary differences will reverse in future years; therefore, no valuation allowance is needed.

Note 9 – Income Taxes *(contined)*

These amounts have been presented in the Company's financial statements at December 31, as follows:

	2016	2015
Noncurrent deferred tax asset	-	40,000
Noncurrent deferred tax liability	(210,000)	(29,000)

Note 10 – Stockholders' Equity

The four classes of common stock are differentiated by ownership. Class A shares are owned by primary care physicians. Class B shares are owned by specialists. Class C shares are hospital-owned. Class D share ownership is at the discretion of the Board of Directors.

On August 16, 2016, the Company's board of directors declared a five-for-one stock split on the shares of the Company's class D, no par value, common stock. Each shareholder of record on August 16, 2016, received four additional shares of class D common stock for each share of class D common stock then held. All references in the financial statements to the number of shares outstanding of the Company's Class D common stock have been restated to reflect the effect of the stock split for all periods presented.

Entities under contract with the Oregon Department of Human Resources, Division of Medical Assistance Programs (DMAP), are required to maintain a level of net worth that will provide for minimum adequate operating capital. The minimum level of net worth is a calculation of Discounted Premium Revenue to Net Worth. This ratio must be less than or equal to 20:1.

At December 31, 2016, the Company met the requirement, as calculated by DMAP, of $2,912,509.

Note 11 – Supplemental Cash Flow Disclosures

Cash paid for income taxes, (net of refunds) in 2016 and 2015 amounted to $1,366,910 and $1,206,543 respectively.

Cash paid for interest in 2016 and 2015 amounted to $-0- and $365, respectively.

Note 12 – Related Party Transactions

The Company has stockholders who are also providers who receive payments for services rendered. Compensation to board members consisted of $323,950 in 2016 and $264,700 in 2015. Members of management of Sky Lakes Medical Center (SLMC) are on the board of the Company. SLMC is the primary hospital in the Company's service area and owns approximately 49% of the Company. The following summarizes amounts paid to SLMC:

	2016	2015
Claims	$ 27,894,038	$ 14,926,644
Capitation	3,349,864	2,506,761
Other provider payments	2,924,736	311,131
Total	$ 34,168,638	$ 17,744,536

Claims payable to SLMC were $1,798,075 for 2016 and $2,001,885 for 2015.

The building occupied by the Company is owned by KMBC, LLC and the Company owns a one half interest in the LLC. The base rent is calculated on the fair market value of the square footage occupied by the Company, plus additional rent (utilities, etc.) and other common expenses incurred. Rental expenses for the years ended December 31, 2016 and 2015 are $167,535 and $175,479, respectively. The lease terminated in November 2009 and turned into month-to-month rent through December 2016.

Note 13 – Concentration of Risks

Substantially all of the Company's business activities are with members in Klamath County.

As stated in Note 1, the Company is under contract with DMAP. Premium revenue represented 100% of total revenues for 2016 and 97% for 2015.

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash deposits. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to certain limits. At December 31, 2016 and 2015, the Company had approximately $14,787,908 and $24,505,176 in excess of FDIC insured limits, respectively. The Company has experienced no losses on those accounts.

Note 14 – Commitments and Contingencies

The Company is party to legal proceedings incidental to its business. Although such litigation sometimes includes substantial demands for compensatory and punitive damages, in addition to contract liability, it is management's opinion that damages arising from such demands will not be material to the Company's financial position.

Note 15 – Subsequent Events

The Company evaluated other subsequent events through June 22, 2017, the date these financial statements were available to be issued.

OTHER SUPPLEMENTARY INFORMATION

Cascade Health Alliance, LLC
Schedule of Assets, Liabilities and Equity
For the Year Ended December 31, 2016

Assets

	2016	2015
Current Assets		
Cash and cash equivalents	$ 10,115,771	$ 26,052,117
Receivables	550,419	636,463
Inventory	6,752	11,950
Recevable from affiliate	12,107,206	3,801,315
Total Current Assets	22,780,148	30,501,845
Other Assets		
Restricted statutory reserve	3,318,026	2,817,866
Total Other Assets	3,318,026	2,817,866
Total Assets	$ 26,098,174	$ 33,319,711

Liabilities and Members' Equity

	2016	2015
Current Liabilities		
Accounts payable	$ -	$ 1,599,679
Accrued expenses	1,163,897	1,284,755
Withheld payable	5,217,670	2,856,508
Claims payable	8,863,920	10,378,422
Risk pool payable	2,423,660	11,680,699
Total Current Liabilities	17,669,147	27,800,063
Total Liabilities	17,669,147	27,800,063
Members' Equity		
Members' Equity	8,429,027	5,519,648
Total Members' Equity	8,429,027	5,519,648
Total Liabilities and Members' Equity	$ 26,098,174	$ 33,319,711

Cascade Health Alliance, LLC
Schedule of Operations
For the Year Ended December 31, 2016

	2016	2015
Revenue		
Contract revenue	$ 94,091,194	$ 91,695,177
HRA plan	(12,395,051)	(13,342,175)
Stoploss recoveries	293,804	238,761
Total Revenue	81,989,947	78,591,763
Operating Expenses		
Claim and capitation expense	71,324,654	69,668,797
Stoploss Insurance	819,541	969,850
Administrative expenses	4,929,930	4,399,881
Total Operating Expenses	77,074,125	75,038,528
Total Operating Income	4,915,822	3,553,235
Other Income (Expense)		
Lease and other income	92,434	4,528
Total Other Income (Expense)	92,434	4,528
Net Income Before Income Tax Provision	5,008,256	3,557,763
Income Tax Provision	(2,098,877)	(1,445,524)
Net Income	$ 2,909,379	$ 2,112,239

Cascade Health Alliance, LLC
Schedule of Cash Flows
For the Year Ended December 31, 2016

	2016	2015
Cash Flows From Operating Activities		
Net income	$ 2,909,379	$ 2,112,239
Adjustments to reconcile net income (loss) to net cash provided (used) by operating activities		
(Increase) decrease in:		
Accounts receivable	86,044	(141,110)
Due from Affiliates	(8,305,892)	1,957,542
Inventory	5,198	11,463
Restricted reserve	(500,160)	(1,405,009)
Increase (decrease) in:		
Accounts payable	(1,599,679)	1,599,679
Accrued liabilities	(120,860)	1,051,446
Claims and risk payables	(8,410,376)	8,291,154
Net Cash Provided/(Used) by Operating Activities	(15,936,346)	13,477,404
Net increase/(decrease) in cash and cash equivalents	(15,936,346)	13,477,404
Cash and cash equivalents at beginning of year	26,052,117	12,574,713
Cash and cash equivalents at end of year	$ 10,115,771	$ 26,052,117

CASCADE COMPREHENSIVE CARE, INC.
AND SUBSIDIARY

CONSOLIDATED FINANCIAL STATEMENTS
AND SUPPLEMENTARY INFORMATION

For the Years Ended December 31, 2017 and 2016

Jones Roth
CPAs & Business Advisors

CASCADE COMPREHENSIVE CARE, INC. AND SUBSIDIARY
CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION
For the Years Ended December 31, 2017 and 2016

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Jones Roth
CPAs & Business Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
Cascade Comprehensive Care, Inc. and Subsidiary
Klamath Falls, Oregon

We have audited the accompanying consolidated financial statements of Cascade Comprehensive Care, Inc. (an Oregon corporation) and subsidiary (an Oregon limited liability company), which comprise the consolidated balance sheet as of December 31, 2017, and the related consolidated statements of income, changes in stockholders' equity, and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We did not audit the financial statements of ATRIO Health Plans, Inc., the investment in which, as described in Note 2 to the financial statements, is accounted for by the equity method of accounting. The investment in ATRIO Health Plans, Inc. was $6,869,102 as of December 31, 2017, and the deficit in its net loss was $3,005,444 for the year then ended. The financial statements of ATRIO Health Plans, Inc. were audited by other auditors, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for ATRIO Health Plans, Inc., is based solely on the report of the other auditors. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Cascade Comprehensive Care, Inc. and subsidiary as of December 31, 2017, and the results of their operations and their cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Adjustments to Prior Period Consolidated Financial Statements

The consolidated financial statements of Cascade Comprehensive Care, Inc. and subsidiary as of December 31, 2016, were audited by other auditors whose report dated June 22, 2017, expressed an unmodified opinion on those consolidated statements. As discussed in Note 17, the Company has restated its 2016 consolidated financial statements during the current year to correctly reflect deferred tax liabilities, additional paid in capital, and retained earnings in accordance with accounting principles generally accepted in the United States of America. The other auditors reported on the 2016 consolidated financial statements before the restatement.

As part of our audit of the 2017 consolidated financial statements, we also audited the adjustments described in Note 17 that were applied to restate the 2016 consolidated financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engage to audit, review, or apply any procedures to the 2016 consolidated financial statements of the Company other than with respect to the adjustments identified and, accordingly, we do not express an opinion or any other form of assurance on the 2016 consolidated financial statements as a whole.

Disclaimer of Opinion on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information, as listed in the table of contents to the consolidated financial statements, which is the responsibility of management, is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, accordingly, we do not express an opinion or provide any assurance on it.

Jones & Roth, P.C.

Jones & Roth, P.C.
Eugene, Oregon
June 25, 2018

CONSOLIDATED FINANCIAL STATEMENTS

CASCADE COMPREHENSIVE CARE, INC. AND SUBSIDIARY
CONSOLIDATED BALANCE SHEETS
December 31, 2017 and 2016

	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ 9,869,181	$ 12,340,063
Short-term investments	600,350	2,051,598
Accounts receivable	1,523,365	840,698
Inventory	5,874	6,752
Prepaid expenses	978,266	219,352
Total current assets	12,977,036	15,458,463
Fixed assets		
Property and equipment, net	946,623	635,041
Other assets		
Investments	11,075,530	10,288,826
Restricted statutory reserve	3,330,867	3,318,026
Organizational fees, net	1,494	1,494
Fees not amortized	68,412	68,412
Goodwill, net	126,328	126,328
Total other assets	14,602,631	13,803,086
Total assets	$ 28,526,290	$ 29,896,590

	2017	Restated 2016
Liabilities and Stockholders' Equity		
Current liabilities		
Accounts payable	$ 458,041	$ 170,484
Income taxes payable	-	56,518
Accrued expenses	6,470,916	2,154,132
Withheld payables	4,243,721	5,217,670
Claims payable	6,815,372	8,863,920
Risk pool payable	3,754,897	2,423,660
Loan payable, current portion	1,210,166	-
Stock redemption payable, current portion	223,553	1,436,364
Total current liabilities	23,176,666	20,322,748
Long-term liabilities		
Loan payable	2,509,497	-
Stock redemption payable	223,554	447,107
Deferred tax liability	539,514	1,864,875
Total long-term liabilities	3,272,565	2,311,982
Total liabilities	26,449,231	22,634,730
Stockholders' equity		
Class A common stock, $1,000 par value, 500 shares authorized, 24 and 25 shares issued and outstanding, respectively	24,000	25,000
Class B common stock, $1,000 par value, 500 shares authorized, 34 shares issued and outstanding	34,000	34,000
Class C common stock, $1,000 par value, 500 shares authorized, 1 share issued and outstanding	1,000	1,000
Class D non-voting common stock, no par value, 100,000 shares authorized, 26,757 and 35,977 shares issued and outstanding, respectively	1,211,783	1,200,015
Retained earnings	806,276	6,001,845
Total stockholders' equity	2,077,059	7,261,860
Total liabilities and stockholders' equity	$ 28,526,290	$ 29,896,590

The accompanying notes are an integral part of these consolidated statements.

CASCADE COMPREHENSIVE CARE, INC. AND SUBSIDIARY
CONSOLIDATED STATEMENTS OF INCOME
For the Years Ended December 31, 2017 and 2016

	2017	2016
Revenue		
Contract revenue	$ 94,713,211	$ 94,091,194
HRA plan	(13,317,478)	(12,395,051)
Stop-loss recoveries	716,077	293,804
Total revenue	82,111,810	81,989,947
Operating expenses		
Claim and capitation expense	70,701,819	71,331,774
Stop-loss insurance	694,611	819,541
Salaries and benefits	4,301,851	3,860,813
Administrative expenses	3,509,999	2,461,355
Total operating expenses	79,208,280	78,473,483
Operating income	2,903,530	3,516,464
Other income (expense)		
Net equity loss in ATRIO Health Plans and Klamath Medical Business Center	(2,938,493)	(707,591)
ATRIO income	1,158,857	828,253
ATRIO medical incentive pool	(1,622,373)	(742,505)
Realized gain (loss) on sale of bonds	32,186	(38,375)
Loss on sale of property and equipment	(888)	(8,737)
Unrealized gain (loss) on bonds	(43,151)	369,599
Lease and other income	126,078	98,653
Investment expense	(9,215)	(11,184)
Interest income	109,957	143,348
Interest expense	(51,017)	-
Net other income (expense)	(3,238,059)	(68,539)
Net income (loss) before (provision for) benefit from income tax	(334,529)	3,447,925
(Provision for) benefit from income tax	283,971	(1,644,428)
Net income (loss)	$ (50,558)	$ 1,803,497

The accompanying notes are an integral part of these consolidated statements.

CASCADE COMPREHENSIVE CARE, INC. AND SUBSIDIARY
CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY
For the Years Ended December 31, 2017 and 2016

	Common Stock		Retained	
	Shares	Amount	Earnings	Total
Stockholders' equity, January 1, 2016, as restated	10,000	$ 1,379,298	$ 10,102,405	$ 11,481,703
Stock issuance	358	216,237	-	216,237
Stock split	29,417	-	-	-
Stock redemption	(3,738)	(335,520)	(5,904,057)	(6,239,577)
Net income	-	-	1,803,497	1,803,497
Stockholders' equity, December 31, 2016, as restated	36,037	1,260,015	6,001,845	7,261,860
Stock issuance	25	15,768	-	15,768
Stock redemption	(9,246)	(5,000)	(5,145,011)	(5,150,011)
Net loss	-	-	(50,558)	(50,558)
Stockholders' equity, December 31, 2017	26,816	$ 1,270,783	$ 806,276	$ 2,077,059

The accompanying notes are an integral part of these consolidated statements.

CASCADE COMPREHENSIVE CARE, INC. AND SUBSIDIARY
CONSOLIDATED STATEMENTS OF CASH FLOWS
For the Years Ended December 31, 2017 and 2016

	2017	2016
Cash flows from operating activities		
Net income (loss)	$ (50,558)	$ 1,803,497
Adjustments to reconcile net income (loss) to net cash provided (used) by operating activities:		
Depreciation and amortization	215,874	119,330
Net equity loss (income) in ATRIO Health Plans and Klamath Medical Business Center	2,938,493	(656,606)
Unrealized loss on bonds	43,151	-
(Increase) decrease in:		
Accounts receivable	(682,667)	1,213,548
Prepaid assets	(758,914)	(18,417)
Inventory	878	5,198
Deferred tax asset	-	40,000
Restricted reserve	(12,841)	(500,160)
Increase (decrease) in:		
Accounts payable	287,557	632,732
Income taxes payable	(56,518)	(271,482)
Accrued expenses	4,316,784	513,358
Withheld payables	(973,949)	2,361,162
Claims and risk payables	(717,311)	(11,730,337)
Deferred tax liability	(1,325,361)	181,000
Net cash provided (used) by operating activities	3,224,618	(6,307,177)
Cash flows from investing activities		
Net purchase of investments	(2,317,100)	(114,160)
Purchases of fixed assets	(527,456)	(470,436)
Net cash used by investing activities	(2,844,556)	(584,596)
Cash flows from financing activities		
Proceeds from loan incurred	3,719,663	-
Repayments on shareholder redemption payables	(1,436,364)	-
Redemption of common stock	(5,150,011)	(6,239,577)
Issuance of common stock	15,768	216,237
Net cash used by financing activities	(2,850,944)	(6,023,340)
Net decrease in cash and cash equivalents	(2,470,882)	(12,915,113)
Cash and cash equivalents, beginning of year	12,340,063	25,255,176
Cash and cash equivalents, end of year	$ 9,869,181	$ 12,340,063

The accompanying notes are an integral part of these consolidated statements.

1. Nature of Activities and Summary of Significant Accounting Policies

Nature of Activities

Cascade Comprehensive Care, Inc. (the Company), successor to Klamath Comprehensive, Inc., was organized under the State of Oregon and started operations January 1996. The Company is currently under contract (the Contract) with the State of Oregon, Oregon Health Authority, and the Division of Medical Assistance Programs (DMAP) to provide prepaid health services to Klamath County, Oregon as a fully capitated health plan. The Contract is funded by the State of Oregon and is reviewed and renewed annually. If the contract were not renewed or discontinued, it would materially affect the financial position of the Company. As of December 31, 2017, the Contract has been renewed for an additional year.

Cascade Health Alliance, LLC was formed in 2012 as a wholly own subsidiary of Cascade Comprehensive Care, Inc. as a Coordinated Care Organization (CCO) for most Klamath County Medicaid residents and is certified by the State of Oregon.

On May 19, 2013, a memorandum of understanding was signed between Klamath County and Cascade Health Alliance regarding the provision of the mental health safety net. The Oregon Health Authority approved a CCO start date of September 1, 2013. With the announcement by the county in June 2013 that they would be closing the County Mental Health Department on June 30, 2013, Cascade Comprehensive Care, Inc. obtained contracts with the private mental health providers in order to have a sufficient mental health provider panel.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Cascade Comprehensive Care, Inc. and its wholly-owned subsidiary, Cascade Health Alliance, LLC. All significant intercompany transactions have been eliminated.

Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Material estimates that are particularly susceptible to significant change in the near term are related to the determination of withheld payables and claims payable. In connection with the determination of the incurred but not reported claims, the Company obtains an independent actuarial review of historical claim expenses.

1. Summary of Significant Accounting Policies, continued

Fair Value of Financial Instruments

Fair value guidance under U.S. GAAP requires the reporting of fair value for assets and liabilities. The carrying amounts of financial instruments, including cash, short term investments, receivables, payables, and accruals, approximate their fair value because of their short term maturity. The recorded value of the long-term certificate of deposit approximates fair value as interest earned approximates market rates. Fixed income bonds are measured at fair value in the statement of financial position.

Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, cash in banks, and cash in a brokerage account. The Company regularly maintains cash balances in financial institutions in excess of the Federal Deposit Insurance Corporation's limit. These cash balances are subject to credit loss in the event of nonperformance by the bank. The Company has not incurred any losses in any of these accounts to date.

Short-term Investments

The Company maintains a brokerage account which invests in various short-term debt securities. These securities are carried at fair value which approximates cost.

Equity Investments

Investments in which the Company has a 20 percent to 50 percent interest or otherwise exercises significant influence are carried at cost adjusted for the Company’s proportionate share of their undistributed earnings or losses.

Capitation Income

Capitation payments received under the Contract are recognized in the month in which the Company is obligated to provide care. During 2017 and 2016, 100 percent, of operating revenues were generated from the Contract. As part of a risk-sharing incentive program, the Company also retains a percentage of the interim payments of certain contractual providers against a risk-sharing fund. For the years ended December 31, 2017 and 2016 the percentage retained was 15 and 20, respectively.

In the event of utilization in excess of budget, those providers bear the risk to the extent of the percentage retained of the fee-for-service fees.

Accounts Receivable

Accounts receivable consist primarily of the Maternity Case Rate Receivable, stop-loss recoveries receivable, amounts due from the State of Oregon, and amounts due from ATRIO Health Plans, a related party. Management believes risk of credit loss is negligible, therefore no allowance for doubtful accounts is provided. Due to the nature of the accounts receivable, the Company requires no collateral and does not charge interest on accounts receivable. Accounts receivable are written off when they are determined to be uncollectible.

1. Summary of Significant Accounting Policies, continued

Inventory

Inventory is valued at the lower of cost or market.

Fixed Assets

Fixed assets are recorded at cost. Depreciation of fixed assets is provided using straight line methods over the estimated useful lives of the assets, ranging from three to thirty-nine years. Depreciation expense for December 31, 2017 and 2016 was $215,874 and $119,330, respectively.

Maintenance and repairs of property and equipment are charged to operations, and major improvements are capitalized. Upon retirement, sale or other disposition of property and equipment, the cost and accumulated depreciation are eliminated from the accounts, and a gain or loss is included in operations.

Goodwill and Intangible Assets

The Company evaluates goodwill for impairment at the entity level if an event occurs or circumstances change that indicate that the fair value of the entity may be below its carrying amount. Impairment loss on goodwill is not recognized unless there is evidence of impairment based on the cash flows of the Company.

Health Care Service Cost Recognition

The Company contracts with various health care providers for the provision of certain health care services to its members. The Company compensates some of its providers on a capitation basis while other providers share the risk as outlined under Capitation Income. Operating expenses include all amounts incurred by the Company under the aforementioned contracts.

The cost of other health care services provided or contracted for includes losses paid during the period and the changes in the liability for unpaid losses and loss adjustment expenses. The reserves for losses and loss adjustment expenses include amounts estimated to settle individual claims that have been reported to the Company and additional amounts, determined based on actuarial assumptions, for losses incurred but not reported. The Company does not discount these reserves. Such liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate cost to settle the incurred losses may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed as the history of the Company grows, and any adjustments are reflected in current earnings.

Risk Pool Payable

Risk pool payable represents certain health care claims payables, which were withheld from providers during 2017 and 2016 and the provider incentive accrual. Payments from the incentive pool reserve may be limited by payment of health care costs to providers in excess of the agreed-upon medical target loss ratio as stipulated in the participating provider's contract. As part of a risk-sharing incentive program, the Company retains a percentage of the interim payments of certain contractual providers against a risk-sharing fund. For years ended December 31, 2017 and 2016 the retain was

1. Summary of Significant Accounting Policies, continued

15 and 20 percent, respectively. In the event of utilization in excess of budget, those providers bear the risk to the extent of the percentage retained of the fee-for-service fees.

Income Taxes

The income tax returns are based on calculations and assumptions that are subject to examination by various tax authorities. As reflected in the accompanying consolidated financial statements, the Company is recognizing its portion of deferred tax assets and liabilities. In accordance with Financial Accounting Standards Board (FASB) guidance, the Company records income taxes using an asset and liability approach that requires the recognition of deferred tax assets and liabilities for the expected future tax consequences of events that have been recognized in the Company's consolidated financial statements or tax returns. A valuation allowance is established when it is more likely than not that a deferred tax asset is not realizable in the foreseeable future. Tax assets are reviewed regularly for recoverability. Current income taxes are based upon the Company's current income and the current tax rate.

Deferred income taxes result from temporary differences between the tax basis of assets and liabilities and their reported amounts in the consolidated financial statements. The principal difference arises primarily from differences in outside versus inside tax basis gains and losses on investments, compensated absences, amortization of intangibles, and depreciation methods. The change in the amount of deferred income taxes is recorded as a credit or debit to current income or loss.

The Company elected to early adopt the provisions of FASB Accounting Standards Update (ASU) 2015-17, *Income Taxes – Balance Sheet Classification of Deferred Taxes*, which requires reporting the net amount of deferred tax assets and liabilities as a single noncurrent item on the classified consolidated balance sheet. Before this change, the net amounts of current and noncurrent deferred tax assets and liabilities were reported separately. The Company has applied the deferred tax reclassifications retrospectively to all years presented within the consolidated financial statements. The adoption of ASU 2015-17 did not have any impact on the consolidated statements of income, changes in stockholders' equity, or cash flows for any period presented.

The Company's policy for accounting for interest and penalties is to include interest in interest expense and penalties under non-deductible expenses, both as an integral part of the consolidated income statement presentation. The Company believes that it has appropriate support for any tax positions taken, and as such, does not have any uncertain positions that are material to the consolidated financial statements. The Company's income tax returns are subject to examination by federal and state taxing authorities, generally for three years after they are filed.

Advertising

All costs of advertising of the Company's services are charged to expense as incurred and totaled $33,527 and $930 for 2017 and 2016, respectively.

1. Summary of Significant Accounting Policies, continued

Compensated Absences

The Company accrues vacation, holiday, and sick leave benefits. Accrued leave was $100,797 and $85,990 for the years ended December 31, 2017 and 2016, respectively. These amounts are included in accrued expenses on the consolidated balance sheets. The total maximum number of days that can be accrued is 34 to 54 based on years of employment.

2. Investments

Investments at December 31, 2017 consisted of the Company's equity investments in ATRIO and KMBC, LLC of $6,869,102 and $481,231, respectively, and a certificate of deposit of $3,725,197. Investments at December 31, 2016 consisted of the Company's equity investments in ATRIO and KMBC, LLC of $9,874,546 and $414,280, respectively.

ATRIO Health Plans, Inc.

ATRIO Health Plans, Inc. (ATRIO) is a Medicare Advantage Plan provider, which has also contracted with the Centers for Medicare and Medicaid Services (CMS) to provide Medicare claims service in various counties in Oregon. The Company has owned an equity investment in ATRIO since its inception in 2004 and currently holds a one-third interest in ATRIO.

The Company purchased additional ATRIO common stock in the amount of $2,001,000 in 2011, and $1,564,197 in 2016. In 2017 and 2016, a net decrease in equity was recognized of $(3,005,444) and $(769,876), respectively.

The total cost of the Company's investment at December 31, 2017 and 2016 was $5,267,581.

There is no fair market for the common stock of ATRIO Health Plans, Inc. or any reasonable method for estimating the fair value of KMBC, LLC, and, accordingly, no quoted market prices are available. ATRIO Health Plans, Inc. is presented on the statutory basis of accounting which differs from generally accepted accounting principles. Following is a summary of financial position and results of operations of ATRIO Health Plans, Inc. and KMBC, LLC:

	2017	2016
Other assets	$ 52,268,684	$ 50,257,429
Property and equipment, net	772,043	960,137
Total assets	$ 53,040,727	$ 51,217,566
Liabilities	$ 35,823,445	$ 24,877,048
Equity	17,217,282	26,340,518
Total liabilities and equity	$ 53,040,727	$ 51,217,566
Sales	$ 257,303,007	$ 203,587,457
Net loss	$ (9,266,061)	$ (4,072,238)

2. Investments, continued

KMBC, LLC

In 2004, the Company acquired one-half interest in KMBC, LLC for $656,197. The other half is owned by Sky Lakes Medical Center. The equity method of accounting was adopted for this investment. Equity investment income (loss) of $66,951 and $(137,716) was recognized in 2017 and 2016, respectively.

Statutory Reserve

Under the OMAP contract, the Company must establish restricted reserve funds to cover fee-for-service liabilities that would need to be covered in the event of insolvency. The reserve fund is required to be held by a third party. The Company maintained a primary restricted reserve in the amount of $397,153 and $395,850 for 2017 and 2016, respectively.

The Company is required to establish a secondary restricted reserve to cover additional state reserve requirements. This fund is held by a third party. This reserve is adjusted quarterly by an amount equal to 50 percent of the difference between the Company's average monthly fee-for-service liabilities and $250,000. At December 31, 2017 and 2016, the secondary reserve was $2,933,714 and $2,922,176, respectively. Investment income from cash, cash equivalents, and short term investments was $31,345 and $19,216 for 2017 and 2016, respectively.

3. Fair Value Measurement

Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Company has the ability to access at the measurement date.

Level 2: Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in inactive markets, inputs other than quoted prices that are observable for the asset or liability; and inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to their fair value measurement.

The Company's financial instruments are valued with Level 1 inputs.

3. Fair Value Measurement, continued

The following tables set forth by level, within the fair value hierarchy, the Company's assets measured at fair value as of December 31, 2017 and 2016:

	Assets at Fair Value as of December 31, 2017			
	Level 1	Level 2	Level 3	Total
Certificate of deposit	$ 3,725,197	$ -	$ -	$ 3,725,197
Fixed income - bonds	600,530	-	-	600,350
Total assets at fair value	$ 4,325,727	$ -	$ -	$ 4,325,727

	Assets at Fair Value as of December 31, 2016			
	Level 1	Level 2	Level 3	Total
Fixed income - bonds	$ 2,051,598	$ -	$ -	$ 2,051,598

4. Accounts Receivable

At December 31, accounts receivable consisted of the following:

	2017	2016
Maternity case rate receivable	$ 675,352	$ 241,520
Stop-loss recoveries receivable	598,610	59,890
Notes receivable	143,954	141,497
ATRIO receivable	95,954	124,890
Purchased interest receivable, bonds	9,211	22,986
Receivable, State of Oregon	-	249,009
Miscellaneous receivables	284	906
Total accounts receivable	$ 1,523,365	$ 840,698

5. Fixed Assets

At December 31, fixed assets consisted of the following:

	2017	2016
Office equipment	$ 707,553	$ 720,881
EZ Cap software and equipment	206,150	206,150
Electronic claims inload software	648,930	172,002
Leasehold improvements	296,631	288,421
	1,859,264	1,387,454
Accumulated depreciation	(912,641)	(752,413)
Fixed assets, net of accumulated depreciation	$ 946,623	$ 635,041

6. Long-term Debt

As of December 31, long-term debt was composed of the following:

	2017	2016
Note payable to Washington Federal, payable in semi-annual installments of $648,049, including an interest rate of 2.54%. The note is due October 2020 and is secured by real property.	$ 3,719,663	$ -
Notes payable to former equity shareholders for stock redemptions, payable in semi-annual installments averaging $55,888. The notes mature between July and November 2019 and are unsecured.	447,107	1,883,471
	4,166,770	1,883,471
Current portion	(1,433,719)	(1,436,364)
Long-term debt, net of current portion	$ 2,733,051	$ 447,107

Maturities of long-term debt are as follows:

Year Ending June 30,	
2018	$ 1,433,719
2019	1,463,736
2020	1,269,315
Total	$ 4,166,770

7. Withhold Payables

The Company and providers have entered into risk/incentive sharing agreements. Generally, under the terms of the agreement, a percentage of fee-for-service payments are retained. For the years ended December 31, 2017 and 2016 the percentage of fee-for-service payments retained was 15 and 20 percent, respectively. Based upon actual medical expenses compared to predetermined criteria, the amount withheld is either increased or decreased and paid annually to the provider. The amounts are as follows:

	2017	2016
Withhold payable	$ 4,243,721	$ 5,217,670
Risk pool payable	3,754,897	2,423,660
Total	$ 7,998,618	$ 7,641,330

8. Claims Payable and IBNR

Claims incurred represent capitation and non-capitation payments to providers for services rendered during the year. The claims payable liability is based on actuarial estimates related to the nature and volume of work performed by non-capitated providers. This estimated liability is evaluated annually by management in order to maintain it at a level that is sufficient to absorb probable incurred but not reported claims. Management's evaluation of the adequacy of the estimate is based on an annual actuarial review of historical claim experience.

9. Retroactive Adjustments

At December 31, 2017, $2,920,740 of accrued expenses are related to recoupments from the State of Oregon and other related party retroactive adjustments associated with prior periods. Retroactive adjustments to revenue and expense are common within the industry and are recognized in the period in which adjustments are determinable.

10. Stop-Loss Insurance

The Company has a stop-loss insurance agreement with an insurance company to limit its losses on hospital inpatient and outpatient service claims and professional services. For hospital inpatient and outpatient services and for professional services, the terms of this agreement state the Company's retention per member per policy year for 2017 and 2016 is $225,000 each year. The maximum amount payable by the insurance company per member per policy year for hospital and professional services combined is $2,000,000. There is no annual lifetime maximum. The coinsurance is 90 percent based on 100 percent of contract provider rates, subject to limitations.

At December 31, stop-loss insurance expense was as follows:

	2017	2016
Stop-loss insurance premium expense	$ 694,611	$ 819,541
Stop-loss recovery revenue	(716,077)	(293,804)
Net (income) expense	$ (21,466)	$ 525,737

11. Profit Sharing Plan

The Company has a 401(k) profit sharing plan. All employees who are at least 21 years of age are eligible to participate in the Company's plan. The 401(k) plan provides for contributions by the Company in such amounts as management may determine. In 2017 and 2016, the Company had 54 and 53, respectively, eligible employees participating in the plan. For 2017 and 2016, the employer 401(k) matching contribution was 1.5 times the employee contribution up to 3 percent of qualified compensation. For 2017 and 2016, the employer discretionary contribution was 2 percent of qualified compensation. The expenses charged to operations for December 31, 2017 and 2016, were $129,969 and $137,254, respectively.

12. Income Taxes

At December 31, the (provision for) benefit from income taxes consisted of the following:

	2017	2016
Current tax expense:		
Federal	$ (862,871)	$ (1,155,000)
State	(178,519)	(268,800)
Total current tax expense	(1,041,390)	(1,423,800)
Deferred tax (expense) benefit:		
Federal	1,120,077	(184,628)
State	205,284	(36,000)
Total deferred tax (expense) benefit	1,325,361	(220,628)
Total (provision for) benefit from income taxes	$ 283,971	$ (1,644,428)

Deferred income taxes are provided for the temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities. The major differences that give rise to the deferred tax liabilities and assets are differences in outside versus inside tax basis gains and losses on investments, depreciation, amortization, and unpaid compensated absences. It is reasonably certain that all deductible temporary differences will reverse in future years; therefore, no valuation allowance is needed.

At December 31, these amounts have been presented in the Company's consolidated financial statements as follows:

	2017	2016
Noncurrent deferred tax liability	$ (539,514)	$ (1,864,875)

13. Stockholders' Equity

The four classes of common stock are differentiated by ownership. Class A shares are owned by primary care physicians. Class B shares are owned by specialists. Class C shares are hospital-owned. Class D share ownership is at the discretion of the Board of Directors.

On August 16, 2016, the Company's board of directors declared a five-for-one stock split on the shares of the Company's class D, no par value, common stock. Each shareholder of record on August 16, 2016, received four additional shares of class D common stock for each share of class D common stock then held. All references in the consolidated financial statements to the number of shares outstanding of the Company's Class D common stock have been restated to reflect the effect of the stock split for all periods presented.

13. Stockholders' Equity, continued

Entities under contract with the Oregon Department of Human Resources, Division of Medical Assistance Programs (DMAP), are required to maintain a level of net worth that will provide for minimum adequate operating capital. The minimum level of net worth is a calculation of Discounted Premium Revenue to Net Worth. This ratio must be less than or equal to 20:1.

At December 31, 2017, and 2016, the Company met the requirement, as calculated by DMAP, of $2,930,528 and $2,912,509, respectively.

14. Supplemental Cash Flow Disclosures

Cash paid for income taxes, (net of refunds) in 2017 and 2016 amounted to $1,686,062 and $1,366,910, respectively.

Cash paid for interest in 2017 and 2016 amounted to $38,682 and $-0-, respectively.

15. Related Party Transactions

The Company has stockholders who are also providers who receive payments for services rendered. Additionally, members of the board of directors are generally executives of the Company's providers. Compensation to board members consisted of $324,450 and $323,950 in 2017 and 2016, respectively. Members of management of Sky Lakes Medical Center (SLMC) are on the board of the Company. SLMC is the primary hospital in the Company's service area and owns approximately 33 percent of the Company. The following summarizes amounts paid to SLMC:

	2017	2016
Claims	$ 21,651,957	$ 27,894,038
Capitation	3,278,340	3,349,864
Other provider payments	4,204,195	2,924,736
Total	$ 29,134,492	$ 34,168,638

Claims payable to SLMC were $2,384,079 and $1,798,075 for 2017 and 2016, respectively.

The building occupied by the Company is owned by KMBC, LLC and the Company owns a one half interest in the LLC. The base rent is calculated on the fair market value of the square footage occupied by the Company, plus additional rent (utilities, etc.) and other common expenses incurred. Rental expenses for the years ended December 31, 2017 and 2016 are $167,513 and $167,535, respectively. The lease terminated in November 2009 and transitioned to a month-to-month basis thereafter.

The Company owns one-third interest in ATRIO, as described in Note 2, and enters into transactions with ATRIO during the normal course of operations. At December 31, 2017 and 2016, the Company had receivables from ATRIO of $95,954 and $124,890 included in accounts receivable, and amounts owed to ATRIO of $2,492,663 and $845,393 included in accrued expenses, respectively. The Company recognized revenue of $1,158,857 and $828,253 and expenses of $1,622,373 and $742,505 during the years ended December 31, 2017 and 2016, respectively, as a result of related party transactions with ATRIO.

16. Concentration of Risks

Substantially all of the Company's business activities are with members in Klamath County.

As stated in Note 1, the Company is under contract with DMAP. Premium revenue represented 100 percent of total revenues for 2017 and 2016.

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash deposits. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to certain limits. At December 31, 2017 and 2016, the Company had approximately $13,425,775 and $14,787,908, respectively, in excess of FDIC insured limits. The Company has not experienced any losses on those accounts.

17. Prior Period Reclassifications and Adjustments

During 2017, management identified and made certain reclassifications to the prior year consolidated financial statements in order to appropriately state 2016 beginning additional paid in capital and retained earnings. Previously reported additional paid in capital was reduced by $429,638 and retained earnings was increased by the same amount in the consolidated financial statements as of January 1, 2016. The reclassification had no effect on previously reported net income or stockholders' equity as of December 31, 2016.

Certain 2016 balances have been restated to correct an error related to deferred taxes. As a result of the correction, the previously reported 2016 deferred tax liability increased by $1,654,875 and beginning 2016 retained earnings decreased by the same amount.

18. Commitments and Contingencies

The Company can be a party to legal proceedings incidental to its business. Although such litigation could include substantial demands for compensatory and punitive damages, in addition to contract liability, it is management's opinion that potential damages arising from such demands would not be material to the Company's financial position.

19. Subsequent Events

Management evaluates events and transactions that occur after the consolidated balance sheet date as potential subsequent events. Management has performed this evaluation through the date of the independent auditor's report.

SUPPLEMENTARY INFORMATION

CASCADE HEALTH ALLIANCE, LLC
SCHEDULES OF ASSETS, LIABILITIES, AND MEMBERS' EQUITY
December 31, 2017 and 2016

	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ 6,452,468	$ 10,115,771
Receivables	1,417,916	550,419
Inventory	5,874	6,752
Receivable from affiliate	18,812,693	12,107,206
Total current assets	26,688,951	22,780,148
Other assets		
Restricted statutory reserve	3,330,867	3,318,026
Total assets	$ 30,019,818	$ 26,098,174
Liabilities and Members' Equity		
Liabilities		
Accounts payable	$ 369,577	$ -
Accrued expenses	3,799,517	1,163,897
Withheld payable	4,243,721	5,217,670
Claims payable	6,815,372	8,863,920
Risk pool payable	3,754,897	2,423,660
Total liabilities	18,983,084	17,669,147
Members' equity	11,036,734	8,429,027
Total liabilities and members' equity	$ 30,019,818	$ 26,098,174

See disclaimer of opinion on supplementary information in independent auditor's report.

CASCADE HEALTH ALLIANCE, LLC
SCHEDULES OF OPERATIONS
For the Years Ended December 31, 2017 and 2016

	2017	2016
Revenue		
Contract revenue	$ 94,713,211	$ 94,091,194
HRA plan	(13,317,478)	(12,395,051)
Stop-loss recoveries	716,077	293,804
Total revenue	82,111,810	81,989,947
Operating expenses		
Claim and capitation expense	70,698,462	71,324,654
Stop-loss insurance	694,611	819,541
Administrative expenses	6,366,564	4,929,930
Total operating expenses	77,759,637	77,074,125
Operating income	4,352,173	4,915,822
Other income		
Lease and other income	37,909	92,434
Net income before provision for income tax	4,390,082	5,008,256
Provision for income tax	(1,782,375)	(2,098,877)
Net income	$ 2,607,707	$ 2,909,379

See disclaimer of opinion on supplementary information in independent auditor's report.

CASCADE HEALTH ALLIANCE, LLC
SCHEDULES OF CASH FLOWS
For the Years Ended December 31, 2017 and 2016

	2017	2016
Cash flows from operating activities		
Net income	$ 2,607,707	$ 2,909,379
Adjustments to reconcile net income to net cash used by operating activities:		
(Increase) decrease in:		
Accounts receivable	(867,497)	86,044
Due from affiliates	(6,705,487)	(8,305,892)
Inventory	878	5,198
Restricted reserve	(12,841)	(500,160)
Increase (decrease) in:		
Accounts payable	369,577	(1,599,679)
Accrued liabilities	2,635,620	(120,860)
Claims and risk payables	(1,691,260)	(8,410,376)
Net decrease in cash and cash equivalents	(3,663,303)	(15,936,346)
Cash and cash equivalents, beginning of year	10,115,771	26,052,117
Cash and cash equivalents, end of year	$ 6,452,468	$ 10,115,771

See disclaimer of opinion on supplementary information in independent auditor's report.

Attachment 12 - Cost and Financial

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Cost and Financial Questionnaire is 20 pages. Items that are excluded from the page limit will be noted in that requirement.

Section A. Evaluate CCO performance to inform CCO-specific profit margin beginning in CY 2022

OHA will implement a provision of its current waiver that requires the state to vary the profit load in CCO capitation rates based on an evaluation of CCO performance. The goal of the policy is to encourage CCOs to provide financial incentives for CCOs to improve the delivery of benefits to CCO Members. This includes more efficient use of Medical Services, increased delivery of high-value services, and an increased use of Health-Related Services when appropriate. The ability to increase the profit load for high-performing CCOs is designed to alleviate concerns that CCO investments that reduce costs and use of Medical Services will lead to capitation rate reductions that threaten CCO ability to maintain access to Health-Related Services and other programs that improve value and efficiency.

12.A.1 Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members? If so, please describe.

Cascade Health Alliance (CHA) uses Value-Based Payment (VBP) measures for oral care, primary care, specialty care, behavioral health, and hospital care. These include measures of access, quality, and satisfaction. Examples include the percent of members seen in each calendar year and results from point of service member satisfaction surveys. These are reported to providers throughout the year to assist them in opportunities to improve service and access.

CHA uses a clinical performance tool that identifies members with chronic conditions that are not annually evaluated. These reports are used to inform outreach efforts by providers and support preparation for comprehensive visits. CHA produces the following reports that reflect clinical value and efficiency:

- **Member Spend:** Annual spend and identification of claims per member.
- **Top % Member Spend Details:** The member spend report is filtered to display only the top 25 high utilizers.
- **Clinic Utilization:** This report highlights the number of members who have been assigned to a PCP and have been seen by said PCP throughout the year. The number of members assigned is based on an average over one year of how many members for which the provider was paid capitation. Members seen is a rolling total each month of members seen during the year.

- **Member Retention:** Identifies members that have fallen off our plan and returned or have not returned.
- **Authorizations:** The amount of authorizations per month, by status, and if the authorization was denied the denial reason.
- **ED Utilization:** Total ED utilization is broken down by PCP assignment and member counts, ED inpatient readmissions, ED triage vs. full charge.
- **Oral Health Dashboards:** This report is per oral health provider and displays the number of members assigned, active, active seen, and by percent seen, complaints, sealants, and oral eval.
- **Medical Provider Complaints:** Number of medical complaints by prescribed state categories for all providers.
- **New Enrollee Utilization:** Provider gap reports with new member enrollments who have had no claim services in their first six months.
- **Provider Scorecards:** CHA provides medical and demographic information to providers and practices through a clinical performance tool. These documents include internal reporting on chronic conditions, CLAS, REAL+D data for our Provider Network, Quality, and Case Management Departments.
- **Pharmacy Report:** This report identifies all claims, is then used to narrow down members using pharmacies outside of Klamath County. It is monitored for members who may have moved outside of coverage area.
- **Specialty Utilization by Drug Within Disease:** Highlights the cost of fill count of paid claims classified as specialty medications, sorted by which disease they are used to treat.
- **RX Greater Than $500:** Prescriptions paid at all pharmacies that cost more than $500.
- **Eligible Utilizing Member Claims Count:** Shows how many plan members are eligible to fill a prescription vs. how many members actually filled their prescriptions.
- **Key Indicators and Trends:** The Key Indicators and Trends dashboard provide an at-a-glance view of cost trends, the key influencers of that trend, and actionable links to the relevant detail about each measure. In this dashboard, you can select your own reporting period and comparison period used to calculate the trend.
- **Top 15 Drugs:** Identifies the top 15 drugs plan paid with the highest spend.
- **Opioid POS Denied Claims Report:** Identifies all opioid claims with a claim status of "denied."
- **Overutilization and Safety:** Provides information relating to Acetaminophen Overuse and Opioid Cumulative Dosing. Detail includes submitted conflict, intervention, and outcome codes which may be used to override such denials. References by claim ID and detail of any

subsequent approvals are also provided. Detail can be limited by selected report type to include all claims, denied claims, approved claims or only impacted claims.

- **Top-N-Prescriber:** Identifies primary care providers whose average prescription drug cost is greater than $50 and specialty care providers whose average prescription drug cost is greater than $700.
- **MED for PIP:** Identifies all adjudicated opioid claims including medication dose, fill quantity, and day supply; calculates daily morphine equivalent dosing used by members.
- **Smoking Cessation Report:** Identifies all members filling prescriptions for Nicotine Replacement/Tobacco Cessation Therapies.
- **AG Reporting:** Pulls quarterly medical and oral health authorizations, including status and determination from our case management system.
- **AG Report Total Authorizations:** Identifies all medical and oral health authorizations completed quarterly, including denied, modified, and completed from our case management system.
- **Pharmacy Notice of Authorization (NOA) Summary:** Summarizes the total number of authorizations processed by Pharmacy, broken down by completed, denied, canceled, etc.
- **Pharmacy NOA Log:** Provides member level authorization NOA details for all pharmacy denials quarterly.

12.A.2 What tools does the Applicant plan to deploy to identify areas of opportunity to eliminate Waste and inefficiency, improve quality and outcomes, and lower costs?

CHA uses multiple tools to identify areas of opportunity to eliminate waste, inefficiency and lower costs. Data analytics tools will analyze utilization and cost data by member, clinical condition and provider. The tools apply predictive analytics capability to identify members expected to be high cost going forward and which members are predicted to have preventable costs. CHA's pharmacy department uses a pharmacy management system to analyze and manage pharmacy costs. CHA also uses Collective Medical (ED system) and a case management system.

CHA uses multiple tools to identify areas of opportunity to improve quality and outcomes including PHTech CCO Metrics Manager (Quality Measures), Crystal Reports, MS SQL reports, provider Network tools, and multiple non-analytic quality improvement tools. We deliver provider scorecards to generate insights on providers' performance across multiple dimensions and inform the actions providers should take to improve clinical performance. Elements of these scorecards/reports include the following:

- Captured clinical score vs. target clinical score.
- Clinical recapture percentage.
- Condition prevalence.
- Members with captured conditions.
- Members with suspected conditions.

These tools will allow CHA to analyze member and provider data to assist in eliminating waste and inefficiencies, improve quality and outcomes, and lower costs.

12.A.3 Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost? If so, please describe.

REDACTED

12.A.4 What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

REDACTED

12.A.5 What process and analysis will the Applicant use to evaluate investments in Health-Related Services and initiatives to address the Social Determinants of Health & Health Equity (SDOH-HE) in order to improve the health of Members?

CHA has engaged a consultant to evaluate the socio-economic impact of its SDOH investments funded during 2017 through 2019. The results of this review will be used to inform future decision making including initial funding and continuing funding of current projects.

CHA will require funded partners to provide reports that track both services provided and outcomes where available. For example, CHA is evaluating its investment in a weight loss program with quarterly data reports at the member and aggregate level that follow weight loss, change in HbGA1c, lipids, and other biometric parameters. CHA will also be doing pre/post referral cost analysis for members receiving case management by one of our partners.

Going forward, CHA will conduct an inventory of community needs and opportunities for HRS with a focus on housing. We will identify needs that are currently addressed by our HRS investments, needs that are currently addressed by other community partners' investments, and those that are partially addressed or unaddressed. Needs will be categorized by the size of financial investment needed, the probability of successful execution, and size and type of potential benefit to the community. CHA will select HRS investments with the goal of improving community and member health and health outcomes, reducing avoidable service utilization and cost, and creating efficiency and improved quality in service delivery.

Section B. Qualified Directed Payments to Providers

Beginning in 2020, OHA will develop a program of qualified directed payments (QDP) for the repayment of most provider taxes paid by Hospitals in Oregon. The specific parameters and methodology of the QDPs for fiscal year 2020 will be determined following completion of the 2019-21 Legislatively Adopted Budget and will rely on input from a variety of stakeholders. OHA will promulgate administrative rules to include a Quality and Access pool for Hospitals reimbursed by Medicare based on diagnostic-related groups (aka, DRG Hospitals).

12.B.1 Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees? If so, please describe.

CHA produces monthly reports to identify claims that 'flag' for Hospital Adverse Conditions or Adverse Events based on diagnosis and procedure codes. CHA pends any questionable hospital claim, obtains medical records and requests evaluation by the Chief Medical Officer (CMO) for any quality concerns.

CHA tracks late or incomplete discharge planning services and reports performance back to hospital leadership. Nurse case managers perform concurrent reviews of all inpatient admissions and brings concerns regarding quality or efficiency to the Director of Case Management. Significant concerns are forwarded to CHA's CMO to review for potential actionable items.

CHA tracks measures reported monthly from the local hospital's Infection Control Coordinator including rates of MRSA bloodstream infections, C-diff infections and days of antibiotic (levofloxacin) therapy. Areas of concern will be evaluated is partnership with the local hospital leadership. Significant concerns will be referred to the Quality Management Committee for investigation.

CHAs 2019 contracts with its local hospital include a value-based payment component based on quality measures that drive quality outcome and sustainable growth targets.

Section C. Quality Pool Operation and Reporting

OHA will adjust the funding mechanism of the quality incentive pool from a bonus to a withhold of a portion of CCO capitation rates. This allows CCO expenditures of Quality Pool funds to be considered in capitation rate development and be included in the Medical Loss Ratio (MLR) requirements that apply to the CCOs. This change is intended to motivate CCOs to make timely investments in their communities and the providers and partners that enable their achievement of metrics associated with the incentive program. Including CCO spending of incentive pool earnings in capitation rate development increases the transparency of the program while retaining significant flexibility for CCOs in how they utilize their Global Budget.

12.C.1 Does the Applicant plan to distribute Quality Pool earnings to any public health partners or non-clinical providers, such as SDOH-HE partners or other Health-Related Services Providers? If so, please specify the types of organizations and providers that will be considered.

CHA does not currently have plans to distribute Quality Pool earnings to public health partners, non-clinical providers or health-related services providers. However, we recognize the importance of SDOH-HE investments and will evaluate the possibility of distributing quality pool earnings to the above partners and providers in the future where quality and value can truly be demonstrated.

12.C.2 How much of the Quality Pool earnings does the Applicant plan on distributing to clinical Providers, versus non-clinical providers? Please discuss the approach as it relates to SDOH-HE partners, public health partners, or other Health-Related Services Providers.

At this time, Quality Pool earnings are distributed to clinical partners only based on performance quality metrics, and the number of members served. This has proven to be an important and successful strategy for maintaining network adequacy and engagement in quality improvement work. CHA recognizes the importance of SDOH-HE investments and will continue to evaluate ways to distribute Quality Pool earnings and other funds to support SDOH-HE partners, public

health partners, or other HRS. CHA will continue assessing the return from its past and current investments in HRS to develop investment strategies going forward.

12.C.3 How much of the Quality Pool earnings does the Applicant plan on investing outside its own organization? On what would Applicant make such investments?

Subject to change, CHA gives approximately REDACT of the Quality Pool earnings to clinical providers. The remaining earnings is kept by CHA and invested in SDOH-HE and HRS initiatives and other investments that affect the overall community.

12.C.4 How will the Applicant decide and govern its spending of the Quality Pool earnings?

The distribution of the Quality Pool is developed by CHA's Quality Department, reviewed by Executive Leadership Team, then presented to the Board of Directors.

12.C.5 When will Applicant invest its Quality Pool earnings, compared with when these earning are received?

CHA will invest its Quality Pool earnings in the same year as received, assuming the funds are collected early enough in the year to allow time to do so. This investment will ensure CHA has the funding necessary to contribute in meaningful ways to the members we serve in Klamath County.

12.C.6 Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?

CHA has enough cash resources to manage a withholding of a portion of its capitation payments. Our company has consistently stayed beneath OHA's sustainable growth target. CHA has developed a strategy to exceed the target for CCO 2.0 while improving the quality of the lives of our members.

Section D. Transparency in Pharmacy Benefit Management Contracts

OHA seeks to address increasing pharmacy costs by increasing the transparency of CCO relationships with Pharmacy Benefit Managers (PBMs) and requiring no-spread contracts between CCOs and PBMs. CCOs will be required to ensure they are receiving competitive pricing from their PBMs by obtaining 3rd party market checks audits.

12.D.1 Please describe the PBM arrangements Applicant will use for its CCO Members.

REDACTED

12.D.2 Does Applicant currently have a "no-spread" arrangement with its PBM? If not, please describe the steps the Applicant will take to ensure its contracts are compliant with these requirements and the intended timing of these changes. If changes cannot be made by January 1, 2020, please explain why and what interim steps Applicant will take to increase

PBM transparency in CY 2020. (In order for an extension in the timeline to be considered, Applicant must show it is contractually obligated to use non-compliant PBM and shall provide OHA a copy of PBM agreement as justification along with a plan to ensure compliance with transparency requirements at the earliest date possible)

CHA has a no-spread arrangement with its PBM. Our pharmacy pricing is 100% pass-through without any spread retained.

12.D.3 Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing? If not, does the Applicant have a plan to receive this analysis? If so, how often are these analyses performed, what is done with this third party data and what terms inside of your PBM contract allow this analysis to have power for the CCO to ensure its pharmacy contract remains competitive?

CHA currently uses a third party to obtain market data to ensure we get competitive pricing from our PBM. Our PBM has agreed to annual market checks. Our contract has language that allows us to address and amend contract pricing to ensure that fee structure is market competitive.

12.D.4 Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?

CHA is not opposed to using the OPDP, however, the current contract with the PBM offers lower rates than those currently offered by the Oregon Prescription Drug Program.

Section E. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

OHA seeks to address increasing pharmacy costs by increasing the alignment of CCO preferred drug lists (PDLs) with the PDL used by OHA for the fee-for-service program with a particular focus on high-cost drugs and on alignment strategies that reduce overall program costs and/or improve the pharmacy benefit for OHP Members. OHA will work in conjunction with Successful Applicants to establish initial PDL alignment criteria and will take additional steps to modify alignment criteria over time. As part of this requirement, CCOs will be expected to make public and accessible their PDLs as well as the coverage and Prior Authorization criteria for all pharmaceutical products.

12.E.1 Does Applicant currently publish its PDL? If not, please describe the steps the Applicant will take to ensure its PDL is publicly accessible concurrent or in advance of the Year 1 Effective Date for prescribers, patients, dispensing pharmacies, and OHA.

CHA's Preferred Drug List (PDL) can be accessed via the CHA website. The formulary is also available on CHA's provider portal.

12.E.2 Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made? If not, please describe the steps the Applicant will take to ensure its pharmacy coverage and PA criteria are both publicly accessible for prescribers, patients, dispensing pharmacies, and OHA and updated in a timely manner.

CHA posts pharmacy coverage and prior authorization criteria at least 30 days in advance on our website. The information is communicated via fax to all local pharmacies and letters highlighting the changes are sent to all contracted providers.

12.E.3 To what extent is Applicant's PDL aligned with OHA's fee-for-service PDL? Please explain whether and how supplemental rebates or other financial incentives drive differences in the Applicant's PDL as compared to the fee-for-services PDL?

CHA's PDL is closely aligned with OHA's fee-for-service PDL. The major exception is the carve out for 7/11 medications. CHA does not seek supplemental rebates to achieve cost savings as generic equivalents tend to provide greater cost savings. CHA also employs specific disease-driven criteria such as the GOLD Guidelines in the management of prior authorizations to achieve decrease duplication of therapy costs.

12.E.4 Does the Applicant plan to fully align its PDL with the fee-for-service PDL? If not, please describe exceptions.

CHA's PDL is closely aligned with OHA's fee-for-service PDL and we are not opposed to a full alignment. Exceptions to this are centralized around cost as generic medications offer greater savings opportunities compared to their branded equivalents. This is significant especially since CHA does not enter into supplemental rebate agreements with manufacturers.

Section F. Financial Reporting Tools and Requirements

OHA will enhance financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBC) tool to evaluate carrier solvency, along with supplemental schedules as requested by OHA (identified in Exhibit L of the Contract). CCOs will file required NAIC reports using Statutory Accounting Principles (SAP). A financial hardship exemption will be available for Year 1 for CCOs with a demonstrated financial hardship related to converting to SAP and filing reports through NAIC. Additional reporting through the Exhibit L Financial Reporting Template will be required. OHA will promulgate administrative rules describing regulatory interventions based on RBC level.

12.F.1 Does Applicant or any Affiliate of Applicant currently report on NAIC health insurance forms? If so, please describe the reporting company or companies and its relationship with Applicant.

CHA does not currently report on NAIC health insurance forms. Our affiliate, ATRIO Health Plans, does currently report on NAIC health insurance forms. CHA's parent company, Cascade Comprehensive Care (CCC), owns a portion of ATRIO Health Plans, which offers Medicare Advantage plans. CCC has a Service Area Contract with ATRIO Health Plans to provide services to Medicare Advantage plan members in Klamath County.

12.F.2 Does the Applicant currently participate and file financial statements with the NAIC?

CHA does not currently participate and file financial statements with the NAIC.

12.F.3 Has Applicant prepared a financial statement which includes a RBC calculation? If so, please submit.

Yes. Please see *RFA4690-CHA-ATT12-UCAA Supplemental Financial Analysis.*

12.F.4 Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?

CHA does not have direct experience reporting in SAP but has indirect experience through its affiliate, ATRIO Health Plans.

12.F.5 Does the Applicant seek an exemption from SAP and NAIC reporting for 2020? If yes, please explain in detail (a) the financial hardship related to converting to SAP for the filing, and (b) Applicant's plan to be ready to use SAP in 2021.

CHA is committed to delivering the best service and outcomes for Klamath County members and is not in a position of financial hardship. Thus, CHA does not seek an exemption from SAP and NAIC reporting for 2020.

12.F.6 Please submit pro forma financial statements of Applicant's financial condition for three years starting in 2020, using Enrollment, rates and cost projections that presume Applicant is awarded a Contract under this RFA. If OHA expects there may be more than two CCOs in Applicant's Service Area, OHA may require Applicant to submit additional pro forma financials based on the expected number of CCOs. OHA will evaluate Applicant's pro forma financials to assure that they provide a realistic plan of solvency. See the RFA Pro Forma Reference Document and UCAA Supplemental Financial Analysis workbook template for a complete description of the requirements and deliverables. The pro forma workbook templates and required supporting documents are excluded from the page limit.

REQUIRED DOCUMENTS

- Completed Pro Forma Workbook Templates (NAIC Form 13H), see enclosed
  - *RFA4690-CHA-ATT12- Pro Forma Financial Statement Workbook BE MM 13H*
  - *RFA4690-CHA-ATT12- Pro Forma Financial Statement Workbook MIN MM 13H*
  - *RFA4690-CHA-ATT12- Pro Forma Financial Statement Workbook MAX MM 13H*
- Completed NAIC Biographical Affidavits (NAIC Form 11), see enclosed *RFA4690-CHA-ATT12-Biographical Affidavits*
- Completed UCAA Supplemental Financial Analysis Workbook Template, see enclosed *RFA4690-CHA-ATT12- UCAA Supplemental Financial Analysis*
- Three years of Audited Financial Reports, see enclosed:
  - *RFA4690-CHA-ATT12-2015 Audited Financial Report*
  - *RFA4690-CHA-ATT12-2016 Audited Financial Report*
  - *RFA4690-CHA-ATT12-2017 Audited Financial Report*

Section G. Accountability to Oregon's Sustainable Growth Targets

OHA seeks to improve the connection between CCO Contracts and the sustainable growth targets established in Oregon's Medicaid waiver and the legislatively enacted budget.

12.G.1 What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?

CHA collaborates with local providers using mutually beneficial contracts to maintain costs while providing adequate care to members. These partnerships aid CHA in achieving a sustainable expenditure growth year over year. Throughout the contract period, CHA will implement effective VBP and quality metrics that produce outcomes to improve the health of our members and community.

CHA is fully invested in expanding value-based partnerships with providers in our community. We deliver actionable data to drive improved outcomes.

12.G.2 How will the CCO allocate and monitor expenditures across all categories of services?

CHA currently has capitation agreements and risk sharing agreements with providers. These contracts are tied to various metrics to ensure contract compliance and effective outcomes for our members. CHA uses internal data analytics to monitor progress and to keep providers informed of their progress as well as gaps in care. We do not limit the expenditure of any one category of service and works within a global budget framework.

12.G.3 What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?

CHA will continue to shift from fee for service payments to VBP to continue to maintain a sustainable expenditure growth rate. CHA will continue to share risk with providers using various mitigation strategies. We will explore use of capitation beyond primary care and will seek partially or fully capitated contracts with its local hospital and possibly its local skilled nursing facility as well. CHA is testing methodologies to adjust both capitated and Fee for Service (FFS) payments based on documented medical complexity. CHA will explore enhancing our VBP on social complexity when reliable data becomes available.

CHA will build its capacity to measure and report efficiency by the contracted entity and by provider where feasible. This reporting will be used initially for feedback and education. After methodologies for adjusting for medical complexity and social complexity are in place, CHA will explore using efficiency as a component of VPBs.

12.G.4 What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

CHA uses data analytics and quality metrics to ensure quality care is provided to members while continuing to contain costs. CHA is currently linking VBPs to measures of quality. CHA plans to enhance the number of quality measures used to trigger VPBs, increase the performance levels

needed to trigger payments and use of more balanced measure sets. In addition, CHA will explore the shift from process measures to outcome measures as providers become better able to manage outcomes and we are better able to measure them.

12.G.5 Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past? Please specify time periods.

CHA has achieved the per member expenditure growth target of 3.4% per year for the past three years. We are fully invested in expanding value-based partnerships with providers in our community. We deliver actionable data to drive improved outcomes.

Section H. Potential Establishment of Program-wide Reinsurance Program in Future Years

OHA seeks to establish a statewide reinsurance program to better control costs related to high-cost medical conditions, treatments, and patients.

12.H.1 What type of reinsurance policy does the Applicant plan on holding for 2020? Please include the specifics. (e.g. attachment points, coinsurance, etc.)

For reinsurance coverage, CHA holds a Provider Excess Insurance Policy for 2020. The attachment point is $225,000 and the coinsurance is 90%/95%. The Individual Contract Year Maximum is $2,000,000

Coverage

Hospital Inpatient Services

Outpatient Facility Services

Home Health Care

Professional Care

Ambulance Services

Durable Medical Equipment

Outpatient Mental Health /Chemical dependency services

Sub-Acute Facility Services

Long Term Acute Care

Hospice Care

Transplant Acquisition Expenses

Transplant Travel Expenses

Inpatient mental health /chemical dependency services

12.H.2 What is the Applicant's reasoning for selecting the reinsurance policy described above?

Based on historic and member experience data this level of reinsurance policy was selected to protect from catastrophic events. CHA has elected the same type of coverage for years and it has served us well.

12.H.3 What aspects of its reinsurance policy are the most important to the Applicant?

The aspects of the reinsurance policy most important to CHA include: Protection for unknown catastrophic cases and Transplant, Pharmaceuticals and Hospital coverage.

12.H.4 Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?

Existing and previous reinsurance contracts have lasered some of CHA members with a higher attachment point deductible but have never excluded a member from coverage.

12.H.5 Is Applicant able to leave or modify existing reinsurance arrangements at any time or is Applicant committed to existing arrangements for a set period of time? If so, for how long is Applicant committed to existing arrangements? Are there early cancelation penalties?

CHA is not able to term or change the existing policy. CHA is under the contract arrangement for the contract year effective on the policy which is for a one-year term.

Section I. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

OHA seeks to ensure continued financial viability of the CCO program as a whole so as to ensure OHP Members are protected from potential access barriers that could come with a CCO insolvency event. In addition, OHA may implement new solvency regulation tools that are similar to those utilized by DCBS in its regulation of commercial carriers that would allow OHA to prevent or meliorate insolvency events.

12.I.1 Please describe Applicant's past sources of capital.

CHA is 100% owned by its parent company Cascade Comprehensive Care, Inc. (CCC). All sources of capital have come from our parent company in the past.

12.I.2 Please describe Applicant's possible future sources of capital.

CHA's possible future sources of capital would also come from the parent company, CCC.

12.I.3 What strategies will the Applicant use to ensure solvency thresholds are maintained?

CHA monitors solvency thresholds every month to ensure compliance with all requirements. We use financial data and data analytics to complete projections to ensure we maintain solvency thresholds. If we need additional capital, we will obtain it from our parent company, CCC.

12.I.4 Does Applicant have a parent company, Affiliate, or capital partner from which Applicant may expect additional capital in the event Applicant becomes undercapitalized? If so, please describe.

CHA is 100% owned by its parent company CCC, Inc. In the unlikely event additional capital is required in the future, CHA will obtain additional funds from CCC.

Section J. Encounter Data Validation Study

12.J.1 Please describe Applicant's capacity to perform regular Provider audits and claims review to ensure the timeliness, correctness, and accuracy of Encounter Data.

CHA employs compliance staff designated to perform annual audits and claim reviews to ensure timeliness, correctness, and accuracy of encounter data. CHA's Compliance Department performs internal and external audits, desk and on-site audits, announced and unannounced audits, as well as the implementation of corrective action plans for deficient audits. Our customer service staff pulls monthly service validation letters that are mailed to our members to validate the services billed to CHA at the claim level were received by the member.

12.J.2 Does Applicant currently perform any activities to validate Claims data at the chart level that the claims data accurately reflects the services provided? If yes, please describe those activities.

Yes, CHA performs a multitude of activities to validate claims data. CHA's encounter data validations occur every year at the physicians' office to assure the billed charges match what is in the charting. CHA staff completes annual audits of all providers and clinics, selecting a random 1%, or the equivalent of five minimum patient charts, for review. The audit results must reference the number of charts tested, weight applied to charts, and weighted score along with the rating. The ratings scores result in substantially, partially or non-compliant and the definition of each overall rating determination will be detailed. CHA's audit process includes Chart Review, Encounter Data Validation, and Administration Audit. Each audit process details a risk category of high, moderate, or low. If the rating is less than 75% compliant, the CO or designee develops a Corrective Action Plan and disciplinary letter to address the areas identified. The Corrective Action Plan will contain an executive summary, list of findings, applicable OARs, required corrective actions, recommendations and date correction action(s) are to be taken. The Corrective Action Plan and disciplinary letter are presented to the Compliance Committee for review and approval. Audit results, including a disciplinary letter, are sent to the provider or clinic. Claim findings are reported to the Claim Department for recoupment and correct claim processing and encounter data reporting to the State.

Attachment 13 — Attestations

Applicant Name: Cascade Health Alliance,LLC

Authorizing Signature: _____

Printed Name: Tayo Akins

Instructions: For each attestation, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all attestations. If an attestation has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These attestations must be signed by a representative of Applicant.

Unless a particular item is expressly effective at the time of Application, each attestation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract. Each section of attestations refers to a questionnaire in an Attachment, which may furnish background and related questions.

A. General Questions Attestations (Attachment 6)

1. Contract

a. Is Applicant willing to enter into a Contract for 2020 in the form of Appendix B?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Subcontracts

a. Is Applicant willing to hold written agreements with Subcontractors that clearly describe the scope of work?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to provide to OHA an inventory of all work described in this Contract that is delegated or subcontracted and identify the entity performing the work?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

☐ Yes ☒ No

If "no" please provide explanation: It depends on which subcontractor agreement as it may contain trade secrets.

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒ Yes ☐ No

If "no" please provide explanation: _____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒ Yes ☐ No

If "no" please provide explanation: _____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☐ Yes ☒ No

If "no" please provide explanation: Contracts or agreements may contain trade secrets.

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒ Yes ☐ No

If "no" please provide explanation: _____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒ Yes ☐ No

If "no" please provide explanation: _____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒ Yes ☐ No

If "no" please provide explanation: _____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒ Yes ☐ No

If "no" please provide explanation: _____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒ Yes ☐ No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Network Adequacy

a. Is Applicant willing to monitor and evaluate the adequacy of its Provider Network?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to remedy any deficiencies in its Provider Network within a specified timeframe when deficiencies are identified?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report on its Provider Network in a format and frequency specified by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to collect data to validate that its Members are able to access care within time and distance requirements?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to collect data to validate that its Members are able to make appointments within the required timeframes?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to collect data to validate that its Members are able to access care within the required timeframes?

☒ Yes ☐ No

g. Is Applicant willing to arrange for Covered Services to be provided by Non-Participating Providers if the services are not timely available within Applicant's Provider Network?

☒ Yes ☐ No

3. Fraud, Waste and Abuse Compliance

a. Is Applicant willing to designate a Compliance Officer to oversee activities related to the prevention and detection of Fraud, Waste and Abuse?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to send two representatives, including the Applicant's designated Compliance Officer and another member of the senior executive team to attend a mandatory Compliance Conference on May 30, 2019?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

C. Value-Based Payment (VBP) Attestations (Attachment 8)

1. Have you reviewed the VBP Policy Requirements set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Have you reviewed the VBP reference documents linked to the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Can you implement and report on VBP as defined by VBP Questionnaire and the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/) and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Will you begin CCO 2.0 – January 2020 – with at least 20% of your projected annual payments to your Providers under contracts that include a Value-Based Payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (https://hcp-lan.org/apm-refresh-white-paper/), Pay for Performance category 2C or higher and the OHA Value-Based Payment Roadmap Categorization Guidance for Coordinated Care Organizations?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Do you permit OHA to publish your VBP data such as the actual VBP percent of spending that is LAN category 2C or higher and spending that is LAN category 3B or higher, as well as data pertaining to your care delivery areas, Patient-Centered Primary Care Home (PCPCH) payments, and other information about VBPs required by this RFA? (OHA does not intend to publish specific payments amounts from an Applicant to a specific rovider.)

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Do you agree to develop mitigation plans for adverse effects VBPs may have on health inequities, health disparities, or any adverse health-related outcomes for any specific population (including racial, ethnic and culturally-based communities; LGBTQ people; persons with disabilities; people with limited English proficiency; and immigrants or refugees and Members with complex health care needs, as well as populations at the intersections of these groups) and to report on these plans to OHA annually?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Do you agree to the requirements for VBP targets, care delivery areas and PCPCH clinics for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Do you agree to the requirements for VBP data reporting for years 2020 through 2024, as set forth in the VBP Questionnaire?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Should OHA contract with one or more other CCOs serving Members in the same geographical area, will you participate in OHA-facilitated discussions to select performance measures to be incorporated into each CCO's VBP Provider contracts for common Provider types and specialties?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. If, after the discussion described in the previous question, OHA informs you of the Provider types and specialties for which the performance measures apply, will you incorporate all selected measures into applicable Provider contracts?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

D. Health Information Technology (HIT) Attestations (Attachment 9)

1. HIT Roadmap

a. Does Applicant agree to participate in an interview/demonstration and deliver an HIT Roadmap with any refinements/adjustments agreed to with OHA during Readiness Review, for OHA approval?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to provide an annual HIT Roadmap update for OHA approval to include status/progress on CCO-identified milestones, and any adjustments to the HIT Roadmap; as well as participate in an annual interview with OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. HIT Partnership

a. Does Applicant agree to participate in the HIT Commons beginning 2020, including agreeing to do all of the following:

- Maintaining an active, signed HIT Commons MOU and adhering to its terms,
- Paying annual HIT Commons assessments, and
- Serving, if elected, on the HIT Commons Governance Board or one of its committees?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to participate in OHA's HIT Advisory Group, (HITAG), at least once annually?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Support for EHR Adoption

a. Will Applicant support EHR adoption for its contracted physical health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant support EHR adoption for its contracted Behavioral Health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant support EHR adoption for its contracted oral health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted physical health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted Behavioral Health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. During Year 1, will Applicant report on the baseline of EHR adoption among its contracted oral health Providers, set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant report to the state annually on which EHR(s) each of its contracted physical health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant report to the state annually on which EHR(s) each of its contracted Behavioral Health Providers are using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

i. Will Applicant report to the state annually on which EHR(s) each of its contracted oral health Providers is using, by means of definitions and data sources agreed upon during Readiness Review? Will reports include product and vendor name, version, and, if applicable, certification year the ONC Certification (CHPL) number for Certified EHR Technology? See https://chpl.healthit.gov/ and https://www.healthit.gov/topic/certification-ehrs/2015-edition for more information about Certified EHR Technology.

☒ Yes ☐ No

If "no" please provide explanation: _____

4. Support for HIE

a. Will Applicant ensure access to timely Hospital event notifications for its contracted physical health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant be responsible for those costs?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant ensure access to timely Hospital event notifications for its contracted Behavioral Health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant ensure access to timely Hospital event notifications for its contracted oral health Providers? If there are costs associated with ensuring access to timely Hospital event notifications for contracted Providers, will the Applicant will be responsible for those costs.

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Will Applicant use Hospital event notifications within the CCO, for example to support Care Coordination and/or population health efforts?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted physical health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted Behavioral Health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Will Applicant support access to health information exchange that enables sharing patient information for Care Coordination for its contracted oral health Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

h. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted physical health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

i. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted Behavioral Health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

j. During Year 1, will Applicant report on the baseline of HIE access and use among its contracted oral health Providers (inclusive of Hospital event notifications and HIE for Care Coordination), set Improvement Targets, and provide supporting detail about its implementation approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

k. Will Applicant report to the state annually on which HIE tool(s) each of its contracted physical health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

l. Will Applicant report to the state annually on which HIE tool(s) each of its contracted Behavioral Health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

m. Will Applicant report to the state annually on which HIE tool(s) each of its contracted oral health Providers is using, using definitions and data sources agreed upon during Readiness Review?

☒ Yes ☐ No

If "no" please provide explanation: _____

5. Health IT for VBP and Population Management.

a. For the initial VBP arrangements, will Applicant have by the start of Year 1 the HIT needed to administer the arrangements (as described in its supporting detail)?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. For the planned VBP arrangements for Years 2 through 5, does Applicant have a roadmap to obtain the HIT needed to administer the arrangements (as described in its supporting detail)?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with timely (e.g., at least quarterly) information on measures used in the VBP arrangement(s) applicable to the Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. By the start of Year 1, will the Applicant provide contracted Providers with VBP arrangements with accurate and consistent information on patient attribution?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. By the start of Year 1, will the Applicant identify for contracted Providers with VBP arrangements specific patients who need intervention through the year, so they can take action before the year end?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. By the start of Year 1, will the Applicant have the capability to risk stratify and identify and report upon Member characteristics, including but not limited to past diagnoses and services, that can inform the targeting of interventions to improve outcomes?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. By the start of each subsequent year for Years 2 through 5, will the Applicant CCO provide risk stratification and Member characteristics to your contracted Providers with VBP arrangements for the population(s) included in the arrangement(s) in place for each year?

☒ Yes ☐ No

If "no" please provide explanation: _____

E. Social Determinants of Health and Health Equity (SDOH-HE) Attestations (Attachment 10)

1. Social Determinants of Health and Health Equity Spending, Priorities, and Partnership

a. Is Applicant willing to direct a portion of its annual net income or reserves, as required by Oregon State Statute and defined by OHA in rule, to addressing health disparities and SDOH-HE?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to enter into written agreements with SDOH-HE partners that describe the following: any relationship or financial interest that may exist between the SDOH-HE partner and the CCO, how funds will be distributed, the scope of work including the domain of SDOH-HE addressed and the targeted population, whether CCO will refer Members to the SDOH-HE partner, the geographic area to be covered, how outcomes will be evaluated and measured, and how the CCO will collect and report data related to outcomes?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. When identifying priorities for required SDOH-HE spending, is Applicant willing to designate, define and document a role for the CAC in directing, tracking and reviewing spending?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to align its SDOH-HE spending priorities with the priorities identified in the Community Health Improvement Plan and its Transformation and Quality Strategy, and to include at least one statewide priority (e.g. housing-related services and supports, including Supported Housing) in addition to its Community priorities?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. Health-related Services

a. Is Applicant willing to align HRS Community benefit initiatives with Community priorities from the CCO's Community Health Improvement Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to align HRS Community benefit initiatives with a designated statewide priority should OHA require it?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to designate, define and document a role for the CAC when determining how Health-Related Services Community benefit initiatives decisions are made?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

3. Community Advisory Council membership and role

a. Is the Applicant willing to provide to OHA an organizational chart that includes the Community Advisory Council, and notes relationships between entities, including the CAC and the Board, how information flows between the bodies, the CAC and Board connection to various committees, and CAC representation on the board?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Health Equity Assessment and Health Equity Plan

a. Is Applicant willing to develop and implement a Health Equity Plan according to OHA guidance, which includes a plan to provide cultural responsiveness and implicit bias education and training across the Applicant's organization and Provider Network? See Sample Contract and Cultural Responsiveness Training Plan Guidance Document.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to include in its Health Equity Plan at least one initiative using HIT to support patient engagement?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to adopt potential health equity plan changes, including requirements, focus areas and components, based on OHA plan review feedback and, when applicable, based on guidance provided by the Oregon Health Policy Board's Health Equity Committee?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to designate a single point of accountability within the organization, who has budgetary decision-making authority and health equity expertise, for the development and implementation of the Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Is Applicant willing to faithfully execute the finalized Health Equity Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Is Applicant willing to a) ask vendors for cultural and linguistic accessibility when discussing bringing on new HIT tools for patient engagement and b) when possible, seek out HIT tools for patient engagement that are culturally and linguistically accessible?

☒ Yes ☐ No

If "no" please provide explanation: _____

5. Traditional Health Workers (THW) Utilization and Integration

a. Is Applicant willing to develop and fully implement a Traditional Health Workers Integration and Utilization Plan?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to work in collaboration with the THW Commission to implement the Commission's best practices for THW integration and utilization?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to fully implement the best practices developed in collaboration with the THW Commission?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to develop and implement a payment strategy for THWs that is informed by the recommendations from the Payment Model Committee of the THW Commission?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Is Applicant willing to designate an individual within the organization as a THW Liaison as of the Effective Date of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Is Applicant willing to engage THWs during the development of the CHA and CHP?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. For services that are not captured on encounter claims, is Applicant willing to track and document Member interactions with THWs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Community Health Assessment and Community Health Improvement Plan

a. Is Applicant willing to partner with local public health authorities, non-profit Hospitals, any CCO that shares a portion of its Service Area, and any Tribes that are developing a CHA/CHP to develop shared CHA and CHP priorities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to align CHP priorities with at least two State Health Improvement Plan (SHIP) priorities and implement statewide SHIP strategies based on local need?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to submit its Community Health Assessment and Community Health Improvement Plan to OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to develop and fully implement a community engagement plan?

☒ Yes ☐ No

If "no" please provide explanation:

F. Behavioral Health Attestations (Attachment 11)

1. Behavioral Health Benefit

a. Will Applicant report performance measures and implement Evidence-Based outcome measures, as developed by the OHA Metrics and Scoring Committee, and as specified in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant work collaboratively with OHA and its partners to implement all of the requirements in Exhibit M of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant be fully responsible for the Behavioral Health benefit for Members beginning in CY 2020?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant manage the Global Budget (as defined in ORS 414.025) in a fully integrated manner? Fully integrated manner means that Applicant will not sub-capitate any Provider or entity for Behavioral Health services separately from physical health services nor will Applicant enter into any Value-Based Payment arrangements under which Behavioral Health spending is tracked separately from physical health services.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant report on the information and data specified in the Performance Expectations section as specified in the Contract and submit an annual report to OAH for review and approval?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant have sufficient resources, including technological, financial, Provider and workforce, to integrate the Behavioral Health benefit with oral and physical health care benefits?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant ensure the provision of cost-effective, comprehensive, person-centered, Culturally Responsive, and integrated Community-based Behavioral Health services for Members?

☒ Yes ☐ No

If "no" please provide explanation: _____

h. Will Applicant provide oversight, Care Coordination, transition planning and management of the Behavioral Health needs of Members to ensure Culturally Responsive and linguistically appropriate Behavioral Health services are provided in a way that Members are served in a most natural and integrated environment possible and that minimizes the use of institutional care?

☒ Yes ☐ No

If "no" please provide explanation: _____

i. Will Applicant follow Intensive Care Coordination standards as identified in OAR 410-141-3160/70?

☒ Yes ☐ No

If "no" please provide explanation: _____

j. Will Applicant ensure Members have access to Referral and screening at multiple health system or health care entry points?

☒ Yes ☐ No

If "no" please provide explanation: _____

k. Will Applicant use a standardized Assessment tool, to adapt the intensity and frequency of Behavioral Health services to the Behavioral Health needs of the Member?

☒ Yes ☐ No

If "no" please provide explanation: _____

l. Will Applicant work collaboratively to improve services for adult Members with SPMI as a priority population? Will Applicant make significant commitments and undertake significant efforts to continue to improve treatment and services so that adults with SPMI can live and prosper in integrated Community settings?

☒ Yes ☐ No

If "no" please provide explanation: _____

m. Will Applicant ensure Members have timely access to all services under the Behavioral Health benefit in accordance with access to service standards as developed in Appendix C, the Administrative Rules Concept Document, under OHPB #17?

☒ Yes ☐ No

If "no" please provide explanation: _____

n. Will Applicant have an adequate Provider Network to ensure Members have timely access to Behavioral Health services and effective treatment in accordance with the Delivery System and Provider Capacity section of the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

o. Will Applicant establish written policies and procedures for Prior Authorizations, in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and be responsible for any inquiries or concerns and not delegate responsibility to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

p. Will Applicant establish written policies and procedures for the Behavioral Health benefit and provide the written policies and procedures to OHA by the beginning of CY 2020?

☒ Yes ☐ No

If "no" please provide explanation: _____

q. Will Applicant require mental health and substance use disorder programs be licensed or certified by OHA to enter the Provider Network?

☒ Yes ☐ No

If "no" please provide explanation: _____

r. Will Applicant require Providers to screen Members for adequacy of supports for the Family in the home (e.g., housing adequacy, nutrition/food, diaper needs, transportation needs, safety needs and home visiting)?

☒ Yes ☐ No

If "no" please provide explanation: _____

s. Will Applicant ensure Applicant's staff and Providers are trained in recovery principles, motivational interviewing, integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/)?

☒ Yes ☐ No

If "no" please provide explanation: _____

t. Will Applicant ensure Providers are trained in Trauma Informed approaches and provide regular periodic oversight and technical assistance to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

u. Will Applicant require Providers, in developing Individual Service and Support Plans for Members, to assess for Adverse Childhood Experiences (ACEs) and trauma in a Culturally Responsive and Trauma Informed framework and approach?

☒ Yes ☐ No

If "no" please provide explanation: _____

v. Will Applicant ensure Behavioral Health services are Culturally Responsive and Trauma Informed?

☒ Yes ☐ No

If "no" please provide explanation: _____

w. Will Applicant assume responsibility for the entire Behavioral Health residential benefit by the beginning of CY 2022?

☒ Yes ☐ No

If "no" please provide explanation: _____

x. Will Applicant include OHA approved Behavioral Health homes (BHHs) in Applicant's network as the BHHs qualify in Applicant's Region?

☒ Yes ☐ No

If "no" please provide explanation: _____

y. Will Applicant assist Behavioral Health organizations within the delivery system to establish BHHs?

☒ Yes ☐ No

If "no" please provide explanation: _____

z. Will Applicant utilize BHHs in their network for Members to the greatest extent possible?

☒ Yes ☐ No

If "no" please provide explanation: _____

aa. Will Applicant provide a full psychological evaluation and child psychiatric consultation for children being referred to the highest levels of care (day treatment, subacute or PRTS)?

☒ Yes ☐ No

If "no" please provide explanation: _____

2. MOU with Community Mental Health Program (CMHP)

a. Will Applicant enter into a written memorandum of understanding (MOU) with the local Community Mental Health Program (CMHP) in Applicant's Region by beginning of CY 2020, in accordance with ORS 414.153?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant develop a comprehensive Behavioral Health plan for Applicant's Region in collaboration with the Local Mental Health Authority and other Community partners (e.g., education/schools, Hospitals, corrections, police, first responders, Child Welfare, DHS, public health, Peers, families, housing authorities, housing Providers, courts)?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the local Community Mental Health Program (CMHP) for the delivery of mental health services under ORS 430.630

☒ Yes ☐ No

If "no" please provide explanation: _____

3. Provisions of Covered Services – Behavioral Health

a. Will Applicant provide services as necessary to achieve compliance with the mental health parity requirements of 42 CFR§ 438, subpart K and ensure that any quantitative treatment limitations (QTLs), or non-quantitative treatment limitations (NQTLs) placed on Medically Necessary Covered Services are no more restrictive than those applied to fee-for-service medically necessary covered benefits, as described in 42 CFR 438.210(a)(5)(i)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant assume accountability for Members that are civilly committed and are referred to and enter Oregon State Hospital; be financially responsible for the services for Members on waitlist for Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA; and be financially responsible for services for Members admitted to Oregon State Hospital after the second year of the Vontract, with timeline to be determined by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant reimburse for covered Behavioral Health services rendered in a primary care setting by a qualified Behavioral Health Provider, and reimburse for covered physical health services in Behavioral Health care settings, by a qualified medical Provider?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant ensure Members receive services from Non-Participating Providers for Behavioral Health services if those services are not available from Participating Providers or if a Member is not able to access services within the timely access to care standards? Will Applicant remain responsible for coordinating Behavioral Health services with Non-Participating Providers and reimbursing for services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant ensure continuity of care throughout episodes of care and provide Intensive Care Coordination and general Care Coordination as specified in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Covered Services Component – Behavioral Health

a. Will Applicant establish written policies and procedures for an emergency response system, including post-stabilization care services and Urgent Services for all Members on a 24-hour, 7-day-a-week basis consistent with OAR 410-141-3140 and 42 CFR 438.114? Will the emergency response system provide an immediate, initial or limited duration response for emergency situations or potential Behavioral Health emergency situations that may include Behavioral Health conditions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant ensure access to Mobile Crisis Services for all Members in accordance with OAR 309-019-0105, OAR 309-019-0150, 309-019-0242, and 309-019-0300 to 309-019-0320 to promote stabilization in a Community setting rather than arrest, presentation to an Emergency Department, or admission to an Acute psychiatric care facility?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant establish written policies and procedures for a Quality Improvement plan for the emergency response system?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant collaboratively work with OHA and CMHPs to develop and implement plans to better meet the needs of Members in Community integrated settings and to reduce recidivism to Emergency Departments for Behavioral Health reasons?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant work with Hospitals to provide data on Emergency Department (ED) utilization for Behavioral Health reasons and length of time in the ED? Will Applicant develop remediation plans with EDs with significant numbers of ED stays longer than 23 hour?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two or more readmissions to an ED in a six-month period?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Will Applicant make a reasonable effort to provide Covered Services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at: http://www.oregon.gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment?

☒ Yes ☐ No

If "no" please provide explanation: _____

h. Will Applicant establish written policies and procedures describing the appropriate use of Emergency Psychiatric Holds consistent with ORS 426 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the Medically Appropriate needs of the Member and the behavior of the Member meets legal standards for the use of an Emergency Psychiatric Hold?

☒ Yes ☐ No

If "no" please provide explanation: _____

i. Will Applicant assure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute, and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant also work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒ Yes ☐ No

If "no" please provide explanation: _____

j. If Applicant identifies a Member, over age 18 with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder, is appropriate for Long Term Psychiatric Care (State Facility level of care), will Applicant request a LTPC determination from the OHA LTPC reviewer?

☒ Yes ☐ No

If "no" please provide explanation: _____

k. If Applicant identifies a Member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the applicable HSD Adult Mental Health Services Unit, as described in Procedure for LTPC Determinations for Members 18 to 64, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. If Applicant identifies a Member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, Acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, will Applicant request a LTPC determination from the State hospital-NTS, Outreach and Consultation Service (OCS) Team as described in Procedure for LTPC Determinations for Member Requiring Neuropsychiatric Treatment, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. For the Member age 18 and over, will Applicant work with the Member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated Community-based setting possible consistent with Member choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant authorize and reimburse Care Coordination services, in particular for Members who receive ICC, that are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are provided to Members receiving care through licensed Community treatment programs? Will Applicant authorize and reimburse for ICC services, in accordance with standards identified in OAR 410-141-3160-70?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant ensure that any involuntary treatment provided under the Contract is provided in accordance with administrative rule and statute and coordinate with the CMHP Director in assuring that all statutory requirements are met? Will Applicant work with the CMHP Director in assigning a civilly committed Member to any placement and participate in circuit court hearings related to planned placements, if applicable?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant provide Acute Inpatient Hospital Psychiatric Care for Members who do not meet the criteria for LTPC?

☒ Yes ☐ No

If "no" please provide explanation: _____

q. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals are provided a Warm Handoff to a Community case manager, Peer bridger, or other Community provider prior to discharge, and that all such Warm Handoffs are documented?

☒ Yes ☐ No

If "no" please provide explanation: _____

r. Will Applicant ensure that all Members discharged from Acute Care Psychiatric Hospitals have linkages to timely, appropriate behavioral and primary health care in the Community prior to discharge and that all such linkages are documented, in accordance with OAR provisions 309-032-0850 through 309-032-0870?

☒ Yes ☐ No

If "no" please provide explanation: _____

s. Will Applicant ensure all adult Members receive a follow-up visit with a Community Behavioral Health Provider within seven (7) days of their discharge from an Acute Care Psychiatric Hospital?

☒ Yes ☐ No

If "no" please provide explanation: _____

t. Will Applicant reduce readmissions of adult Members with SPMI to Acute Care Psychiatric Hospitals?

☒ Yes ☐ No

If "no" please provide explanation: _____

u. Will Applicant coordinate with system Community partners to ensure Members who are homeless and who have had two or more readmissions to an Acute Care Psychiatric Hospital in a six-month period are connected to a housing agency or mental health agency to ensure these Members are linked to housing in an integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

v. Will Applicant ensure coordination and appropriate Referral to Intensive Care Coordination to ensure that Member's rights are met and there is post-discharge support? If Member is connected to ICC coordinator, will Applicant ensure coordination with this person as directed in OAR 410-141-3160-3170?

☒ Yes ☐ No

If "no" please provide explanation: _____

w. Will Applicant work with OHA and the CMHPs to ensure that Members who are discharged from Acute Care Psychiatric Hospitals are discharged to housing that meets the individuals' immediate need for housing and work with Acute Care Psychiatric Hospitals in the development of each individual's housing assessment?

☒ Yes ☐ No

If "no" please provide explanation: _____

x. Will Applicant establish a policy and procedure for developing a management plan for contacting and offering services to each Member who has two (2) or more readmissions to an Acute Care Psychiatric Hospital in a six-month period?

☒ Yes ☐ No

If "no" please provide explanation: _____

y. Will Applicant work with OHA, other state agencies, and other state funded or operated entities to identify areas where treatment and services for adult Members with SPMI can be improved?

☒ Yes ☐ No

If "no" please provide explanation: _____

z. Will Applicant coordinate services for each adult Member with SPMI who needs assistance with Covered or Non-covered Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

aa. Will Applicant provide oversight, Care Coordination, transition planning and management for Members receiving Behavioral Health services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such settings are transitioned to a Community placement in the most integrated Community setting appropriate for that person?

☒ Yes ☐ No

If "no" please provide explanation: _____

bb. Will Applicant provide Utilization Review and utilization management, for Members receiving Behavioral Health Services, including Mental Health Rehabilitative Services and Personal Care Services, in licensed and non-licensed home and Community-based settings, ensuring that individuals who no longer need placement in such setting transition to the most integrated Community setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

cc. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

dd. Will Applicant ensure that Members with SPMI receive Intensive Care Coordination (ICC) support in finding appropriate housing and receive coordination in addressing Member's housing needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ee. Will Applicant ensure Members with SPMI are assessed to determine eligibility for ACT?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ff. Will Applicant ensure ACT services are provided for all adult Members with SPMI who are referred to and eligible for ACT services in accordance with OAR 309-019-0105 and 309-019-0225 through 309-019-0255?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

gg. Will Applicant ensure additional ACT capacity is created to serve adult Members with SPMI as services are needed?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

hh. Will Applicant, when ten (10) or more of Applicant's adult Members with SPMI in Applicant's Service Area are on a waitlist to receive ACT for more than thirty (30) days, without limiting other Applicant solutions, create additional capacity by either increasing existing ACT team capacity to a size that is still consistent with Fidelity standards or by adding additional ACT teams?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

If Applicant lacks qualified Providers to provide ACT services, will Applicant consult with OHA and develop a plan to develop additional qualified Providers? Will lack of capacity not be a reason to allow individuals who are determined to be eligible for ACT to remain on the waitlist? Will no individual on a waitlist for ACT services be without such services for more than 30 days?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ii. Will Applicant ensure all denials of ACT services for all adult Members with SPMI are: based on established, evidence-based medical necessity criteria; reviewed, recorded and compiled in a manner that allows denials to be accurately reported out as appropriate or inappropriate; and follow the Notice of Adverse Benefit Determination process for all denials as described in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

jj. Will Applicant be responsible for finding or creating a team to serve Members who have appropriately received a denial for a particular ACT team but who meet ACT eligibility standards?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

kk. Will Applicant be responsible for engaging with all eligible Members who decline to participate in ACT in an attempt to identify and overcome barriers to the Member's participation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

ll. Will Applicant require that a Provider or care coordinator meets with the Member to discuss ACT services and provide information to support the Member in making an informed decision regarding participation? Will this include a description of ACT services and how to access them, an explanation of the role of the ACT team and how supports can be individualized based on the Member's self-identified needs, and ways that ACT can enhance a Member's care and support independent Community living?

☒ Yes ☐ No

If "no" please provide explanation: _____

mm. Will Applicant provide alternative evidence-based intensive services if Member continues to decline participation in ACT, which must include coordination with an ICC?

☒ Yes ☐ No

If "no" please provide explanation: _____

nn. Will Applicant report the number of individuals referred to ACT, number of individuals admitted to ACT programs, number of denials for the ACT benefit, number of denials to ACT programs, and number of individuals on waitlist by month?

☒ Yes ☐ No

If "no" please provide explanation: _____

oo. Will Applicant ensure a Member discharged from OSH who is appropriate for ACT shall receive ACT or an evidence-based alternative?

☒ Yes ☐ No

If "no" please provide explanation: _____

pp. Will Applicant document efforts to provide ACT to individuals who initially refuse ACT services, and document all efforts to accommodate their concerns?

☒ Yes ☐ No

If "no" please provide explanation: _____

qq. Will Applicant offer alternative evidence-based intensive services for individuals discharged from OSH who refuse ACT services?

☒ Yes ☐ No

If "no" please provide explanation: _____

rr. Will Applicant ensure a Member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet their needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

ss. Will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI in accordance with OAR 309-091-0000 through 0050?

☒ Yes ☐ No

If "no" please provide explanation: _____

tt. Will Applicant ensure access to Supported Employment Services for all adult Members eligible for these services, in accordance with OAR 309-019-0275 through 309-019-0295? ("Supported Employment Services" means the same as "Individual Placement and Support (IPS) Supported Employment Services" as defined in OAR 309-019-0225.)

☒ Yes ☐ No

If "no" please provide explanation: _____

uu. Will Applicant work with local law enforcement and jail staff to develop strategies to reduce contacts between Members and law enforcement due to Behavioral Health reasons, including reduction in arrests, jail admissions, lengths of stay in jails and recidivism?

☒ Yes ☐ No

If "no" please provide explanation: _____

vv. Will Applicant work with SRTFs to expeditiously move civilly committed adult Members with SPMI who no longer need placement in an SRTF to a Community placement in the most integrated setting, Supported Housing to the extent possible, consistent with the individual's treatment goals, clinical needs, and the individual's informed choice?

☒ Yes ☐ No

If "no" please provide explanation: _____

ww. Will Applicant provide Substance Use Disorder (SUD) services to Members, which include outpatient, intensive outpatient, medication assisted treatment including Opiate Substitution Services, residential and detoxification treatment services consistent with OAR Chapter 309, Divisions 18, 19 and 22, and OAR Chapter 415 Divisions 20, and 50?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

xx. Will Applicant comply with Substance Use Disorder (SUD) waiver program designed to improve access to high quality, clinically appropriate treatment for opioid use disorder and other SUDs, upon approval by Centers for Medicare and Medicaid Services (CMS)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

yy. Will Applicant inform all Members using Culturally Responsive and linguistically appropriate means that Substance Use Disorder outpatient, intensive outpatient, residential, detoxification and medication assisted treatment services, including opiate substitution treatment, are Covered Services consistent with OAR 410-141-3300?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

zz. Will Applicant participate with OHA in a review of OHA provided data about the impact of these criteria on service quality, cost, outcome, and access?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Children and Youth

a. Will Applicant develop and implement cost-effective comprehensive, person-centered, individualized, and integrated Community-based Child and Youth Behavioral Health services for Members, using System of Care (SOC) principles?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant utilize evidence-based Behavioral Health interventions for the needs of children 0-5, and their caregivers, with indications of Adverse Childhood Experiences (ACEs) and high complexity?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant provide Intensive Care Coordination (ICC) that is Family and youth-driven, strengths based and Culturally Responsive and linguistically appropriate and abide by ICC standards as set forth in Appendix C, Administrative Rules Concept under OHPB #24 and in accordance with the ICC section in the Contract? Will Applicant abide by ICC standards as forth in Appendix C, Administrative Rules Concept, under OHPB #24, and in accordance with the ICC section in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant provide services to children, young adults and families of sufficient frequency, duration, location, and type that are convenient to the youth and Family? Will Services alleviate crisis while allowing for the development of natural supports, skill development, normative activities and therapeutic resolution to Behavioral Health disorders and environmental conditions that may impact the remediation of a Behavioral Health disorder?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant adopt policies and guidelines for admission into Psychiatric Residential Treatment Services (PRTS), Psychiatric Day Treatment Services (PDTS) and/or Intensive Outpatient Services and Supports?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure the availability of service, supports or alternatives 24 hours a day/7 days a week to remediate a Behavioral Health crisis in a non-emergency department setting?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant encourage utilization of Peer-Delivered Services (PDS) and ensure that Members are informed of their benefit to access and receive PDS from a Peer Support Specialist, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist as applicable to the Member's diagnosis and needs?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. If Applicant identifies a Member is appropriate for LTPC Referral, will Applicant request a LTPC determination from the applicable HSD Child and Adolescent Mental Health Specialist, as described in Procedure for LTPC Determinations for Members 17 and Under, available on the Contract Reports Web Site?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant arrange for the provision of non-health related services, supports and activities that can be expected to improve a Behavioral Health condition?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including Members in the care and custody of DHS Child Welfare or OYA? For a Member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), will Applicant also coordinate with such Member's parent or legal guardian?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant ensure a CANS Oregon is administered to a Member who is a child or youth and the data is entered into OHA approved data system according to the eligibility and timeline criteria in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have funding and resources to implement, to fidelity, Wraparound Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant enroll all eligible youth in Wraparound and place no youth on a waitlist?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant screen all eligible youth with a Wraparound Review Committee in accordance with Wraparound Services as described in the OHA System of Care Wraparound Initiative (SOCWI) guidance document found at the link below and in Wraparound Service OARs? http://www.oregon.gov/oha/hsd/amh/pages/index.aspx.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant establish and maintain a functional System of Care in its Service Area in accordance with the Best Practice Guide located at https://www.pdx.edu/ccf/best-practice-guide including a Practice Level Workgroup, Advisory Committee and Executive Council with a goal of youth and Family voice representation to be 51 percent?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant have a functional SOC governance structure by the beginning of CY 2020 that consists of a practice level work group, advisory council, and executive council?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. By end of CY 2020, will Applicant have written Charters and new Member handbooks for Practice Level Work group, Advisory Council and Executive Council?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

G. Cost and Financial Attestations (Attachment 12)

1. Rates

Does Applicant accept the CY 2020 Rate Methodology appended to Attachment 12?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

2. Evaluate CCO performance to inform CCO-specific profit margin

a. Does Applicant agree to performance and efficiency evaluation being used to set profit margins in CCO capitation rates?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant agree to accept the CCO 2.0 capitation rate methodology as described in the Oregon CY20 Procurement Rate Methodology document and also accept the performance evaluation methodology and its use in setting CCO-specific profit margins?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Does Applicant agree to report additional data as needed to inform the performance evaluation process, including data on utilization of Health-Related Services?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to have OHA use efficiency analysis to support managed care efficiency adjustments that may result in adjustments to the base data used in capitation rate development to further incentivize reductions in Waste in the system?

☒ Yes ☐ No

If "no" please provide explanation: _____

3. Qualified Directed Payments to Providers

a. Is Applicant willing to make OHA-directed payments to certain Hospitals within five Business Days after receipt of a monthly report prepared and distributed by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to report to OHA promptly if it determines payments to Hospitals will be significantly delayed?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to exclude the portion of OHA-directed payments for provider tax repayment when negotiating alternative or Value-Based Payment reimbursement arrangements?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to provide input and feedback to OHA on the selection of measures of quality and value for OHA-directed payments to Providers?

☒ Yes ☐ No

If "no" please provide explanation: _____

4. Quality Pool Operations and Reporting

a. Does Applicant agree to having a portion of capitation withheld from monthly Capitation Payment and awarded to the Applicant based on performance on metrics based on the Quality Incentive Pool program?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Does Applicant agree to report to OHA separately on expenditures incurred based on Quality Pool revenue earned?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Does Applicant agree to report on the methodology it uses to distribute Quality Pool earnings to Providers, including SDOH-HE partners and public health partners?

☐ Yes ☒ No

If "no" please provide explanation: Our distribution methodology may contain trade secrets.

d. Does Applicant have a plan to evaluate contributions made by SDOH-HE and public health partners toward the achievement of Quality Pool metrics?

☒ Yes ☐ No

If "no" please provide explanation: _____

5. Transparency in Pharmacy Benefit Management Contracts

a. Will Applicant select and contract with the Oregon Prescription Drug Program to provide Pharmacy Benefit Management services? If yes, please skip to section 5. If not, please answer parts b-f of this question.

☐ Yes ☒ No

If "no" please provide explanation: It depends on if it's cost effective to the CCO and the state to achieve sustainable growth rate.

b. Will Applicant use a pharmacy benefit manager that will provide pharmacy cost passthrough at 100% and pass back 100% of rebates received to Applicant?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant separately report to OHA any and all administrative fees paid to its PBM?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Will Applicant require reporting from PBM that provides paid amounts for pharmacy costs at a claim level?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant obtain market check and audits of their PBMs by a third party on an annual basis, and share the results of the market check with the OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

f. Will Applicant require its PBM to remain competitive with enforceable contract terms and conditions driven by the findings of the annual market check and report auditing?

☒ Yes ☐ No

If "no" please provide explanation: _____

6. Alignment Preferred Drug Lists (PDLs) and Prior Authorization Criteria

a. Will Applicant partner with OHA on the goal of increasing the alignment of CCO preferred drug lists (PDL) with the Fee-For-Service PDL set every year by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant align its PDL in any and all categories of drugs as recommended by the P&T committee and as required by OHA?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Will Applicant post online in a publicly accessible manner the Applicant's specific PDL with coverage and Prior Authorization criteria in a format designated by OHA and update the posting concurrently or before any changes to the PDL or coverage/PA criteria become effective?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Financial Reporting Tools and Requirements

a. Is Applicant willing to partake of all financial, legal and technological requirements of the National Association of Insurance Commissioners (NAIC) in whatever capacity necessary to file its financial information with OHA under NAIC standards?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant report its required financial information to OHA on the NAIC's Health Quarterly and Annual Statement blank ("Orange Blank") through the NAIC website as described in this RFA, under NAIC standards and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant report its financial information to OHA using Statutory Accounting Principles (SAP), subject to possible exemption from SAP for 2020 as described in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant file the financial reports described in this RFA, including Contract Exhibit L and supplemental schedules with the instructions referenced in this RFA?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Is Applicant willing to resubmit its pro forma financial statements for three years starting in 2020, modified to reflect the Enrollment expected assuming other CCOs that may operate in Applicant's Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Does Applicant commit to preparing and filing a Risk Based Capital (RBC) report each year based on NAIC requirements and instructions?

☒ Yes ☐ No

If "no" please provide explanation: _____

g. Is Applicant willing to submit quarterly financial reports including a quarterly estimation of RBC levels to ensure financial protections are in place during the year?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Is Applicant willing to have its RBC threshold evaluated quarterly using a proxy calculation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. If Applicant's estimated RBC falls below the minimum required percentage based on the quarterly estimation, is Applicant willing to submit a year-to-date financial filing and full RBC evaluation?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Accountability to Oregon's Sustainable Growth Targets

a. Does Applicant commit to achieving a sustainable growth in expenditures each calendar year (normalized by membership) that matches or is below the Oregon 1115 Medicaid demonstration project waiver growth target of 3.4%?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Does Applicant similarly commit to making a good faith effort towards achievement of future modifications to the growth target in the waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Does Applicant agree that OHA may publicly report on CCO performance relative to the sustainable growth rate targets (normalized for differences in membership)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Does Applicant agree that OHA may institute a Corrective Action Plan, that may include financial penalties, if a CCO does not achieve the expenditure growth targets based on the current 1115 Medicaid waiver?

☒ Yes ☐ No

If "no" please provide explanation: _____

9. Potential Establishment of Program-wide Reinsurance Program in Future Years

a. Will Applicant participate in any program-wide reinsurance program that is established in years after 2020 consistent with statutory and regulatory provisions that are enacted?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Will Applicant use private reinsurance contracts on only an annual basis so as to ensure ability to participate in state-run program if one is launched at the start of a calendar year?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Does Applicant agree that implementation of program-wide reinsurance program will reduce capitation rates in years implemented as a result of claims being paid through reinsurance instead of with capitation funds?

☒ Yes ☐ No

If "no" please provide explanation: _____

10. CCO Solvency Standards and OHA Tools to Regulate and Mitigate Insolvency Risk

a. Is Applicant willing to have its financial solvency risk measured by Risk Based Capital (RBC) starting in 2021?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to achieve a calculated RBC threshold of 200% by end of Q3 of 2021 and thereafter to maintain a minimum RBC threshold of 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

c. Is Applicant willing to report to OHA promptly if it determines that its calculated RBC value is or is expected to be below 200%?

☒ Yes ☐ No

If "no" please provide explanation: _____

d. Is Applicant willing to report to OHA promptly if it determines that its actual financial performance departs materially from the pro forma financial statements submitted with this Application?

☒ Yes ☐ No

If "no" please provide explanation: _____

e. Will Applicant maintain the required restricted reserve account per Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

11. Encounter Data Validation Study

a. Is Applicant willing to perform regular chart reviews and audits of its encounter claims to ensure the Encounter Data accurately reflects the services provided?

☒ Yes ☐ No

If "no" please provide explanation: _____

b. Is Applicant willing to engage in activities to improve the quality and accuracy of Encounter Data submissions?

☒ Yes ☐ No

If "no" please provide explanation: _____

H. Member Transition Plan (Attachment 16)

1. Is Applicant willing to faithfully execute its Member Transition Plan as described in Attachment 16?

☒ Yes ☐ No

If "no" please provide explanation: _____

Attachment 14 — Assurances

Applicant Name: Cascade Health Alliance, LLC

Authorizing Signature: _____

Printed Name: Tayo Akins

Instructions: Assurances focus on the Applicant's compliance with federal Medicaid law and related Oregon rules. For each assurance, Applicant will check "yes," or "no." A "yes" answer is normal, and an explanation will be furnished if Applicant's response is "no". Applicant must respond to all assurances. If an assurance has more than one question and Applicant's answer is "no" to any question, check "no" and provide an explanation.

These assurances must be signed by a representative of Applicant.

Each assurance is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. **Emergency and Urgent Care Services.** Will Applicant have written policies and procedures, and oversight and monitoring systems to ensure that emergency and urgent services are available for all Members on a 24-hour, 7-days-a-week basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? (See 42 CFR 438.114 and OAR 410-141-3140]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

2. **Continuity of Care.** Will Applicant implement written policies and procedures that ensure a system for the coordination of care and the arrangement, tracking and documentation of all Referrals and Prior Authorizations to other Providers? Will Applicant follow Intensive Care Coordination (ICC)/ENCC standards and Care Coordination standards, including transition meetings, as directed in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208 and OAR 410-141-3160]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

3. Will Applicant implement written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the privacy and security of records as required by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Members from the Applicant's Primary Care and Referral Providers? Will Applicants communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any Corrective Action necessary to ensure Participating Provider compliance? Will Applicants document all monitoring and Corrective Action activities? Will such policies and procedures will ensure that records are secured, safeguarded and stored in accordance with applicable Law? [See 45 CFR Parts 160 – 164, 42 CFR 438.242, ORS 414.679 and OAR 410-141-3180]

   ☒ Yes ☐ No

   If "no" please provide explanation: _____

4. Will Applicant have an ongoing quality performance improvement program for the services it furnishes to its Members? Will the program include an internal Quality Improvement program based on written policies, standards and procedures that are designed to achieve through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas and that are expected to have a favorable effect on health outcomes and Member satisfaction? The improvement program will track outcomes by race, ethnicity and language. The Applicant will communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance. [See OAR 410-141-0200]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

5. Will Applicant make Coordinated Care Services accessible to enrolled Members? Will Applicant not discriminate between Members and non-Members as it relates to benefits to which they are both entitled including reassessment or additional screening as needed to identify exceptional needs in accordance with OAR 410-141-3160 through 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance.? [See 42 CFR 438.206 to 438.210; and OAR 410-141-3220]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

6. Will Applicant have written procedures approved in writing by OHA for accepting, processing, and responding to all complaints and Appeals from Members or their Representatives that are consistent with Exhibit I of the Appendix B "Sample Contract"? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.228, 438.400 – 438.424]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

7. Will Applicant develop and distribute OHA-approved informational materials to Potential Members that meet the language and alternative format requirements of Potential Members? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.10; OAR 410-141-3280]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

8. Will Applicant have an on-going process of Member education and information sharing that includes appropriate orientation to the Applicant provided in the Member handbook or via health education, about the availability of intensive Care CoordinationCare Coordination for Members who are aged, blind and/or disabled, or are part of a prioritized population, and appropriate use of emergency facilities and urgent care? Will Applicant 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]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

9. Will Applicant have written policies and procedures to ensure Members are treated with the same dignity and respect as other patients who receive services from the Applicant that are consistent with Appendix B, Core Contract? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.100, ORS 414.635 and OAR 410-141-3320]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

10. Will Applicant provide Intensive Care Coordination (otherwise known as Exceptional Needs Care Coordination or ENCC) to Members who are Aged, Blind or Disabled; Members with high health needs or multiple chronic conditions; Members receiving Medicaid-funded long-term care or long-term services and supports or receiving Home and Community-Based Services (HCBS) under the state's 1915(i), 1915(j), or 1915(k) State Plan Amendments or the 1915(c) HCBS waivers, or Behavioral Health priority populations in accordance with OAR 410-141-3170? Will Applicant ensure that Prioritized Populations, who sometimes have difficulty with engagement, are fully informed of the benefits of Care Coordination? Will Applicant ensure that their organization will be Trauma Informed by January 1, 2020? Will Applicant utilize evidence-based outcome measures? Will Applicant ensure that Members who meet criteria for ENCC receive contact and service delivery as required in OAR 410-141-3170? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.208]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

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

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

13. Will Applicant maintain an efficient and accurate system for capturing Encounter Data, timely reporting the Encounter Data to OHA, and regularly validating the accuracy, truthfulness and completeness of that Encounter Data based on written policies, standards, and procedures that are in accordance with accepted professional standards, CCO and OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242; and the Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

14. Will Applicant maintain an efficient and accurate process that can be used to validate Member Enrollment and Disenrollment based on written policies, standards, and procedures that are in accordance with accepted professional standards, OHP Administrative Rules and OHA Provider Guides? Will Applicant have monitoring systems in operation and review the operations of these systems on a regular basis? Will Applicant communicate these policies and procedures to Providers, regularly monitor Providers' compliance and take any Corrective Action necessary to ensure Provider compliance? [See 42 CFR 438.242 and 438.604; and Contract]

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

15. Assurances of Compliance with Medicaid Regulations

Item 15 of this Attachment 14 has ten assurances of Compliance with Medicaid Regulations. These Assurances address specific Medicaid regulatory requirements that must be met in order for the Applicant to be eligible to contract as a CCO. For purposes of this section and the federal Medicaid regulations in 42 CFR Part 438, a CCO falls within the definition of a "managed care organization" in 42 CFR 438.2. This section asks the Applicant to provide a brief narrative of how the Applicant meets each applicable Assurance. The Applicant must provide supporting materials available to the OHA upon request.

Please describe in a brief narrative how Applicant meets the standards and complies with the Medicaid requirements cited in the Medicaid Assurances in Item 15:

a. Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

See pages 6-9 for Question 15 a-j

Attachment 14 — Assurances

Question 15.a-j Assurances of Compliance with Medicaid Regulations

14.15.a Medicaid Assurance #1 – 42 CFR § 438.206 Availability of services.

Cascade Health Alliance (CHA) assures that it has an adequate network of providers to meet the availability requirements of 42 CFR § 438.206. If we do not have a provider for a specific specialty in Klamath County, CHA will contract with out of area specialists to meet our members' needs. CHA conducts geographical mapping by member and provider addresses and includes time and distance standards by provider types.

Our members will continue to receive timely access to care and appropriate services delivered in a culturally competent manner, including those members with diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation or gender identity. CHA will continue to provide physical access, reasonable accommodations, and accessible equipment for members with physical or intellectual disabilities. CHA's Provider Network Management Committee frequently meets to oversee and identify action plans to meet gaps in access. CHA continuously invests in people, processes, technology, and infrastructure. We are committed to delivering the best service and outcomes for Klamath County members.

14.15.b Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

CHA conducts geographical mapping by member and provider and includes time and distance standards by provider types. CHA uses a multitude of data points to assess and monitor our provider network capacity. It is CHA policy that our contracted providers have a mechanism to assure that members have access to routine, urgent, and emergency care and services 24 hours a day, seven days a week. CHA ensures continuous monitoring of all mandated reports and provides the reports on time per our contract.

The provider network is analyzed quarterly in areas of primary care, behavioral health, oral health, and specialty care to assure an adequate number of contracted providers are available to ensure access to our members. CHA uses a geocoding software to establish a geographic mapping of our members and providers as well as collecting and cultivating member zip code data to create adequate network capacity and to comply with member-provider time and distance standards.

Geographic information software is used to map member and provider location by address. The ability to analyze and understand where our members live and where we offer services gives CHA the tools to optimize access to care. Distance rings and drive time buffers are used to analyze accessibility. This visualization helps CHA make informed decisions when gaps are identified. If we do not have a particular specialty in Klamath County, CHA will contract with that out of area specialty to meet our members' needs.

CHA will explore utilizing visualization to identify disease hotspots and create epidemiology maps. Contracted providers are required to cooperate and assist in obtaining and verifying quarterly access data. Collectively, this data is then analyzed to establish adequate capacity and service areas.

Provider Network capacity is also established by pulling claims data extracts from a claims-based and eligibility system. This system tracks services used by CHA members and their eligibility to receive appropriate medical care. This data is placed in a visualization tool, combined with monthly updated member and provider data, that formulates into CHA's capacity report. CHA's capacity report is then shared internally and with our Provider Network Management Committee. It is also shared with each provider to assess any potential gaps in data and to share and assess any past, present or future capacity issues. Capacity is also available in our provider scorecards. CHA monitors its provider network and has policies that require: (1) Contracted providers to provide a minimum of 90 days prior written notice of provider's intent to close his or her practice to all new members; (2) Contracted providers to provide a minimum of 90 days prior written notice of provider's intent to close his or her practice; and (3) where providers have not fulfilled their agreed upon capacity assignments, providers may not "close" his or her practice to new Medicaid members while continuing to accept commercial members.

14.15.c Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

CHA's case management team follows local and out of the area hospital admissions for our members. The team collaborates with the hospital, post-acute, and community resources to develop a care plan and to assure a safe discharge as well as minimize the risk of readmission for the member. For dual eligible members, the care team coordinates with providers, to achieve appropriate care and or discharge plan. CHA utilizes a health risk assessment to screen all new dual eligible members within 90 days of enrollment. A nurse case manager reviews all positive assessments, and care coordination instituted, as needed. For Long-Term Services and Supports (LTSS) members, unique treatment plans are developed in coordination with the healthcare team and member input. CHA prior authorization procedures allow for members to have direct access to most specialty services as appropriate for the members' condition and identified needs.

14.15.d Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

The amount, duration, and scope of services that CHA is required to offer are defined in ORSs, OARs and by OHA's prioritized list with attached guideline notes. The services furnished in an amount, duration, and scope that CHA supplies are no less than the amount, duration, and scope for the same services provided to beneficiaries under FFS Medicaid. Oregon's 1115 waiver allows for no more restrictive services than the State Medicaid program which is based on medical necessity. Review of requests that require authorization is conducted in accordance with CHA's and CHA's subcontractor's written policies and procedures. Which include consultation with requesting provider when appropriate. Any potential denials of service are referred to a licensed physician or pharmacist for determination. All denials or modification of requests are communicated to the requesting provider and member in writing. Standard authorization

decisions are made within 14 days, and expedited authorization decisions are made within 72 hours after receipt of the request for service.

14.15.e Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

CHA follows all rules and regulations as set forth by the State of Oregon as it pertains to 42 CFR 438.214. We have policies and procedures specific to the selection and retention of providers. These policies and procedures encompass all aspects of credentialing and re-credentialing of providers and facilities, including delegated entities and fair hearings and appeals. CHA has a Provider Selection and Retention policy that ensures CHA does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment when determining who to select as an in-network or out-of-network provider. CHA does not employ or contract with any provider or facility that has been excluded from participation in Federal health care programs. CHA queries the following websites at the time of initial credential, re-credential, and monthly in between: Office of the Inspector General and Systems of Aware Management. CMS Opt-Out is queried on all providers at the time of initial credential and re-credential.

14.15.f Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

CHA complies with 42 CFR 438.224. Per our contract with OHA, CHA trains staff on its confidentiality policy and procedure and their responsibility for safeguarding each member's right. CHA requires employees to agree to and sign a confidentiality agreement upon hire. CHA staff and contracted providers and their staff must be trained and adhere to the HIPAA and CFR regulations regarding privacy. Per this policy, staff will only discuss information obtained in employee conferences, provider practice, and in the members' care relationship for professional purposes.

Confidential information is only used as needed to perform legitimate duties and will not be accessed otherwise. Staff will not in any way divulge, copy, sell, loan, review, alter or destroy any confidential information except as authorized by CHA, nor will they misuse or carelessly manage confidential information.

CHA's grievance policy and procedure references provision of member assurance of confidentiality in all written, oral and posted material. CHA will request an authorization for release of information from the member regarding grievances or appeals if necessary.

CHA's Member Handbook explains the confidentiality of member information and that no information will be divulged without their permission except to receive payment for services from OHA.

14.15.g Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

CHA complies 42 CFR 438.228. Per our contract with OHA, CHA has a Grievance System policy and procedure (grievances, appeals, hearings and NOA/ABD) to correct identified deficiencies. CHA conforms to all CFR and OAR regulations regarding how CHA acknowledges receipt, disposition, documentation, and reporting of each grievance, appeal and hearing from a member or their representative. CHA's grievance policy stipulates zero retaliation against members who file grievances, appeals, and hearings consistent with our compliance plan.

CHA's Member Handbook states the Grievances, Appeals and Hearings related to member rights and responsibilities, as well as processes and contact information for filing.

14.15.h Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

CHA abides by the provisions of 42 CFR § 438.230 and CHA remains responsible for subcontracted services per the OHA contract. Subcontractors' delegated responsibilities will be outlined in their respective contract. Subcontractors agree to accept delegated duties and agree to termination in the event of unsatisfactory services. Subcontractors are audited for up to ten years from the final date of the contract.

14.15.i Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

CHA assures that it will abide by the provisions of 42 CFR § 438.236. CHA practice guidelines are based on valid and reliable clinical evidence or a consensus of providers in a particular field. CHA considers the needs of our members by adopting guidelines in consultation with contracted health care professionals and will be reviewed and updated periodically as appropriate. Providers receive copies of our practice guidelines; guidelines are distributed to our members at their request. Decisions regarding utilization management, member education, and coverage of services, are consistent with the guidelines.

14.15.j Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

CHA uses and maintains multiple health information systems that collect, analyze, integrate, and report required data in compliance with CFR438.242. CHA's systems provide information to OHA on utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility. CHA data collection systems include both member and provider data. The system validates the accuracy and timeliness of data including data from providers compensated via capitation. CHA system ensures secure information exchanges for quality improvement and care coordination.

Attachment 15 — Representations

Applicant Name: Cascade Health Alliance, LLC (CHA)

Authorizing Signature: _____

Printed Name: Tayo Akins

Instructions: For each representation, Applicant will check "yes," or "no,". On representations, no particular answer is normal, and an explanation will be furnished in all cases. Applicant must respond to all representations.

These representations must be signed by a representative of Applicant.

Each representation is effective starting at the time of Readiness Review and continuing throughout the term of the Contract.

1. Will Applicant have an administrative or management contract with a contractor to manage/handle all staffing needs with regards to the operation of all or a portion of the CCO program?

☒ Yes ☐ No

Explanation: CHA leases its employees from its parent company Cascade Comprehensive Care.

2. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the systems or information technology to operate the CCO program for Applicant?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all systems and information technology operational work.

3. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the claims administration, processing and/or adjudication functions?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all claims administration, processing and adjudication functions.

4. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Enrollment, Disenrollment and membership functions?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all enrollment, disenrollment and membership functions.

5. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the credentialing functions?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all credentialing functions except those allowed per statute that may be delegated to behavioral health entities.

6. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the utilization operations management?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all utilization operations management functions.

7. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the Quality Improvement operations?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all quality improvement operational functions.

8. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of its call center operations?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all call center operational functions.

9. Will Applicant have an administrative or management contract with a contractor to perform all or a portion of the financial services?

☒ Yes ☐ No

Explanation: CHA's leased employees will perform all financial services functions.

10. Will Applicant have an administrative or management contract with a contractor to delegate all or a portion of other services that are not listed?

☐ Yes ☒ No

Explanation: There are no other operational services for which CHA will have an administrative or management contract.

11. Will Applicant will have contracts with related entities, contractors and Subcontractors to perform, implement or operate any aspect of the CCO operations for the CCO Contract, other than as disclosed in response to representation 1-10 above?

☐ Yes ☒ No

Explanation: All disclosures are accurate in numbers 1-10 above.

12. Other then VBP arrangements with Providers, will Applicant sub-capitate any portion of its Capitation Payments to a risk-accepting entity (RAE) or to another health plan of any kind?

☒ Yes ☐ No

Explanation: CHA does sub-capitate a portion of its Capitation Payments to a RAE to align with our sustainable growth methodology.

13. Does Applicant have a 2019 CCO contract? Is Applicant a risk-accepting entity or Affiliate of a 2019 CCO? Does Applicant a management services agreement with a 2019 CCO? Is Applicant under common management with a 2019 CCO?

☒ Yes ☐ No

Explanation: CHA has a current CCO contract with OHA for 2019.

Attachment 16 – Member Transition Plan

The information requested in this questionnaire should be provided in narrative form, answering specific questions in each section and providing enough information for the OHA to evaluate the response.

Page limits for this Member Transition Plan is 10 pages. Items that are excluded from the page limit will be noted in that requirement.

16.1 Background and Supporting Sources

As described in Section 5.8 Member Enrollment, OHA will hold an Open Enrollment period for Members in Choice Areas of the state. Members in these areas may move from their current plan to another plan during the Open Enrollment period. For purposes of its Application, Applicant should assume that all of its service areas will be Choice Areas.

The Member Transition Plan should describe the process for the safe and orderly transfer of Members to another CCO and receiving Members from another CCO during the Open Enrollment period. and how the plan will maximize and maintain continuity of care for Members. This includes, but is not limited to, continuity of care with primary and specialty care Providers, primary care and Behavioral Health homes, plans of care, Prior Authorizations, prescription medications, medical Case Management Services, and Transportation.

The Member Transition Plan should include specific processes for Members who may suffer serious detriment to their physical and mental health or who are at-risk of hospitalization or institutionalization, if any breakdown in service provisions or access to care were to occur, including services provided by Practitioners that may not be contracted with the new CCO. OHA considers these populations to include, but not limited to:

• Prioritized Populations;

• Medically fragile children;

• Breast and Cervical Cancer Treatment program Members;

• Members receiving CareAssist assistance due to HIV/AIDS;

• Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services;

• Members discharged from the Oregon State Hospital or Medicaid funded residential Behavioral Health programs in the last 12 calendar months; and

• Members participating in Oregon's CMS approved 1915 (k) and 1915 (c) programs for individuals who have met institutional level of care requirements in order to access Home and Community-Based Services (HCBS) under these federal authorities. These individuals are at risk of institutionalization or would require services in an institution within 30 days.

Institution is defined as Hospital, Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

A successful Member Transition Plan will result in a seamless transition experience for Members changing CCOs during the Open Enrollment period, with minimal and ideally no disruptions of care.

OHA will inform Applicants, in connection with RFA awards, which of its service areas are likely to be Choice Areas. In light of that information, Applicants are expected to submit an complete Member Transition Plan (not subject to the page limits of this RFA), gain OHA approval of its Plan, and update the Plan as part of negotiation activities, contracting, and Open Enrollment period processes.

16.2 Plan Contents

16.2.a Coordination between Transferring and Receiving CCOs

OHA expects the Transferring and Receiving CCOs to work together and cooperate to achieve a successful transition for Members who change CCO during the Open Enrollment period. This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This include but is not limited to establishing working relationships and agreements between CCOs to facilitate data sharing and validation, Member Prior Authorization history, Provider matching and Assignment, continuity of care and customer support.

The receiving and transferring CCOs will have a Business Associate Agreement and a data sharing agreement to facilitate the continuity of care for the member.

Cascade Health Alliance (CHA) as a transferring CCO:

- CHA will contact receiving CCOs for transferring members as identified on the 834 Eligibility Transaction Report.
- Data sharing of the member's medical record such as prior authorization history, case management, primary care, medication, and transportation.
- CHA will facilitate a case manager (CM) to case manager handoff for high needs members if such handoff is approved by the member.

CHA as a receiving CCO:

- A welcome package will be sent to the member to include a health assessment form. CHA will contact the member within 30 days of sending the welcome packet to ensure the health assessment has been completed.
- Data sharing of the member's medical record such as prior authorization history, case management, primary care, medication, and transportation.
- CHA will receive historic case management data to facilitate the transferring case manager to CHA case manager handoff for high needs members, if such handoff is approved by the member.
- Members identified with case management needs are assigned to a case manager.

16.2.b Transferring CCOs with Outgoing Members

This section of the Member Transition Plan is required if Applicant (1) has a 2019 CCO contract, (2) is a risk-accepting entity or Affiliate of a 2019 CCO, or (3) has a management services agreement with or is under common management with a 2019 CCO.

16.2.b.1 Data Sharing This section should describe the plan to compile and share electronic health information regarding the Member, their treatment and services. Include data elements to be shared, formatting and transmittal methods, and staffing/resource plans to facilitate data transfers to the Receiving CCO(s)

CHA will develop a secure File Transfer Protocol (FTP) site to share data with other CCOs to assure the transition is seamless.

The process will include:

- Obtaining consent from the member to share Protected Health Information (PHI) with another CCO
- Compiling the following information for the packet to transfer to the receiving CCO
  - Member personal identify information, including most current phone number
  - Current list of providers
  - Current treatment plan including ongoing care needs and active treatment (for continuity of care)
  - Current medication list and pharmacy
  - Prior authorization history
- Transfer of information to be performed by staff

16.2.b.2 Provider Matching This section should describe the methods for identifying Members' primary care and Behavioral Health home providers and any specialty providers and transmitting that information to the Receiving CCO(s).

CHA will develop a secure FTP site to share data with other CCOs to assure the transition is seamless for members transferring in and out of our CCO.

The process will include:

- Obtaining consent from the member to share PHI with another CCO.
- Compiling the following information to transfer to the receiving CCO
  - Member personal identify information, including most current phone number
  - Current list of providers to include but not limited to primary care, specialists, homecare, durable medical equipment, oral health, behavioral health, and substance use disorder specialist if applicable
  - Current medication list and pharmacy

A handoff with the receiving CCO – preferably by phone between the case managers – will be provided for any member identified as having Intensive Care Manager (ICM) needs.

16.2.b.3 Continuity of Care This section should describe plans to support Member continuity of care, including but not limited to prior authorizations, prescription medications, medical case management services, and transportation. This section should include all members regardless of health status with specific details to address those members at risk as described in Section (1).

CHA will develop a secure FTP site to share data with other CCOs to assure the transition is seamless for members transferring in and out of our CCO.

For members who have ongoing care needs and will require continued treatment, the following process will be followed:

- Obtaining consent from the member to share PHI with another CCO.
- Compiling the following information to transfer to the receiving CCO
  - Member personal identify information, including most current phone number
  - All open and ongoing authorizations
  - Current treatment plan including ongoing care needs and active treatment (for continuity of care)
  - Current medication list and pharmacy
  - Case management notes for all members currently being followed by case management
  - Current transportation needs, and services provide by applicant

CHA will use our patient management software to supply data on all claims, and medications, transportation Non-Emergent Medical Transportation (NEMT). ICC patients will include a warm handoff via telephone to the receiving case management department.

16.2.c Member/Provider Outreach for Transition Activities

This section should describe plans to work directly with outgoing Members and their providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping members and providers understand the coverage in place and the plan for transition of care, monitoring the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Receiving CCO to ensure a seamless transition of care for the member.

CHA will work with outgoing members to make the transition as seamless as possible. We will identify and contact the receiving CCO to alert them to an incoming member. Any member identified as having ICM needs a warm handoff, which will be provided to the receiving CCO, preferably telephonically, transferring CM to receiving CM.

16.2.d.1 Receiving CCOs with Incoming Members

Data Sharing. This section should describe the data reception plan for incoming Members, including but not limited to receiving and storing data files, front-end validation, system entry, output validation, and distribution.

CHA can receive patient data for incoming members from the transferring CCO using a secure FTP site or secure fax. Data will be stored as received on CHA's secure services. Once the data is received, CHA will cross-reference and validate it with existing CHA member roster and notify OHA of any members that do not match.

High-value information will be entered to CHA's information systems manually. Data elements may include but are not limited to recent case management notes, current authorizations including pharmacy authorizations, primary care provider assignment and, if available, behavioral health providers. The feasibility of ingesting electronic and integrating data files will be evaluated based on the number of members received and the structure, size, and integrity of files received.

16.2.d.2 Provider Matching. This section should describe the methods for identifying Members' primary care and Behavioral Health home Providers and any specialty Providers, and enrolling Members with their assigned Providers. This includes contingency plans for assigning Members to appropriate Providers if they cannot be enrolled with the Provider from the Transferring CCO.

Once the member data is validated, and we receive the transferring provider data, CHA will attempt to match the member with their existing provider. If this is not possible, we will match the member to a similar provider in our network.

16.2.d.3 Continuity of Care. This section should describe plans to support Member continuity of care, including but not limited to honoring prior authorizations, prescription medications, and treatment plans from the Transferring CCO, medical case management services, and transportation. This section should address the approach for all members regardless of health status with specific details to address those persons described in Section (1). As the receiving CCO, the plan should address how the receiving CCO will ensure access to all medically necessary services for members at risk of serious detriment to their physical and mental health, hospitalization, or institutionalization.

We will honor the existing CCO's care plan for 90 days. We will establish a new care plan for the member which will provide a seamless transition of care. Prior authorizations and medications from the previous CCO will be honored.

16.2.d.4 Member/Provider Outreach for Transition Activities. This section should describe plans to work directly with incoming Members and their providers to perform Warm Handoff activities for high-need Members and other specific Member groups identified as requiring additional support during the transition. This includes, but is not limited to, helping members and providers understand the coverage in place and the plan for transition of care, monitoring

the transition of care to identify and address issues during the transition process, and collaborating with stakeholders and the Transferring CCO to ensure a seamless transition of care for the member.

CHA will contact the incoming high-needs members identified by the transferring CCO and assist them with finding a new Primary Care Medical Home. CHA's CM will contact transferring CM and request a warm handoff to include case management history, medical history, and previous provider information. The current, active treatment plan will be maintained and reassessed by the CHA CM for treatment plan validation and continuity of care. During the warm handoff, CHA will help members and providers understand the coverage in place and the plan for the transition of care, monitor the transition of care to identify and address issues during the transition process, collaborate with stakeholders and the transferring CCO to ensure a seamless transition of care for the member.