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: Umpqua Health Alliance, LLC

Address: 3031 NE Stephens St

Roseburg, OR 97470

State of Incorporation: Oregon **Entity Type:** Limited Liability Company

Contact Name: Michael von Arx **Phone:** 541-229-7035 **Email:** mvonarx@umpquahealth.com

Oregon Business Registry Number: 312689-98

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:** Chief Executive Officer **Date:** 18 April 2019

(Authorized to Bind Applicant)

OFFICIAL STAMP
NICHOLE K SPURLIN
NOTARY PUBLIC-OREGON
COMMISSION NO. 985735
MY COMMISSION EXPIRES APRIL 07, 2023

State of Oregon)
) ss:
County of Douglas)

Signed and sworn to before me on April 18, 2019 (date) by Brent Eichman (Affiant's name).

_____

Notary Public for the State of Oregon

My Commission Expires: April 7, 2023

Attachment 4 - Disclosure Exemption Certificate

Brent Eichman ("Representatve"), representing [Umpqua 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 [April 18, 2019] (the "Application"), to the State of Oregon in response to Request for Application #OHA-4690-18 for CCO 2.0 (the RFA). I am familiar with the contents of the Application.
3. I have read and am familiar with the provisions of Oregon's Public Records Law, Oregon Revised Statutes ("ORS") 192.311 through 192.478, and the Uniform Trade Secrets Act as adopted by the State of Oregon, which is set forth in ORS 646.461 through ORS 646.475. I understand that the Application is a public record held by a public body and is subject to disclosure under the Oregon Public Records Law unless specifically exempt from disclosure under that law.
4. I have checked Box A or B as applicable:

A. ■ The Applicant believes the information listed in Exhibit A to this Exhibit 4 is exempt from public disclosure (collectively, the "Exempt Information"), which is incorporated herein by this reference. In my opinion, after consulting with a person having expertise regarding Oregon's Public Records Law, the Exempt Information is exempt from disclosure under Oregon's Public Records Law under 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
See Attached Spreadsheet 'redactions' for reference		**1.**
		2.
		3.
		4.
		5.

Exhibit A- Attachment 4 Response

Section Redacted	ORS or Authority	Reasons for Redaction
Attachment 6.C.1.b	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Related to an insurer's trend, claims cost, administrative expenses and target loss ratio (actual or projected). Commercial value.
Attachment_6_Required (Subcontractor and Delegated Entities Report)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing comparisons. Information relating to rate setting (i.e., rate ranges, methodology).
Attachment 7.3.a.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 7.7.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 7.7.c	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 7.7.d	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 7.9.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 7.9.c	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 7.12.f.6	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 7 (DSN Report)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 8.C.1 (VBP Data Template Lowest Enrollment Viability 3.11.2019)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.1 (VBP Data Template with Highest enrollment 4.11.19)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.2	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)

Attachment 8.C.2.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.2.b	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.3.b	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.4	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.5.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 8.C.5.b	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 9.B.1.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.1.c	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.b.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.b.2	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.b.3	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.c	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.e	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.

Attachment 9.D.2.f	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.g.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.g.3.a	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.g.3.b	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9.D.2.g.5	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9 (Decision Support- Reporting Master List.xlsx)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 9 (Enrollment Eligibility and Encounter Data Diagram.pdf)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 11.A.5	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 11.A.7	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 12 (Biographical Affidavit)	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Confidential personal information
Attachment 12.A.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 12.A.2	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Commercial value, proprietary reporting.
Attachment 12.C.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 12.C.2	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)

Attachment 12.C.3	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 12.D.2	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 12.G.1	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)
Attachment 12.G.3	ORS 192.345(2); ORS 192.355(9); ORS 646.461 to 646.475	Trade secret: Pricing methodology. Information relating to rate setting (i.e., rate ranges, methodology)

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: 6

   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: Umpqua Health Alliance, LLC	RFA: 4690 Project Name: CCO 2.0

Signature: _____ **Title:** Chief Executive Officer **Date:** 4.18.2019

(Authorized to Bind Applicant)

Certificate of Completion

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

Umpqua Health Umpqua Health

Has successfully completed the following:

DAS - CHRO - Overview of Pay Equity

On *2/21/2019*

BRENT EICHMAN, MBA, CHFP

PROFESSIONAL PROFILE

Brent Eichman is the Chief Executive Officer of Umpqua Health, which administers the Umpqua Health Alliance CCO. With over 20 years of experience in hospitals, health systems, physician groups, and health information technology companies, Brent is a well-seasoned executive with a variety of unique healthcare stakeholder perspectives. Against the backdrop of system transformation, Brent is dedicated to improving health care delivery through the mechanisms of payment reform and the leveraging of information technology. Brent holds a BA in Finance and a Master's Degree in Business / Health Care Administration.

AREAS OF EFFECTIVENESS / QUALIFICATIONS SUMMARY

- Health Policy Development
- Financial Analysis/Forecasting
- Business Development
- Strategic Planning
- Board Relations
- Analytics Development
- Service Line Analysis
- Risk Analysis
- Government Affairs
- Capital Budgeting
- Project Management
- Contract Negotiation

WORK HISTORY

Chief Executive Officer, **Umpqua Health**
Roseburg, OR, May 2016 to present

Chief Financial Officer, Architrave Health
Roseburg, OR, January 2012 to 2016

Chief Financial Officer, DCIPA
Roseburg, OR, January 2006 to 2012

Finance Director, Payer Relations & Contracting Allina Hospitals & Clinics
Minneapolis, MN, November 2004 to January 2006

Decision Support Business Analyst, Southwest Washington Medical Center
Vancouver, WA, November 2002 to November 2004

Senior Manager, Business Development, **WebMD (WellMed)**
Portland, OR, October 1999 to November 2001

EDUCATION

BBA Finance, University of Iowa, graduated with honors
MBA, HCA, REGIS University, graduated with honors

GOVERNANCE / DIRECTORSHIPS

ATRIO Health Plan – Board Member Emeritus
SOASTC – Southern Oregon Adolescent Treatment Center- Board Member Emeritus
Umpqua Community College Foundation – Board Member

TECHNICAL EXPERTISE

Decision Support/CRM/SFA: Cognos Impromptu, Crystal Reports, MicroJ, Maximizer, Act!, SQL Reporting Services, Pathways Decision Support, inteligenz
Healthcare Systems: Mckesson (Trendstar, Star, HBI), NextGen, Outcomes Advisor, Cerner Lab, Cascade, MediPac, Epic, GE Centricity, HCC, GuidingCare Pathways
Revenue Cycle Management: IMaCS, RCMS
Budgeting/Productivity/Payroll Systems/GL: Lawson, ReportSmith (query), SRC, QuickBooks, ADP (payroll), Mas90

ELAINE M. SCHWEITZER, CPA

PROFESSIONAL SUMMARY

Senior Financial Executive and Chief Financial Officer with strong business focus. Significant health care finance experience with recent focus on Medicaid, Medicare and Marketplace (Health Benefit Exchange) products and prior experience with Commercial products.

- Business and strategic planning
- Financial Planning, Analysis and Reporting
- Revenue Optimization including Medicare Risk Adjustment
- Medical Cost Trend analysis and cost reduction strategies and opportunities.
- State Medicaid Rate Analysis and Negotiation
- Provider contracting negotiation and support.

PROFESSIONAL HISTORY

Chief Financial Officer, Umpqua Health
Roseburg, OR, April 2019 to current

Regional CFO, Molina Healthcare of Washington, Utah and Idaho
Bothell, WA, September 2013 to March, 2019

Chief Financial Officer, Humana Puerto Rico
San Juan, PR, December, 2012 to September, 2013

Senior VP Finance/CFO, Arcadian Health Plans (Interim role)
Oakland, CA, February, 2012 to September, 2012

Chief Financial Officer, American Health Medicare/Triple S
Guaynabo, PR, June 2006 to June, 2011

Vice President Finance (and other prior senior Finance positions), Kaiser Foundation Health Plan
Oakland, CA, 1999 to 2006

Regional Finance Officer (and other prior senior Finance positions), Aetna Health Plans
Hartford, CT, Irving TX, and Walnut Creek, CA, 1985 to 1998

Auditor and Tax Accountant, Price Waterhouse
Hartford, CT, 1980 to 1985

EDUCATION /PROFESSIONAL CERTIFICATIONS

BA Commerce (Accounting)
University of Virginia
Charlottesville, VA. 1980

Certified Public Accountant, State of Connecticut

F. Douglas Carr, MD, MMM

PROFESSIONAL EXPERIENCE

Umpqua Health: Chief Medical Officer
7/2017-present Roseburg, OR

Molina Healthcare, Washington: Medical Director, Risk Management
2/2017-6/2017 Bothell, WA

Roseburg VA Health System (Eugene VA HCC): Director, Medical Specialties
10/2015 to 2/2017 Eugene & Roseburg, OR

New West Health Services (dba New West Medicare): Chief Medical Officer
3/2015 to 1/2016 Helena, MT

PeaceHealth Medical Group: Vice President/Medical Director, Oregon West Network
9/2013 to 2/2015 Eugene, OR

Billings Clinic
1989 to 8/2013 Billings, MT
Medical Director, Education & System Initiatives 2006 to 8/2013
Medical Director, Clinical Operations 2000 to 2006

RiverStone Health
2001 to 2013 Billings, MT
Loaned Executive from Billings Clinic
Board of Health (Chair, 2005-20010)
Montana Family Medicine Residency Board (Chair, 2005-2010)

New West Health Services
1997 to 2012 Helena, MT
Board of Directors (1997-2012), Executive Committee (2004-2012), Medical Steering Committee (1997-2012)

Practice of Internal Medicine

Billings Clinic, Billings, MT 1989 to 2004

Cody, WY 1981 to 1989

EDUCATION

- **Master of Medical Management**, Health System Management, School of Public health and Tropical Medicine, Tulane University, New Orleans, LA (2002)
- **Doctor of Medicine** − Feinberg School of Medicine, Northwestern University − Chicago, IL (1978)
  Honors Program in Medical Education, allowing degree completion 6 years post high school.
- **Residency in Internal Medicine**: R1 Metropolitan Medical Center, New York, NY; R2/3 Kaiser Foundation Hospital, San Francisco, CA; ABIM Certification
- **Fellow of the American College of Physicians**
- **American Board of Internal Medicine** (1981)

LICENSE

Oregon, Washington, Montana (active)
California and Wyoming (inactive)

COMMUNITY SERVICE

- National Alumni Board, Feinberg School of Medicine, Northwestern University (President 2010-2012)
- Board of Trustees, Yellowstone Art Museum, Billings, MT 2008-2013 (President 2012-2014)
- Advisory Board, Master of Health Administration Program, College of Allied Health, Montana State University- Billings (Chair 2006-2011)

MICHAEL A. VON ARX, MHA, MA, CHC

CAREER EXPERTISE

Health Plan Operations: Medicaid Managed Care, Medicare Advantage, Marketplace, Claims, Member Services, Network Development, Contract Negotiation, Case Management, Care Coordination, Utilization Management, Quality Improvement, and Population Health

Compliance: Program Development, Policies / Procedures Development, Investigations, Auditing, Conflict of Interests, Compliance Plan, Corrective Action

Medical Facility Operations: Physician Practices, Clinics, Medicare and Medicaid Regulations, Rural Health Clinics, Provider Recruitment, Project Management, Performance Improvement, Program Development, Strategic Planning, Quality Improvement, and Contracting.

Human Resources: Employee Relations, Provider Relations, Coaching, Hiring, Staff Management, Scheduling (24/7 coverage), Cost Controls, Productivity Tracking, Training, Performance Reviews, Conflict Resolution, Improvement Plans, and Team Building.

Fiscal Management: P&L, Budgeting, Accounts Receivable, Accounts Payable, Billing Procedures, Statistical Analysis, Financing, and Cost Accounting.

ADMINISTRATIVE / PROJECT MANAGEMENT EXPERIENCE

Umpqua Health – Roseburg, OR
Chief Operating Officer, 11/2017–present
Chief Compliance & Privacy Officer, 06/2016–11/2017

Molina Healthcare of Michigan – Troy, MI
Director of Compliance, 09/2014–06/2016

Oregon Imaging Centers and Radiology Associates, P.C. – Eugene, OR
Director of Compliance and Privacy, 11/2012–09/2014

FamilyCare Health Plans – Portland, OR
Regulatory Compliance Coordinator, 9/2011–11/2012

Albertina Kerr – Portland, OR
Compliance and Billing Specialist, 10/2009–9/2011

Christie Care, Marylhurst, Oregon
Residential Counselor Supervisor, 9/2005–10/2009

ADDITIONAL BACKGROUND:
Pacific University College of Health Professional – Hillsboro, OR
Adjunct Faculty, 1/2012–12/2017

EDUCATION

Pacific University – Forest Grove, OR
Masters of Healthcare Administration
Master of Arts in Counseling Psychology
(Specializing in organizational psychology/consulting and cognitive behavioral therapy)

Portland State University – Portland, OR
Bachelor of Arts in Psychology
Bachelor of Arts in German
(Studied abroad at Karls–Ruprect Universitat Heidelberg, Germany)

Professional development:

- HIPAA and Medical Records Law by Cross Country Education Seminar – Portland, OR (2011)
- Certified in Healthcare Compliance – Compliance Institute by Healthcare Compliance Association – Scottsdale, AZ (2012)
- Radiology Summit by Radiology Business Management Association – Colorado Springs, CO (2013)
- Cascade Range Regional Conference – Healthcare Compliance Association – Portland, OR (2013)
- Cascade Range Regional Conference – Healthcare Compliance Association – Portland, OR (2014)
- Health Care Compliance Institute – Healthcare Compliance Association – San Diego, CA (2014)
- Health Care Compliance Institute – Healthcare Compliance Association – Orlando, FL (2015)
- Health Care Compliance Institute – Healthcare Compliance Association – Washington, D.C. (2017)
- Cascade Range Regional Conference – Healthcare Compliance Association – Portland, OR (2018)
- National Conferences on Medicare, Medicaid & Duals – America's Health Insurance Plans – Washington, D.C. (2018)

6.A.1.m Contact List

The Application	Each Attachment to the RFA	The Sample Contract	Each Exhibit to the Sample Contract
Michael von Arx 541-229-7035 mvonarx@umpquahealth.com	Michael von Arx 541-229-7035 mvonarx@umpquahealth.com	Michael von Arx 541-229-7035 mvonarx@umpquahealth.com	Michael von Arx 541-229-7035 mvonarx@umpquahealth.com

Rates and solvency	Readiness Review	Membership and Enrollment
Elaine Schweitzer 541-464-4084 eschweitzer@umpquahealth.com	Michael von Arx 541-229-7035 mvonarx@umpquahealth.com	Naomi Brazille 541-229-7010 nbrazille@umpquahealth.com

State of Oregon

OFFICE OF THE SECRETARY OF STATE
Corporation Division

Certified Copy 234D965F6

I, DENNIS RICHARDSON, Secretary of State of Oregon, and Custodian of the Seal of said State, do hereby certify:

That the attached

Document File

for

UMPQUA HEALTH ALLIANCE, LLC

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

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

DENNIS RICHARDSON, SECRETARY OF STATE

2/15/2019

DCIPA, LLC

09/23/2005 1:14PM 000001 #6878 0001
BUSINESS REG $50.00

ARTICLES OF ORGANIZATION
Limited Liability Company

REGISTRY NUMBER:
312689-98

FILED
SEP 23 2005
OREGON
SECRETARY OF STATE

1. **Name of Company**. DCIPA, LLC

2. **Duration**. The duration of the company is perpetual.

3. **Management**. The company shall be member-managed.

4. **Name of Registered Agent**. The name and address of the initial registered agent:

Donald R. Laird
425 SE Jackson Street
Roseburg, OR 97470

5. **Notification Address**. The address where the Division may mail notices if different than registered agent's address:

Donald R. Laird
PO Box 10567
Eugene, OR 97440-2567

6. **Name and Address of Each Organizer**.

Donald R. Laird
425 SE Jackson Street
Roseburg, OR 97470

Donald R Laird

Donald R. Laird, Organizer

Person to contact about this filing:

DCIPA, LLC

31268998-8110049 NEWORG

9/23

Restated Articles of Organization - Limited Liability Company

Secretary of State - Corporation Division - 255 Capitol St. NE, Suite 151 - Salem, OR 97310-1327 - http://www.FilingInOregon.com - Phone: (503) 986-2200

FILED

JAN 05 2017

OREGON SECRETARY OF STATE

For office use only

REGISTRY NUMBER: 312689-98

In accordance with Oregon Revised Statute 192.410-192.490, the information on this application is public record. We must release this information to all parties upon request and it will be posted on our website.

Please Type or Print Legibly in Black Ink. Attach Additional Sheet if Necessary.

1. **NAME OF ENTITY:** DCIPA, LLC

2. **NEW NAME OF THE LIMITED LIABILITY COMPANY:** (If changed)

   Umpqua Health Alliance, LLC

3. **A COPY OF THE RESTATED ARTICLES IS ATTACHED.** (•) (Required)

4. **CHECK THE APPROPRIATE STATEMENT:**

   ( ) The restated articles contain amendments which do not require member approval. These amendments were duly adopted by the manager(s).

   (•) The restated articles contain amendments which require member approval. The date of adoption of the amendments and restated articles was Jan 3, 2017.

   The amendment(s) was (were) approved by the members. 100 percent of the members approved the amendment(s).

5. **EXECUTION:** By my signature, I declare as an authorized signer, that this filing has been examined by me and is, to the best of my knowledge and belief, true, correct, and complete. Making false statements in this document is against the law and may be penalized by fines, imprisonment or both.

Signature:	Printed Name:	Title:
	Brent Eichman	CEO

CONTACT NAME: (To resolve questions with this filing)

Terrence Ehlers

PHONE NUMBER: (Include area code)

503-294-9381

UMPQUA HEALTH ALLIANCE, LLC

31268998-17602582 RSTART

UMPQUA HEALTH ALLIANCE, LLC

RESTATED ARTICLES OF ORGANIZATION
Limited Liability Company

REGISTRY NUMBER: 312689-98

1. **Name of Company:**

   Umpqua Health Alliance, LLC

2. **Duration:**

   The duration of this company is perpetual.

3. **Name and Address of Registered Agent:**

   C T Corporation
   388 State St STE 420
   Salem, OR 97301

4. **Address Where Division May Mail Notices:**

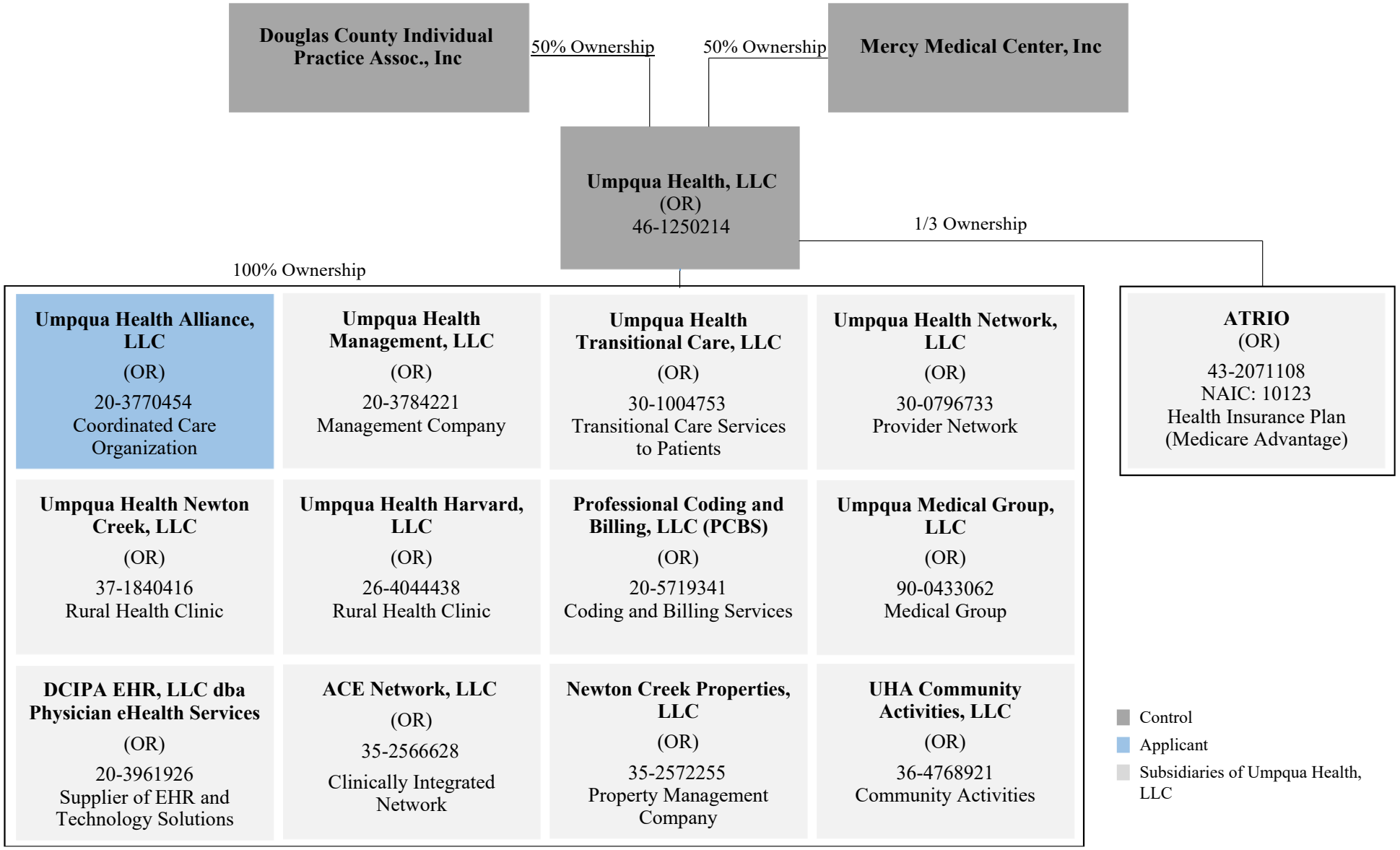
   1813 W Harvard Suite 448
   Roseburg, OR 97471

5. **Management:**

   The company shall be manager-managed.

81064370.2 0048143-00110

Corporate Organization Chart



UMPQUA HEALTH ALLIANCE

Evergreen Family Medicine:
Credentialing & Recredentialing Services Work Example (6.D.1.b)

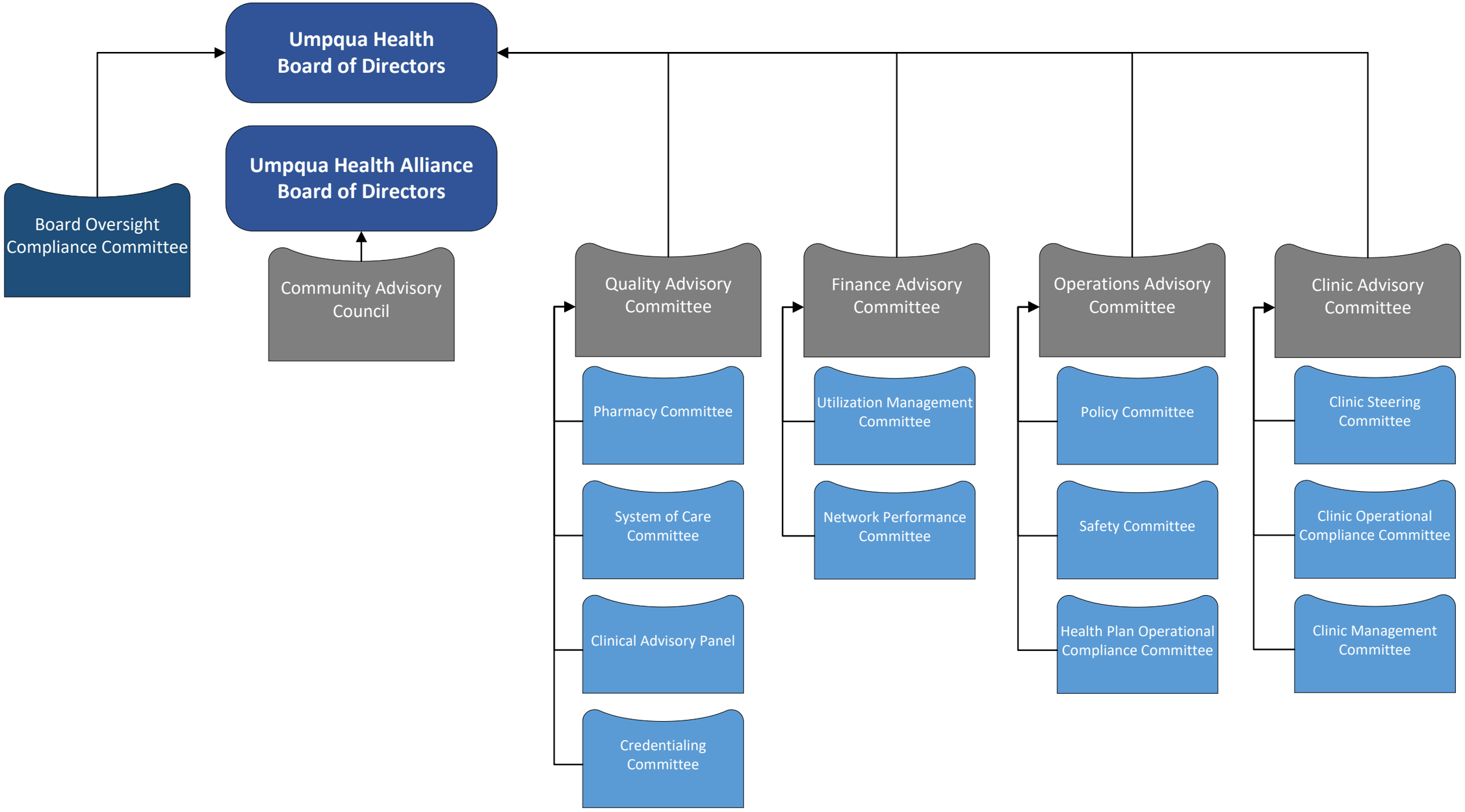
1. Delegate shall be responsible for accepting applications, reapplications, and attestations. Delegate shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application for credentialing under the Oregon Health Plan.
2. Delegate shall establish, maintain and carry out a reporting policy that complies with the applicable Standards, including but not limited to the Delegated Provider/Medical Group Monthly Reporting in the A TRIO DelCred Agreement, as appropriate. Such reporting policy shall include but not be limited to the frequency, content and format of each required report.
3. Delegate shall establish, maintain and carry out a site visit policy that complies with the Standards. Such site visit policy shall include but not be limited to the frequency of site visits, procedures for detection of deficiencies, and mechanisms to address deficiencies.
4. Delegate shall obtain and verify all information listed below (the "Credentials") through primary and/or NC QA-approved sources, as required by the Standards. If there are conflicting requirements for Credentials in a Plan's Policies and Procedures (e.g., the Credentialing and Recredentialing Standards in Exhibit A of the ATRIO DelCred Agreement), such Plan's requirements for Credentials shall govern.
    a. Licensure. Current, unrestricted state licensure, verified' within ninety (90) days from the date of approval. Alternatively, if a provider is not required to be licensed or certified by a State of Oregon board or licensing agency, Delegate shall document, certify and report the date that the person's education, experience, competence, and supervision are adequate to permit the person to perform his or her specific assigned duties.
    b. Controlled Substances. Current DEA or CDS certificate, if applicable, or plan for prescribing controlled substances.
    c. Insurance. Current professional liability insurance coverage in the amount of at least $1 million per claim and $3 million aggregate.
    d. Education and Training. Verification of education status and training, including verification of current Board certification status, if applicable.
    e. Professional Liability Claims History. Past five years' professional liability claims history, obtained through the malpractice carrier or a query of the National Practitioner Data Bank ("NPDB").
    f. NPDB Query Report. Obtained within ninety (90) days from the date of approval.
    g. Work History. Work history since medical or professional education. A curriculum vita is acceptable verification of work history providing that start and end dates are provided in month **(XX)** and year **(XXXX)** format.
        i. Any gap in work history of more than six (6) months requires an explanation.
    h. Attestation. Attestation questions to include the following, signed by the provider within ninety (90) days from the date of approval:

i. Reasons for inability to perform the essential functions of the position, with or without accommodation.
ii. Lack of present illegal drug use.
iii. History of loss of license and felony convictions.
iv. History of loss or limitation of privileges or disciplinary actions.
v. Current malpractice insurance coverage.
vi. Confirmation of the correctness and completeness of the application.

i. Program Integrity. Compliance with 42 CFR 455.410 through 42 CFR § 455.470 regarding provider screening and enrollment.
j. Exclusions. Sanctions and exclusions through the OIG and SAM.
k. Medicare Opt-Out. Medicare opt-out status through Noridian.
l. Hospital Privileges. Current hospital admitting privileges or plan for admitting patients.
m. NPI. Verification of National Provider Identifier ("NPI").
n. Oregon Health Systems Division ("HSD") Enrollment. Verification of enrollment with HSD and Medicaid provider ID number.
o. Medicare ID. Medicare provider ID number.

5. Delegate shall verify the applicable participating health care provider's Credentials at reappointment, which shall occur at minimum every thirty-six (36) months, and monitor practitioner sanctions, complaints and quality issues between the recredentialing cycles as described in this Schedule A. To the extent that issues are identified as a result of these monitoring activities, Delegate shall take appropriate action consistent with the Standards.
6. Delegate shall maintain an NCQA-approved review and approval process including a credentialing committee.
    a. All verifications and approval/appointment shall be completed within one hundred and eighty (180) days from the date of the health care provider's signature on the credentialing application and attestation.
    b. To ensure that a consistent and equitable process is used throughout the UHN network, the credentialing and recredentialing policies of Delegate shall adhere to at least the same criteria, qualification standards, and participation terms and conditions set forth in UHM's and Plan's credentialing Policies and Procedures. Delegate shall maintain credentialing policies and procedures compliant with all applicable Standards and this Agreement.
7. Delegate shall ensure that all Clinic Providers submitted to UHN for approval meet UHN's selection criteria and have been reviewed and approved by the Delegate's credentialing committee. UHN shall submit all credentialing decisions made by Delegate to the UHM Quality Management Committee for review. UHN reserves the right to approve, suspend, reject or terminate any health care provider credentialed or recredentialed by Delegate.
8. Delegate shall make all credentialing policies and procedures available for review by UHN, as requested by UHN, prior to pre-delegation review, during UHN audits, and at any time that there are revisions made to such policies and procedures by Delegate. Such policies and procedures shall provide for practitioner appeal rights as required by the Standards.

		Correspondence Address					Subcontractor/Affiliate Physical Address												Subcontract Begin Date			Subcontract End Date					
Name	Tax ID# (SSN/FEIN)	Street Address (PO box)	City	State	Zip	County	Street Address (PO box)	City	State	Zip	County	Parent Company (if applicable)	State	Country	Service Type(s)	Subcontractor/Affiliate Owner(s) Business Name or Individual's Last Name	Subcontractor/Affiliate Owner(s) Individual's First Name (if applicable)	Percent Ownership	Payment Methodology	Payment Methodology: Other	Month	Day	Year	Month	Day	Year	Date of most recent Compliance Review	Downstream Delegation Services	Describe the work being Subcontracted or Delegated
Adapt, Inc. (SUD)	930611783	PO Box 1121	Roseburg	OR	97470	US	621 W Madrone St.	Roseburg	OR	97470	US	N/A	N/A	N/A	Credentialing and Re-Credentialing Services.	Nonprofit	Nonprofit	100	[redacted]	[redacted]	1	1	2018	Annual auto-renew			12/21/2018	None.	None.
Adapt, Inc. dba Compass Behavioral Health	930611783	PO Box 1121	Roseburg	OR	97470	US	621 W Madrone St.	Roseburg	OR	97470	US	Adapt, Inc.	N/A	N/A	• Children's System of Care Governance Structure ("SOC"). • Crisis, Urgent, & Emergency Services for Mental Health. • Mental Health Conditions that may Result in Involuntary Psychiatric Care. • Covered Services for Members Receiving Long Term Psychiatric Care. • Acute Inpatient Hospital Psychiatric Care. • Adult, Children, and Youth Mental Health • Wraparound Services • Credentialing Services • Community Integration of Services for Individuals with SPMI. • Outpatient Mental Health Director. • CMHP Reporting Requirements. • Technical Assistance, in coordination with UHA, from OHA.	Nonprofit	Nonprofit	100	[redacted]	[redacted]	7	16	2014	Annual auto-renew			12/21/2018	None.	None.
Advantage Dental Group	931195386	442 SW Umatilla, Suite 200	Redmond	OR	97756	US	442 SW Umatilla, Suite 200	Redmond	OR	97756	US	Advantage Community Holding Company, LLC	OR	US	Administer dental benefits.	DentaQuest, LLC. Advantage Consolidated, LLC.	N/A	80% 20%	[redacted]	[redacted]	7	1	2014	12	31	2021	10/25/2018	None.	None.
Bay Cities Brokerage	205640086	3505 Ocean Blvd SE	Coos Bay	OR	97420	US	3505 Ocean Blvd SE	Coos Bay	OR	97420	US	HMW Services, Inc.	OR	US	NEMT & Transportation pertaining to Health Related Services	Fuiten,	James Duane	100	[redacted]	[redacted]	6	25	2015	Annual auto-renew			10/25/2018	None.	None.
Vituity (fka CEP America)	271369141	2100 Powell St, Ste 900	Emeryville	CA	94608	US	2100 Powell St, Ste 900	Emeryville	CA	94608	US	N/A	N/A	N/A	Credentialing & Recredentialing Services	Vituity (CEP America)	N/A	Distributed equitably among practicing physicians.	[redacted]	[redacted]	1	1	2015	12	31	2019	10/25/2018	None.	None.
Evergreen Family Medicine	273383688	2570 NW Edenbower Blvd Ste 100	Roseburg	OR	97471-6214	US	2570 NW Edenbower Blvd Ste 100	Roseburg	OR	97471-6214	US	Centennial Medical Group East	OR	US	Credentialing & Recredentialing Services	Individual Owners/Board Members: Powell, Powell, Brittain, Russell, Clyde,	Tim John Shelley Cory Patrick	Each owner holds 20%	[redacted]	[redacted]	10	1	2018	Annual auto-renew			10/5/2018	None.	None.
MedImpact Healthcare Systems, Inc	33-0567651	8150 S Kyrene Rd	Tempe	AZ	85284-2115	US	10181 Scripps Gateway Ct.	San Diego	CA	92131	US	MedImpact is a privately-owned C corporation, founded by pharmacists.	N/A	N/A	Pharmacy Benefit Manager (PBM) Flu Vaccines Smart 340B	Frederick Howe, RPh, Founder, Chairman/CEO and majority shareholder Employee Shareholders	N/A	>90% <10%	[redacted]	[redacted]	5	7	2001	Annual auto-renew			11/16/2018	None.	None.
Performance Health Technology (PhTech)	931211733	3993 Fairview Industrial Drive SE	Salem	OR	97302	US	3993 Fairview Industrial Drive SE	Salem	OR	97302	US	Providence Plan Partners	OR	US	Claims Processing	Providence Plan Partners	N/A	100	[redacted]	[redacted]	4	1	2017	Annual auto-renew			2/5/2019	None.	None.


Umpqua Health
Board of Directors
Umpqua Health Alliance
Board of Directors
Board Oversight
Compliance Committee
Community Advisory
Council
Quality Advisory
Committee
Pharmacy Committee
System of Care
Committee
Clinical Advisory Panel
Credentialing
Committee
Finance Advisory
Committee
Utilization Management
Committee
Network Performance
Committee
Operations Advisory
Committee
Policy Committee
Safety Committee
Health Plan Operational
Compliance Committee
Clinic Advisory
Committee
Clinic Steering
Committee
Clinic Operational
Compliance Committee
Clinic Management
Committee

Attachment 6 — General Questions

6.A. Background Information about the Applicant

6.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.

6.A.1.a. Describe Applicant's Affiliates as relevant to the Contract.

The Applicant delegates management services to Umpqua Health Management, LLC "Manager". Manager is a management services company and a licensed worker leasing company engaged in the business of administering health care benefits programs by providing services such as financial services, human resources, employee leasing, medical management, utilization review, data processing, claims payment, records maintenance and other services, and has employees qualified to provide such services for Applicant.

Manager delegates Provider Panel Contracting and Credentialing Services to Umpqua Health Network, LLC "UHN". UHN provides provider panel contracting services sufficient to provide Applicant's Enrollees with all Covered Services required by the CCO Contract.

Manager provides management services to Umpqua Health Harvard, LLC "UHH" and Umpqua Health Newton Creek, LLC "UHNC". UHH and UHNC both operate as a Rural Health Clinic "RHC" in Oregon.

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

Applicant is not invoking alternative dispute resolution with respect to any provider.

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

Applicant's primary office and administration is located at 3031 NE Stephens Street Roseburg, OR, 97470.

6.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.

Applicant's service area includes Douglas County. Currently, a County Commissioner serves on the Applicant's Board of Directors to work to establish written agreements required. UHA actively coordinates with Douglas County Public Health Network (DPHN) in several ways:

- DPHN has a designated spot for a UHA employee on their Board.
- UHA partnered with what was Douglas County Public Health to complete UHA's initial Community Health Assessment (CHA) and Community Health Improvement Plan.
- UHA collaborated on a provider training for childhood immunizations in June 2018.
- UHA has funded DPHN's Oral Health for Pregnant Women project in 2018 and 2019.
- UHA has a designated spot for DPHN to submit content in the monthly provider newsletter (the only agency to which UHA has extended this offer).
- UHA's Director of Quality Improvement sits on a DPHN grant advisory council.

This DPHN collaboration has been active for many years and UHA is in the process of formalizing this relationship to meet CCO 2.0 contract requirements before Readiness Review.

Compass, as the CMHP, has contracted with UHA for many years to provide services as described below in Section 6.D.1.a.

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

Applicant is the Legal Entity that has a contract with OHA as a CCO as of January 1, 2019.

6.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.

Applicant currently holds a contract with OHA for Cover All Kids (Contract #156267).

6.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?

Applicant's parent corporation, Umpqua Health, LLC, is an owner in ATRIO Health Plans, Inc., a Medicare Advantage contractor with a current Medicare Advantage contract servicing Douglas, Josephine, Jackson, Klamath, Marion and Polk counties in Oregon.

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

Applicant currently has a Dual Special Needs Coordination of Benefits Agreement with OHA.

6.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?

Applicant does not hold a current certificate of authority with the Department of Consumer and Business Services, Division of Financial Regulation.

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

Applicant does not hold a current contract with the Oregon Health Insurance Marketplace

6.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.

For many years, UHA has successfully used a partnership with community stakeholders and the Community Health Improvement Plan (CHP) to guide a funding stream that supports community projects and programs. The CHP process brings together community partners and UHA's leadership. UHA engages the community through its Community Advisory Council (CAC), which is a crucial component of UHA's governing structure and has diverse representation from

throughout the whole community. See Community Engagement Plan, Attachment 10 for details.

6.A.1.l. Identify and furnish résumés for the following key leadership personnel (by whatever titles designated):

UHA's key leadership personnel are listed below. Their respective resumes are attached.

- Chief Executive Officer: Brent A. Eichman
- Chief Financial Officer: Elaine Schweitzer
- Chief Medical Officer: Douglas M. Carr, MD
- Chief Operations Officer: Michael A. von Arx

6.A.1.m. Provide a chart (as a separate document) 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

6.A.2. Required Documents

We have included the Background Narrative above and the following required documents:

Résumés (excluded from pages limit) and Contact list (excluded from pages limit)

6.B. Corporate Organization and Structure

6.B.1. Questions

6.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.

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

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

Applicant does not hold any licenses relevant to this application.

6.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 in Section C.

UHA does not have any active administrative services or management contracts with other parties where UHA is the provider or recipient of the services under the contract.

6.B.2. Required Documents

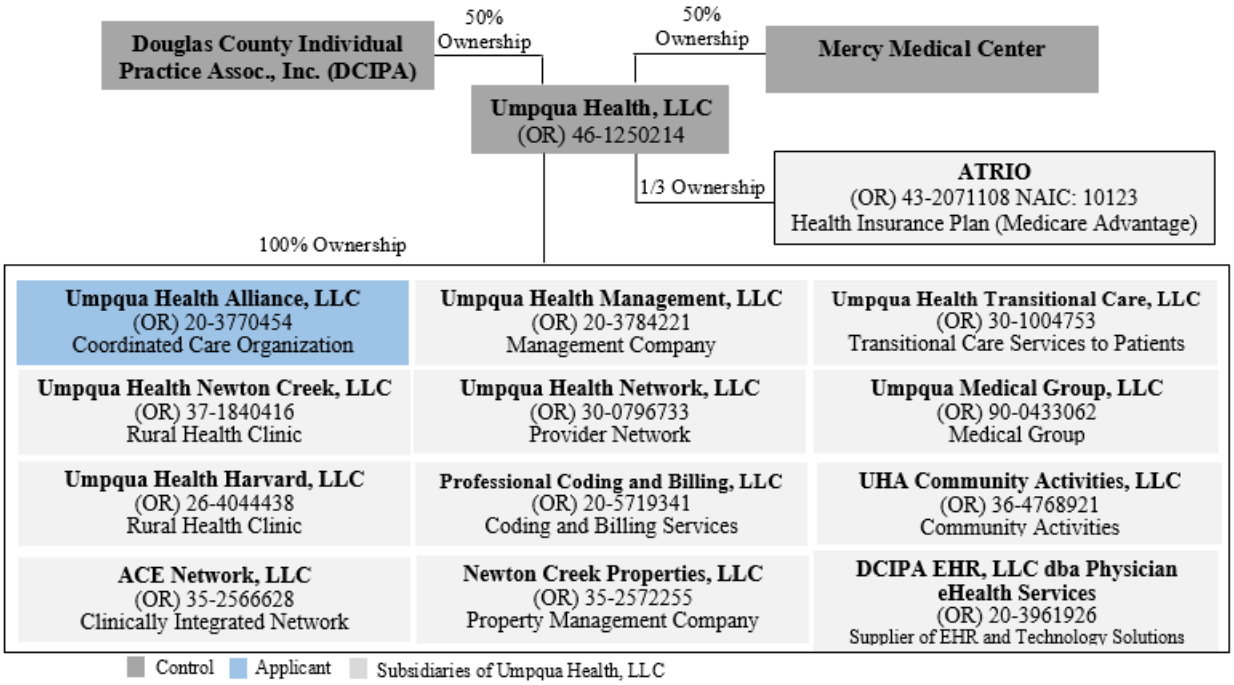
We have included narrative of Items c and d above and attached the following required documents: Articles of Incorporation and Organizational Chart

6.C. Corporate Affiliations, Transactions, Arrangements

6.C.1. Questions

6.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.



6.C.1.b. Describe 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.

Umpqua Health Alliance (UHA) [redacted] with Umpqua Health Management (UHM), an affiliate, for all CCO employee wages and benefits and other related business activates. UHA also pays UHM [redacted] for managing the care and quality aspects of the CCO contract.

6.C.1.c. Describe Applicant's demonstrated experience and capacity for:

Managing financial risk and establishing financial reserves: UHA monitors the financial risk and adjusts provider contracts on an annual/ as needed basis to accommodate changes in premium rates and metric goals delivered by OHP. UHA has established both a restricted reserves for solvency and a claim liability reserves associated with Healthcare costs. The claim liability reserve is evaluated on a monthly basis by an outside actuarial firm to ensure adequacy of the reserve and is adjustment accordingly.

Meeting the minimum financial requirements for restricted reserves and net worth in OAR 410-141-3350: Restricted Reserve and minimum net worth valuation for UHA has been established. UHA holds almost double the restricted reserve required with both a primary ($250,000) and secondary reserve (50 % of the difference between the average monthly medical

expenses and the primary reserve of $250,000) which equals almost double the requirement and monitors the account monthly to ensure adequate funding.

Minimum net worth is the greater of 10% of annualized total net healthcare revenue or 200 % of its authorized control level risk-based capital as of January 1, 2019.

6.C.2. Required Documents

We have included the organization chart attached (excluded from page limit).

6.D. Subcontracts

6.D.1. Informational Questions

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

Umpqua Health ("Organization") delegates the following activities to its affiliates:

- Umpqua Health Management, LLC.
    - Accounting and financial services.
    - Administrative and executive supports.
    - Sales, marketing, and public relation services.
    - Quality assurance and utilization review.
    - Property management.
    - The leasing of employees to the Organization.
- Umpqua Health Network, LLC.
    - Contracting and Credentialing and Re-Credentialing Services.

Additionally, the Organization subcontracts with the following entities:

- Adapt "SUD" has been delegated to provide credentialing services and in doing so to ensure providers are qualified prior to servicing UHA members.
- Adapt dba Compass Behavioral Health ("Compass") provides UHA members with:
    - Children's System of Care Governance Structure ("SOC").
    - Crisis, Urgent, & Emergency Services for Mental Health.
    - Mental Health Conditions that may Result in Involuntary Psychiatric Care.
    - Covered Services for Members Receiving Long Term Psychiatric Care.
    - Acute Inpatient Hospital Psychiatric Care.
    - Adult, Children, and Youth Mental Health
    - Wraparound Services
    - Credentialing Services
    - Community Integration of Services for Individuals with SPMI.
    - Outpatient Mental Health Director.
    - CMHP Reporting Requirements.
    - Technical Assistance, in coordination with UHA, from OHA.
- Advantage Dental Services, LLC provides UHA members with all dental benefits and services associated there within.
- Bay Cities Brokerage (BCB) provides UHA members with non-emergent transportation

(NEMT) services to provide transportation to and from covered services. Additionally, BCB provides NEMT as part of the CCO's health-related services to help members meet such needs as picking up prescriptions or fresh groceries to maintain or improve their health.

- Evergreen Family Medicine has been delegated to provide credentialing and re-credentialing services on behalf of UHA for its providers.
- MedImpact is used by UHA for its pharmacy benefit manager (PBM), flu vaccine program, and Smart340B program. Using the PBM aids with formulary maintenance, contracting with pharmacies, negotiating with drug manufactures, and processing prescription drug claims.
- PH Tech has been delegated by UHA for claims processing and helps prevent payment of claims that either contain errors or lack information necessary for appropriate processing.
- Vituity provides credentialing and re-credentialing service for emergency department and inpatient doctors.

6.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. (example of subcontracted work does not count toward page limit)

UHA anticipates continuing with the subcontractors stated in 6.D.1.a and will procure additional subcontractors as needed to meet member needs. For an example for subcontracted work, please see the attached Att6-D.1.b-Evergreen Work Example.

Currently, UHA monitoring occurs through routine reports submitted by subcontractors and through data mining and routine auditing (annual at minimum). UHA uses the submitted reports to measure compliance with contractual and/or regulatory requirements. Additionally, UHA staff routinely mine data using a business intelligence vendor to analyze claims data for utilization patterns and anomalies; this allows early detection of potential issues. Subcontractors are also audited annually by the Compliance department during which they are evaluated on their performance of the delegated duties. Furthermore, screening for exclusion from participation in federally funded programs is conducted prior to contracting as well as monthly thereafter.

In 2020, UHA will enhance its oversight functions to include meeting the new requirements laid out in the sample contract. Specifically UHA will add in the following:

- enhanced oversight functions of onboarding, routine monitoring, and annual auditing
- criminal background checks incorporated into readiness reviews and screening for exclusion from federal programs prior to contracting.
- readiness review findings provided to OHA's Contract Administrator promptly for new subcontractor agreements and the initial and annual Subcontractor Reports.
- subcontractor audits reviewing the quality of performance; complaints; late submission of deliverables or incomplete data; employee screening for federal Medicaid exclusion; compliance adequacy; and any OHA-identified deficiencies.
- enhanced corrective action plan process (CAP) incorporating OHA into the communication of identification and remediation when deficiencies are identified. If a discovery is made by OHA, subcontractors are required to respond and rectify those deficiencies. UHA will provide CAP status updates to OHA's Contract Administrator until the CAP is successfully completed and validated or of the subcontractor's failure to

fully remedy the underlying deficiency.

6.E. Third Party Liability

6.E.1. Informational Questions

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

UHA's Third Party Recovery (TPR) department has a robust and comprehensive policy and procedure ensuring all contractual requirements are met. The TPR department is responsible for taking all reasonable actions to pursue recovery of Third Party Liability (TPL) for covered services. The TPR department implements written policies for TPL recovery; reports to the OHA Contract Administration Unit annually and to OHA as required; maintains TPL recovery; and reports all TPL to the Oregon Health Authority (OHA). UHA has a written policy establishing the threshold for determining when it is not cost effective to pursue recovery action.

UHA's TPR department is committed to timely and thorough investigations of all TPL matters involving our members. Confirmation of TPL coverage is accomplished by directly contacting the legally responsible resource, such as private (individual) or Employer (group) health insurance, Automobile insurance, Worker's compensation, Medicare A & B, Homeowners Insurance, or Claims, judgments, settlements or assignments of restitution. The TPR department uses multiple resources to help identify members with TPL: Providers and Facilities, Attorneys, Members, Insurance Companies, Weekly/Monthly Audit Reports, Claims Department, Medical Review Personnel, Unsolicited Refunds, Oregon Health Authority, and Law Enforcement. Timely updates are critical to UHA cost-avoidance endeavors and productivity.

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

UHA's TPR department investigates as described above when Medicare is involved. However, there is a difference when verifying coverage with Medicare. Members under the age of 65 are assigned Medicare due to disability, in which case coverage can be retroactive further back per the direction of a judge. Our department works closely with CMS and the Medicaid/Medicare Buy in Unit in these cases.

6.E.2. Required Documents: Narrative for Items a and b is included above.

6.F. Oversight and Governance

6.F.1. Informational Questions Please describe:

6.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.

Umpqua Health Alliance, LLC (UHA) is managed by a Board of Directors ("the Board") with decision-making authority for the organization. Individually, directors do not have the authority or capacity to bind UHA or conduct its business. The Board is comprised of up to 16 directors in compliance with ORS 414.625(2)(o), including 10 persons serving on the Umpqua Health, LLC Board of Directors. In addition to these 10, the Board may appoint persons meeting the following criteria: A physician in active practice license under ORS 677 or a nurse practitioner in active practice certified under ORS 678.375 whose area of practice is primary care; A mental health or chemical dependency treatment provider; and at least one member of the community advisory council.

If one or more of the directors serving on the Board meets any of these three criteria, additional directors may not be required. The following may also be appointed provided that the total number of directors does not exceed 16:

- A representative of a dental care organization selected by the coordinated care organization;
- The major components of the health care delivery system;
- At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; or

Directors serve for one-year terms without contractual rights to serve. They hold office until the effective date of appointment of their successor(s) or earlier if individuals cease to be a director upon resignation or removal from, or expiration of his or her term on the Board. A Chair of the Board, Vice Chair of the Board, and a Secretary of the Board may be appointed by the Board. Umpqua Health, LLC may appoint the President and Chief Executive Officer of UHA. The Board holds regular quarterly meetings and may hold additional meetings called by the Board Chair, the President and Chief Executive Officer, or a majority of the directors in office. A director may also designate another director to vote on his or her behalf with written notice by proxy. To constitute a quorum, at least 6 directors must be in person or by proxy. Any action by the Board is taken by an affirmative vote of a majority. Board Decision-making includes:

- Amendment of the UHA operating agreement or articles;
- A merger, consolidation, conversation, liquidation or dissolution of the UHA;
- The sale, lease, exchange, mortgage, pledge or other transfer of substantially all of UHA's assets;
- Any action related to the appointment of a receiver, trustee, or liquidator of UHA, or the voluntary filing of a petition in bankruptcy of UHA;
- Admission of new organizations under Umpqua Health, LLC;
- Approval of annual operating and capital budgets for UHA;
- Incurrence of indebtedness by UHA in excess of $250,000.00, not included in UHA's annual capital budget or operating budget;
- Individual capital expenditures of UHA of $250,000.00 or more;
- Reviewing recommendations of the Board of Directors and making final determinations concerning matters pertaining to provider agreements, provider payment structure and rates, and distributions by UHA.
- Any tax or other election by UHA;
- Appointment and removal of the President and Chief Executive Officer of UHA.

UHA's President and Chief Executive Officer are responsible for the day-to-day, ordinary operations of UHA. They have the authority to execute contracts, certificates, documents, and instruments on behalf of UHA within the scope of their level of responsibility and authority.

6.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.

The Umpqua Health, LLC Board of Directors oversees multiple committees. While the CAC reports directly to the UHA Board of Directors, other advisory committees and subcommittees report to the Umpqua Health, LLC Board of Directors. All committees maintain written minutes of meetings and report activities and recommendations as appropriate to the Board.

Committee Name	Oversight Responsibility	Activities Performed	Other
Board Oversight Compliance Committee	Umpqua Health Compliance Program	Ensure the Program aligns with both State and Federal regulations and is implementing best practices to mitigate risk.	Members appointed by a majority vote of the Board for a 2-year term. Chairperson may remain one extra year.
Community Advisory Council	Community Health Improvement Plan (CHP)	Identify the community needs Administer and allocate CHP funds for HRS	
Quality Advisory Committee	Quality Assurance and Performance Improvement (QAPI) and transformation programs	Monitor UHA's annual quality strategy and work plan Reports on quality improvement, metrics, and quality assurance	Enables change recommendations for clinical policies and standards of UHA provider network
Finance Advisory Committee	Contracts, clinical utilization practice/rewards, and network adequacy alignment with financial solvency	Review and measure effectiveness of contracts across clinical and non-clinical functions	Collaborates with Utilization Management and Network Performance Committees
Operations Advisory Committee	Operational excellence, profitability, and strategic initiatives	Review programs and committee work for effectiveness and efficiency and implement changes	
Clinic Advisory Committee	Umpqua Health, LLC clinic performance	Review financial performance, progress on quality metrics and goals, alignment w/ strategy	

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

UHA's CAC is a crucial component of UHA's governing structure. The individuals on the CAC advise UHA on ways to make positive health changes that impact UHA members, local families and the community as a whole. UHA's CAC is a broad representation of the community with a balance of age, sex, ethnic, socioeconomic, geographic, professional, and consumer interests represented. The CAC consists of 15 regular members and one Chairperson. At least eight members will represent consumers of health services under the responsibility of UHA. Five positions on the CAC are at-large community positions. Additional positions are filled by persons with special interest in or knowledge of the following: seniors and people with disabilities; mental health and addictions; health/medical; dental; education; local government; children; tribe; housing; and faith community.

The CAC advises the UHA Board of Directors on health care needs of consumers and the community, health care access, and ease of navigation, and identifies and advocates for preventive care practices, overseeing a community health assessment and adopting a CHP to serve as a strategic population health plan. To accomplish this work, CAC members are allocated funding and tasked with identifying projects and programs that would best serve UHA members, local families and the community as a whole. These projects and programs address social determinants of health, and at least one of the five key focus areas identified in UHA's most recent CHP: access, addictions, mental health, parents and children and healthy lifestyles.

Last Name of Provider	Provider Taxonomy Code	Provider Category	Provider Service Category	Provider NPI #	Provider TIN #	DMAP # (Medicaid ID)	Credentialing Date	Non-English Language Spoken 1	Non-English Language Spoken 2	Non-English Language Spoken 3	Group/Clinic Name	Address	Address #2	City	Zip Code	County	State	Phone

Facility Name	Provider Category	Provider Service Category	Business (facility) NPI #	Business (facility) TIN#	DMAP # (Medicaid ID)	Facility Taxonomy Code	Address	Address 2	City	Zip Code	County	State	Phone	Status of Medicaid Contract (Yes, Pend, No, Term)
Adapt/Compass Behavioral Health	05	MHCS	XXXXXXXXXX				621 W Madrone St		Roseburg	97470-3090	Douglas	Oregon	541-440-3532	
Adapt/MH	05	AD	XXXXXXXXXX				548 SE Jackson St		Roseburg	97470	Douglas	Oregon	541-672-2691	
Adapt/SUD	05	SUDPP/SUDPA	XXXXXXXXXX				548 SE Jackson St		Roseburg	97470	Douglas	Oregon	541-672-2691	
Advantage Dental Clinics LLC	05	DSPP, DSPA	XXXXXXXXXX				422 SW Umatilla Ave Ste 200		Redmond	97756	Deschutes	Oregon	866-468-0022	
Avalon Health Care-Rose Haven, LLC dba Rose Haven Nursing Center	04	SNF	XXXXXXXXXX				740 NW Hill Place		Roseburg	97471	Douglas	Oregon	541-672-1631	
Avalon Health Care-Umpqua Valley, LLC	04	SNF	XXXXXXXXXX				525 W Umpqua Street		Roseburg	97471	Douglas	Oregon	541-464-7100	
HMS Services Inc dba Bay Cities	05	EMT, NEMT	XXXXXXXXXX				3505 Ocean Blvd		Coos Bay	97420	Coos	Oregon	541-269-1155	
Byram Healthcare Centers Inc	05	DME	XXXXXXXXXX				10202 E Burnside St Ste 7		Portland	97216-2963	Multnomah	Oregon	503-233-2201	
CEP America LLC Roseburg	05	SPP, SPA	XXXXXXXXXX				2700 NW Stewart Pkwy		Roseburg	97471	Douglas	Oregon	800-498-7157	
CEP America - Psychiatry PC	05	MHCS	XXXXXXXXXX				2700 NW Stewart Pkwy		Roseburg	97471	Douglas	Oregon	800-498-7157	
CMG East dba Evergreen Family Medine	04	RHC/UCC	XXXXXXXXXX				2570 NW Edenbower Blvd		Roseburg	97471	Douglas	Oregon	541-677-7200	
Community Cancer Center	04	SPP, SPA	XXXXXXXXXX				2880 NW Stewart Pkwy Ste 100		Roseburg	97471	Douglas	Oregon	541-673-2267	
Connect The Dots Pediatric Therapy	05	SPP	XXXXXXXXXX				84 Centennial Loop		Eugene	97401	Lane	Oregon	541-255-2681	
DVA Healthcare Renal Care Inc dba Roseburg Mercy Dialysis	04	SPP, SPA	XXXXXXXXXX				2410 NW Edenbower Blvd, Ste 178		Roseburg	97471	Douglas	Oregon	541-672-4608	
Galen Inpatient Physicians Inc	05	SPP, SPA	XXXXXXXXXX				2700 NW Stewart Parkway		Roseburg	97471	Douglas	Oregon	541-673-0611	
Jasper Mountain-Residential Care	04	MHPP, MHPA	XXXXXXXXXX				37875 Jasper-Lowell Rd		Jasper	97438	Lane	Oregon	541-747-1235	
Jasper Mountain-SAFE Center	04	MHPP, MHPA	XXXXXXXXXX				89124 Marcola Rd		Springfield	97478	Lane	Oregon	541-741-7402	
Lincare, Inc	05	DME	XXXXXXXXXX				1810 NW Mulholland Dr		Roseburg	97470	Douglas	Oregon	541-957-0907	
Lower Umpqua Hospital District dba Reedsport Medical Clinic	04	PCPP/PCPA	XXXXXXXXXX				600 Ranch Rd		Reedsport	97467	Douglas	Oregon	541-271-2171	
Lower Umpqua Hospital District - Walk In/Specialty Clinic	04	SPP/SPA	XXXXXXXXXX				600 Ranch Rd		Reedsport	97467	Douglas	Oregon	541-271-2171	
Lower Umpqua Hospital District	04	HOSP	XXXXXXXXXX				600 Ranch Rd		Reedsport	97467	Douglas	Oregon	541-271-2171	
Lower Umpqua Hospital District dba Dunes Family Health Care	04	RHC	XXXXXXXXXX				620 Ranch Rd		Reedsport	97467	Douglas	Oregon	541-271-2163	
Mercy Medical Center	04	HOSP	XXXXXXXXXX				2700 NW Stewart Parkway		Roseburg	97471	Douglas	Oregon	541-673-0611	
Mercy Medical Center Home Health Agency	04	HH	XXXXXXXXXX				2675 NW Edenbower Blvd		Roseburg	97471	Douglas	Oregon	541-677-2384	
Mercy Medical Center Hospice	04	Hospice	XXXXXXXXXX				2675 NW Edenbower Blvd		Roseburg	97471	Douglas	Oregon	541-677-2384	
National Seating & Mobility	05	DME	XXXXXXXXXX				8239 SW Cirrus Dr, Ste 16G		Beaverton	97008	Washington	Oregon	503-746-6332	
Optical Shop Equipment, Inc	05	SPP, SPA	XXXXXXXXXX				341 NW Medical Loop #120		Roseburg	97471	Douglas	Oregon	541-673-1340	
Option Care at Legacy Health, LLC	05	DME	XXXXXXXXXX				161955 W 72nd Ave		Portland	97224	Multnomah	Oregon	503-536-8300	
Oregon SurgiCenter, LLC	04	SPP, SPA	XXXXXXXXXX				2400 Hartman Lane		Springfield	97477	Lane	Oregon	541-343-1603	
PeaceHealth Medical Group - Siuslaw	04	SPP, SPA	XXXXXXXXXX				340 9th St		Florence	97439	Lane	Oregon	541-997-7134	
PeaceHealth Peace Harbor Medical Center	04	HOSP	XXXXXXXXXX				400 9th St		Florence	97439	Lane	Oregon	541-997-8412	
PeaceHealth Medical Group - Cottage Grove	04	SPP, SPA	XXXXXXXXXX				1515 Village Dr		Cottage Gro	97424	Lane	Oregon	800-597-7826	
PeaceHealth Cottage Grove Community Medical Center	04	HOSP	XXXXXXXXXX				1515 Village Dr		Cottage Gro	97424	Lane	Oregon	541-349-7827	
PeaceHealth Sacred Heart Medical Center at RiverBend	04	HOSP	XXXXXXXXXX				3333 Riverbend Dr		Springfield	97477	Lane	Oregon	541-222-7300	
PeaceHealth Sacred Heart Medical Center, University District	04	HOSP	XXXXXXXXXX				1255 Hilyard St		Eugene	97401	Lane	Oregon	541-686-7191	
PeaceHealth Sacred Heart Medical Center, University District (Inpt Rehab)	04	MHCS	XXXXXXXXXX				740 E 13th Ave		Eugene	97401	Lane	Oregon	541-686-7191	
PeaceHealth Sacred Heart Medical Center, University District (inpt Psych)	04	MHCS	XXXXXXXXXX				1255 Hilyard St		Eugene	97401	Lane	Oregon	541-686-7191	
RGH Enterprises, Inc dba Edgepark Medical Supplies	05	DME	XXXXXXXXXX				1810 Summit Commerce Pk		Twinsburg	44087	Summit	Ohio	330-963-6998	
Rick's Medical Supply	05	DME	XXXXXXXXXX				482 NE Winchester St		Roseburg	97470-3256	Douglas	Oregon	541-672-3042	
Serenity Lane Coburg	04	SUDPA	XXXXXXXXXX				1 Serenity Lane 91150 N Coburg Ind Way		Coburg	97408	Lane	Oregon	541-687-1110	
Serenity Lane Roseburg	04	SUDPA	XXXXXXXXXX				2575 NW Kline St		Roseburg	97471	Douglas	Oregon	541-673-3504	
SouthRiver Community Health Center	04	FQHC	XXXXXXXXXX				671 SW Main St		Winston	97496	Douglas	Oregon	541-492-4550	
Trillium Family Services	04	MHPP, MHPA	XXXXXXXXXX				3415 SE Powell Blvd		Portland	97202	Multnomah	Oregon	503-205-4362	
Tucker Maxon Oral School	04	SPP, SPA	XXXXXXXXXX				2860 SE Holgate Blvd		Portland	97202	Multnomah	Oregon	503-235-6551	
Umpqua Community Health Center - Roseburg	04	FQHC	XXXXXXXXXX				150 NE Kenneth Ford Dr		Roseburg	97470	Douglas	Oregon	541-672-9596	
Umpqua Community Health Center - Glide	04	FQHC	XXXXXXXXXX				20170 N Umpqua Hwy		Glide	97443	Douglas	Oregon	541-496-3504	
Umpqua Community Health Center - Myrtle Creek	04	FQHC	XXXXXXXXXX				790 S Main St		Myrtle Creek	97457	Douglas	Oregon	541-860-4070	
Umpqua Community Health Center - Sutherlin	04	FQHC	XXXXXXXXXX				123 Ponderosa Dr		Sutherlin	97479	Douglas	Oregon	541-672-9596	
Umpqua Health - Harvard, LLC	04	RHC	XXXXXXXXXX				1813 W HarvardAve Ste 201		Roseburg	97471	Douglas	Oregon	541-440-6390	
Umpqua Health Newton Creek, LLC	04	RHC	XXXXXXXXXX				3031 NE Stephens St		Roseburg	97470	Douglas	Oregon	541-229-7038	
Valley Opticians, Inc	05	SPP, SPA	XXXXXXXXXX				780 NW Garden Valley Blvd, Ste 50B1		Roseburg	97471	Douglas	Oregon	541-672-5400	
Willamette Community Health Solutions dba Cascade Health Solutions	04	Hospice	XXXXXXXXXX				2650 Suzanne Way #200		Eugene	97408	Lane	Oregon	541-228-3008	

Attachment 7 —Provider Participation & Operations Questionnaire

7.1. Governance and Organizational Relationships

7.1.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:

1) The proposed Governance Structure, consistent with ORS 414.625

Umpqua Health Alliance (UHA) governance structure is designed to comply with the requirements in ORS 414.625. The following is a makeup of its 15 Board Members:

- 11 Board Members have some financial risk within the CCO
- One Board Member currently works for a Dental Care Organization
- 12 Board Members represent the health care delivery system.
- Nine Board Members are healthcare providers.
- Seven Board Members are physicians.
- Two Board Members are mental health and/or chemical dependency providers.
- Four Board Members are community members and two Board Members also serve on UHA's Community Advisory Council.

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

The Community Advisory Council (CAC) in Douglas County was selected in accordance with ORS 414.625, which requires that an organization's community advisory council meets the criteria specified in ORS 414.627. The CAC includes community members with consumer representatives constituting a majority of the membership. The council meets monthly, satisfying the requirement of meeting every three months. The council posts a report of its meetings and discussion to a public website. The regular council meetings are open to the public, and provide a public comment period. UHA has posted contact information for the CAC chairperson and a designated staff member of the organization.

3) The relationship of the Governance Structure with the CAC

Both the CAC Chairperson and Vice-Chairperson are members of the UHA Board. Every UHA Board meeting, the CAC Chairperson or Vice-Chairperson provides a report of CAC business, to include recommendations from the CAC to the UHA Board. All UHA Board meetings are now open to the public, thus CAC members who do not sit on the UHA Board may attend. This structure will ensure transparency and accountability for the governing body's consideration of recommendations from the CAC.

4) How 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.

UHA has a strong relationship with local organizations serving members with severe and

persistent mental illness and members receiving DHS Medicaid-funded LTC services and supports. Adapt provides many services for UHA members with severe and persistent mental illness, including treatment for substance use and behavioral health disorders, psychiatric and behavioral health care, community and population health, and operates a federally qualified health center. Several members of the executive leadership of Adapt serve on the UHA Board, including the Chief Executive Officer.

Another member of executive leadership at Adapt serves on UHA's Community Advisory Council. In addition, UHA's CAC has a member who is a program manager at Douglas C.A.R.E.S., an organization that provides child abuse response and evaluation services. Our CAC has specific seats set aside for individuals with particular focus areas, which include the focus areas of seniors, people with disabilities, mental health, and addictions. At least eight members of UHA's Community Advisory Council represent consumers of health services under the responsibility of UHA, including those with knowledge of long-term care. UHA is able to recruit individuals with passion and experience to serve on the CAC, ensuring these populations will continue to be represented.

7.1.b. Clinical Advisory Panel as a way of assuring best clinical practices across the CCO's entire network of Providers and facilities. Describe the role of the Clinical Advisory Panel and its relationship to the CCO governance & organizational structure.

UHA has a Clinical Advisory Panel (CAP) composed of 14 community providers and eight (8) UHA staff members representing physical, behavioral, and dental health services from a cross-section of the service community. The CAP's purpose is to oversee key activities related to UHA's clinical service and functions. The CAP's mission is to ensure that the clinical activities of UHA align with the "Triple Aim" of:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of our different populations, and
3. Reducing the per capita cost of health care.

The CAP selectively identifies and approves peer-reviewed, evidence-based clinical practice guidelines from national and/or international professional organizations for the CCO to adopt. Specifically, the CAP meets quarterly to provide clinical oversight to the following CCO activities: Population Health/Quality Improvement; Utilization Management; and Pharmacy and Therapeutics. They also provide oversight and feedback to the TQS program, which is described below in Section 7.9, under Quality Improvement. They receive reports from committees in each of these areas, review them, suggest changes, and offer advice on their implementation. The CAP reports to the Quality Advisory committee, and new or updated practice guidelines are rolled out electronically throughout the UHA healthcare system.

7.1.c. Agreements with Type B Area Agencies on Aging and DHS local offices for APD. Describe the Applicant's current status in obtaining MOU(s) or contracts with Type B AAAs or DHS local APD office.

UHA has Memorandum of Understanding (MOU) in place with DHS Aging and People Disabilities District 6 office (APD) and Douglas County Senior Service (AAA). This MOU is reviewed and updated by all parties annually. The MOU consists of expectations for each party related to interdisciplinary care teams, transition care practices, improvement on member and clinical engagement participation, health prevention and promotion, and access to member

resources and responsibilities to facilitate access. UHA hosts monthly meetings to review identified members requiring interventions and a care plan is created in collaboration with all parties. The care plan may consist of both medical and non-medical information, with both long- or short-term goals as needed. The APD transition coordinator will bring complex transitions to monthly meeting for coordination of services. APD and AAA provide a monthly report of UHA members receiving Medicaid-funded long-term care services and supports including key information on members' needs for assistance with activities of daily living, case management contact, and care provider contact information. UHA and AAA/APD hold each other accountable through quarterly collection of and reporting on activity measures. AAA/APD is responsible for collecting and reporting the data to APD central office. The results will be shared with UHA at a regularly scheduled team meeting and with the manager of the case management department.

7.1.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.

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

UHA has been in a longstanding contractual relationship with Douglas County's CMHP, Adapt dba Compass. It is important to note that Adapt is also designated as the LMHA in Douglas County. UHA has a long standing contract with Adapt with regards to services and support for the CMHP and LMHA.

3) Describe how the Applicant has established and will maintain relationships with social and support services in the Service Area.

Our relationships with social and support organizations are centered around Compass, our local mental health provider, with whom we have an extensive working relationship and well-established contract. Case management coordinators from UHA work closely with Compass case managers and social workers. For the children, youth, and young adults, a case management representative from UHA is involved in the weekly wraparound meetings, and the monthly steering committee meetings. These committees include community partners, such as Oregon youth authority (OYA), Juvenile court department, DHS child welfare case managers, UCAN for housing, Ford Family foundation, the Roseburg school district, the Early Learning Hub, and court appointed special advocates (CASA). UHA has worked with the local public safety coordinating council (LPSCC) on creating a one-stop referral process for new mothers, and children from birth to five years old. UHA also works with LPSSC and the department of corrections in re-enrolling UHA members once released from custody. UHA has established a Community Interdisciplinary Team (IDT) meeting. This monthly meeting brings together community partners, such hospital discharge planners, home health agency representatives, APD/AAA case managers, DHS case managers, dental care coordinators, and clinic care coordinators/navigators. During the meeting, the group reviews complex members that require multiple levels of services and finds ways to decrease identified barriers by creating a care plan with specific goals, interventions, and outcomes.

In mid-2016, UHA was one of the first CCOs to contract with a local tribal organization, the Umpqua Band of the Cow Creek Indians. Through this contractual arrangement UHA serves its tribal members by having providers within the Cow Creek Health and Wellness Center, which is a Cow Creek Tribal clinic with over 700 assigned members. This PCPCH clinic offers not only physical health and behavioral health, but also diabetes medical nutritional therapy and education, adult and child psychiatry, and child psychiatry via telemedicine. A UHA case management coordinator is currently working with Cow Creek and Mercy Foundation to create a support program for families with kids that have Type 1 diabetes.

7.2. 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.

7.2.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.

Effective communication between UHA, the provider, and the member will better enable members to participate responsibly in their care. Care plans address more than just clinical needs. They consider demographic and personal characteristics to meet the unique needs of the member. UHA is continually working to:

- Collaborate with the member and their families and support networks to develop a mutually agreed upon care plan;
- Include the member and their families or support person of choice in care plans and care instruction;
- Ask members if they have any cultural, religious, or spiritual beliefs/practices that may influence care; and
- Identify follow-up providers that can meet unique member needs.

To assist with these efforts, UHA utilizes Community Integration Manager (CIM), a web-based platform, to house all member eligibility, demographics, and language information, prior authorization requests, and claims processing. This system collects member race and ethnicity information provided by OHA, and all UHA staff and providers have access to this information when they engage with patients. All member needs will be documented in CIM and tracked statistically, such as the following needs:

- A preferred language for discussing health care;
- Sensory communication needs;
- Limited English proficiency (EP);
- Name or gender preferences;
- Have auxiliary aide needs; or
- Any other need that affects care.

UHA incorporates effective communication methods, cultural competence, and patient-centered care into staff training curriculum (CLAS standards). Staff who communicate with cultural and linguistic competence can improve trust and rapport with members, which leads to better health

outcomes. Member feedback is reviewed as part of our Quality Improvement processes. Member input is captured in the appeals and grievance data, which is regularly reviewed by UHA to identify trends and opportunities for improvement (described in Sections 7.9 and 7.5 below).

7.2.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**

UHA uses a multipronged approach to engaging members in culturally and linguistically appropriate ways. In our offices, we strive to provide a welcoming environment for members of diverse backgrounds who come to UHA offices and providers for assistance (such as bilingual signage and a diverse collection of magazines and brochures in the waiting room). As described above, we use a web-based platform (CIM) to ensure providers have the information to meet the communication, linguistic, and cultural needs and preferences of members actively seeking care.

To reach members who are not accessing services, UHA will apply data from our Business Intelligence (BI) systems using a range of communication methods. We can use health plan data stored in CIM and the BI systems to identify and eliminate disparities through outreach interventions. UHA will also use data collected in the Community Health Assessment to identify needs in the member population and larger community and tailor interventions to improve the identified issues. The CAC plays an integral role in developing this health assessment and selecting interventions (see Attachment 12, Section A.4) that support healthy lifestyles in the community and encourage people to become partners in their own care.

Once we have identified target populations, we will use email, SMS, mailed letters, phone calls, websites, posters, presentations, and one-on-one discussions to inform members of wellness and prevention opportunities and resources. These communications will be designed to account for SDOH as well as the patients' health needs, cultural preference, and preferred language. UHA plans to involve members of diverse populations to help plan outreach. If possible, UHA will use geocoding to match addresses to community needs for a more targeted approach. We plan to:

- Share information on UHA's Facebook page regarding available wellness programs;
- Feature relevant wellness and health literacy topics in the member newsletter;

- Distribute multilingual member material on relevant wellness and prevention services;
- Perform health risk assessment (HRA) survey on all new members within first 90-days;
- Use data collected in the HRA survey for members' wellness outreach programs;
- Include THWs as part of the member's primary care team to help with health plan navigation as needed;
- Distribute multilingual member material advertising the availability of communication and language assistance services. UHA contracts with Certified Languages International (CTL) for interpretive services by telephone and remote video. CTL is available to translate for medical, behavioral health, or dental care visits, and home health visits.
- Engage members telephonically to assign a PCP and explain benefits; and
- Engage members via written communications such as mailings, fliers and member newsletters to inform them of available services.

7.3. Transforming Models of Care

7.3.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.

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

Since its inception as a CCO, UHA has fully embraced the PCPCH program. UHA's contracted PCPCHs are key pillars in its delivery network and are crucial component of UHA's success over the years. Beginning in 2013, UHA has made substantial investments in PCPs that have embraced the PCPCH model and attested successful for a tiered status. [redacted]

The investment and technical assistance UHA has provided to its PCP community has resulted in over 83% of its PCPs operating within a PCPCH environment. UHA's PCPCH delivery system comprises clinics ranging from Tier-2 to Tier-5 recognition; with 96% of UHA's membership receiving primary care through a PCPCH, and over 85% of the CCO population being served by Tier 4 or 5 PCPCH.

UHA's goal is to have a majority of its Medicaid members enrolled at Tier-5 PCPCH clinics. [redacted]

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

UHA's has written MOUs with local area DHS AAA and APD service providers. Based on the MOU requirements, UHA case management and DHS service providers meet monthly at the Interdisciplinary Care Team (IDT) meeting to review care plans for UHA Medicaid members. In 2020, UHA will invite PCPCHs and LTCs representatives to attend the IDT meetings. This will ensure a higher level of collaboration and engagement between the CCO, LTCs, and PCHCHs.

In 2020, UHA will look to create a requirement in its PCPCH incentive program to help bridge the gap for better coordination between PCPCH and LTC Providers. UHA is still evaluating how it will effectively implement this requirement but will look for some evidence of coordination including MOUs between PCPCH and LTC Providers, medical directorships at the PCPCH, in-house visits, etc. The hope is that with financial incentives and program requirements, the two parties will achieve higher levels of coordination.

7.3.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.

UHA has a long history in supporting FQHC, rural health clinics (RHC), and other safety net clinics. Currently, UHA has good standing with entities that provide high-quality, cost-effective health care to members seeking medical services. Over 77% of primary care is provided to UHA members either through FQHCs, RHC, or tribal clinics. To ensure our members are encouraged to use our many community-based partners, UHA has taken several measures to contract with professionals who will improve outcomes and reduce disparities. We are focused on community involvement and our service delivery. UHA's contracted FQHC, RHC, tribal clinics, and other safety net clinics are supported not just through adequate rates, but through other incentives and investments dollars, as a mean to offset and subsidize the cost for these organizations to deliver care to UHA's members.

UHA's affiliates, Umpqua Health Newton Creek and Umpqua Health Harvard, are both RHCs that provide primary and pediatric care along with mental health counseling. The clinics also provide integrated buprenorphine services. In addition to these services, an urgent care clinic is located in the same setting to provide a robust provider network to invest in the physical and economic health for residents in Douglas County. These two RHCs provide seamless integration with UHA to ensure members receive timely and quality care.

Our FQHC partners, such as Umpqua Community Health Center (UCHC) and South River, provide outpatient diabetes self-management training for patients with diabetes or renal disease provided by qualified practitioners. Other partners, including the RHC, Evergreen Family Medical, ensure that the homebound population and other patient communities receive face-to-face medical or mental health visits from visiting nurses. UHA is also contracted with the School Based Health Clinics (SBHC), which deliver physical behavioral and dental health services. Meetings are held in the community to coordinate and identify opportunities for UHA to build continued partnerships with the SBHCs. In addition, UHA has a strong collaborative relationship with Cow Creek Health & Wellness Center, an Indian Health Care Provider, located on sovereign Tribal lands of the Cow Creek Tribe in Roseburg, Oregon to provide primary care services. UHA is proud to be the second CCO in the state to contract with a tribal organization.

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

UHA does not use models other than PCPCH as described above.

7.4. Network Adequacy

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.

7.4.a. Evaluation Questions

7.4.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.

UHA is committed to the Triple Aim: improving the patient experience of care for its members, improving the health of its members, and reducing the cost of health care. UHA annually performs a network adequacy study to ensure that it has a highly functioning, robust network of providers and that members are receiving adequate access to and availability of care. In addition, UHA uses a geomapping software to ensure the network is in compliance for access time and distances to health care services.

UHA monitors network availability several ways, including reviewing grievances and appeals from members, grievance and utilization trends, requests for out-of-network services, requests for special accommodations, requests for second opinions, community health assessments, and member satisfaction survey results.

In 2018, UHA developed a process to monitor provider availability and wait times (described below in Section 7.4.a.4) using a providers' survey verified by secret shopper calls to determine if wait times align with provided survey responses. UHA will not allow a ratio of greater than 1,500 members per PCP and ensures that its network is meeting the member-to-patient ratio. UHA evaluates this ratio by comparing the number of in-network PCPs with the current list of members. The number of PCPs at each clinic is compared with the current list of members assigned to that clinic. UHA's network of PCPs is well within the member-to-PCP ratio standards. We also monitor when a practice is open or closed to accepting new UHA members so the PCPs are able to take into account their entire patient population and payer mix. UHA's member services department will then assign members accordingly to meet practice standards.

With regards to time and distance standards for medical services to our community provider partners, UHA confirms that:

PCPs

- 99.3% of members are within either 30 miles or 30 minutes of a PCP.
- 99.7% of members are within either 60 miles or 60 minutes of a PCP.

Specialists

- 99.6% of members are within either 60 miles or 60 minutes of an endocrinologist.
- 99.7% of members are within either 60 miles or 60 minutes of an OB/GYN.
- 99.6% of members are within either 60 miles or 60 minutes of an infectious disease specialist.
- 99.7% of members are within either 60 miles or 60 minutes of an oncologist

• 99.7% of members are within either 60 miles or 60 minutes of a radiation oncologist
• 99.7% of members are within either 60 miles or 60 minutes of a pediatrician.
• 99.6% of members are within either 60 miles or 60 minutes of a cardiologist.
• 99.6% of members are within either 60 miles or 60 minutes of a rheumatologist.
• 99.6% of members are within either 60 miles or 60 minutes of an outpatient dialysis center.

Hospitals
• 89.1% of members are within either 60 miles or 60 minutes of a hospital.

Mental Health
• 99.9% of members are within either 60 miles or 60 minutes of a mental health provider.
• 99.8% of members are within either 60 miles or 60 minutes of inpatient psychiatric facility services.

UHA's Pharmacy Benefit Manager (PBM), MedImpact, manages the pharmacy network under our supervision. Our network has over 54,000 chain and independent pharmacies nationwide. In Oregon, UHA members have access to nearly 600 pharmacies. The locations of the pharmacies meet the access needs of the CCO.

To our participating providers and pharmacies, UHA provides our formulary and information about how to make requests for drugs not on our formulary or that require prior authorization. We provide notice of updates made to our network or formulary within 30 days of a change including additions of a new drug or removal of a previously listed drug.

Adapt (LMHA) utilizes THW and peer support specialist in mental health and SUD settings. UHA plans hiring THWs to extend the reach of UHA's care and coordination. THWs will be integrated into UHA's case management department and offer follow-up to assigned members via home visits, meetings in our transitional care clinic, or other appropriate setting. By providing life coaching, health education and social support the THWs are an important resource to build capacity and improve care coordination.

UHA contracts with a vendor to provide universal translating services and supplements that with live oral language and sign language providers under PRN contracts.

7.4.a.2. How does Applicant intend to establish the capacity of its Provider Network?

UHA currently has over 360 providers that service Douglas county members. We track the provider visits using our network adequacy reporting system and we also incorporate a geo mapping software program that allows us to see deficiencies in our market of specialist and primary care providers. Our Clinical Engagement Department uses this methodology to identify gaps using referral and authorization data for our members as they seek care outside of our region. UHA uses the following multi-faceted data sources to evaluate its network capacity and assess its network:

- Provider availability requirements.
- Time and distance standards.
- Member-to-PCP ratio.
- Grievance analysis.
- Special requests and accommodations.
- Utilization trends.

- Requests for out-of-network services.
- Requests for second opinions.
- Community Needs Assessment.
- CAHPS access to care and satisfaction survey results.

UHA will assess its network capacity at least annually, and the results will help guide its Provider Network Department in terms of the network needs. (See the attached DSN required documents for detailed Network capacity and adequacy calculations.)

UHA uses Quest Analytics to complete geo mapping and ensure all providers meet the time and distance standards. This process is completed on a monthly basis. Through contracts, UHA requires providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services. Our contract also requires services to be available 24 hours a day/7 days a week when medically necessary. UHA has systems in place to coordinate across all provider types and care settings, regardless of geographic location. UHA also analyzes utilization of services as necessary and we monitor timeframes for emergent, urgent, routine PCP, specialist, and dental care appointments. In addition to the above, UHA reviews the timeframe for non-urgent behavioral health appointments.

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

UHA routinely monitors and identifies utilization trends to make timely informed decisions. We currently use data that analyzes ways to determine trends both at the specialty and health plan level. Based on information such as the referral requests for our network providers, UHA will engage its current network providers to identify barriers to access. UHA identifies areas for potential remediation and recommends improvement strategies. Resulting actions may include more care coordination, recommendations for the providers, or establishing additional contracting outside of Douglas County. UHA's Utilization Management committee shall review utilization for trends that indicate access and availability issues. UHA's utilization analysis may include, utilization by specialty, office or provider and expected utilization versus actual utilization.

UHA's Utilization Management committee, which reports to the Quality Advisory committee, can help identify opportunities for interventions using the above analysis.

7.4.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.

At the beginning of 2018, UHA began sending quarterly surveys to network providers to collect each office's current availability and wait times for the relevant standards for its particular specialty or specialties. On a random basis, about two times a year or as-needed, UHA performs secret shopper calls to determine if the office's current wait times align with the responses provided in its surveys. Additionally, UHA is looking at other solutions such as the ability to request schedules from practices from their practice management software to determine the time from initial member request for an appointment to the date of the appointment. UHA has a Provider Relations Director that visits the PCP and Specialist offices monthly to ensure that the efficiency measures of wait times are being met. During these visits, the Provider Relations Director reviews the survey results while building a rapport with the office managers to ensure times align with the responses provided in its surveys.

UHA will monitor, at least biannually, network availability standards. If during the monitoring

process, UHA determines that a provider is out of compliance with this policy, the Provider Network Department will notify UHA's Compliance Department. For any provider who does not meet the same appointment timeframe for two consecutive months, UHA's Compliance Department will assign the provider a corrective action plan to remediate the matter. Once numbers indicate that a provider fell below the threshold, UHA works to assist the provider. UHA will close membership assignment to the provider and help members find a new physician in network. In addition to assisting the member, if wait times are too long, UHA will provide out-of-network referrals to ensure that members can schedule appointments and receive their medical care.

7.4.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.

UHA has a contract with a dental care organization (DCO). UHA routinely monitors its network for adequacy, including monitoring provider availability and provider access. UHA's annual network adequacy study (described above) includes oral health providers. Findings across ten areas of evaluation are combined and discussed, with a recommended plan of action. Dental providers self-report monthly to UHA with percentages showing how quickly they were able to see members for urgent, emergent, and routine dental visits. Contracted Dental providers may be eligible to receive an annual incentive bonus for assisting and supporting UHA in developing processes to achieve the CCO benchmarks. A Risk Withhold is directly tied to Quality and Access metrics, which include dental services for pregnant women, ED follow-up appointments, and to increase the dental penetration rate measured as any CDT code service per calendar year. Through grievance and appeals and member services, UHA gets updated information via member services when patients are not able to be seen as quickly as needed.

7.4.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.

UHA is dedicated to ensuring its members have timely and adequate access to primary care providers (PCP). UHA, has developed standards and policies in accordance to OAR and we periodically update our policies to ensure UHA is meeting adequacy requirements for our members. UHA monitors network adequacy, network availability and network access. Our annual reports examine Member-to-PCP Ratios, Special Requests and Accommodation Requests for out-of-network services and Access to Care and Satisfaction Survey Results. UHA's study is committed to the Triple Aim so our improvement is focused on the health of our members and reducing the cost of healthcare.

UHA enjoys some relative security in our current provider panel for Douglas County, as our two owners are the local hospital that employs a number of primary care and specialists, and the Douglas County IPA, to which nearly all employed and self-employed providers are members. We engage with both of these partners in furthering discussions about provider recruitment planning for our rural county.

That said, we currently restrict panel sizes for our PCPCH providers to no more than 1,200; we transparently report PCP panel reports for our membership weekly and perform reconciliation quarterly. Our current excess PCP capacity is a comfortable 20,000 (nearly 100% above current

levels). Given our committed provider partners, we do not anticipate the need for such a capacity surge. Specialty providers, however, are indeed a challenge for recruitment and retention to a rural county. To remedy this, we supplement our local resources with specialists in adjoining counties. We make every effort to maintain optimal communication, service and support of specialists outside our county to ensure that they will continue to accept our members in their practices, as they currently do. We encourage the use of local satellite clinics for visiting specialists and the use of telehealth wherever appropriate. For example, our paucity of psychiatric services 24/7 led to contracting with a vendor to supply this service to our local emergency room to facilitate care and make the hospital inpatient and outpatient facilities more efficient.

7.4.b. Requested Documents

The completed DSN Provider Report is attached. (does not count towards page limitations)

7.5. Grievance & Appeals

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:

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

UHA maintains a comprehensive appeal and grievance process, with data reported quarterly to the OHA. This data is regularly reviewed by UHA to identify trends and opportunities for improvement. Grievances are categorized as Access, Interaction with Provider or Plan, Consumer Rights, Quality of Care, Quality of Service, and Client Billing Issues.

As part of the appeal and grievance review process, specific outreach is done when a provider or subcontractor is involved, with issues escalated as appropriate. Trends specific to provider interactions, access, and subcontractors are reported to the CAP, Quality Advisory committee, and Network Performance committee. UHA also monitors the work of subcontractors, such as the non-emergent medical transportation providers. This information may result in additional action with providers/subcontractors when appropriate, and may present a recommendation for expanding the provider network.

Appeals relating to service requests that may have been denied or supplied out-of-network are also analyzed with trends reported to the committees and panel indicated above. This information can suggest the potential for insufficiencies in the provider network, or the need for member and provider education. UHA's case management team is also used as a diverse resource to assist members. If an issue with access was identified, the case management team may intervene to ensure the member receives timely and appropriate care. If this service cannot be accomplished in-network, UHA helps coordinate obtaining services out-of-network for the individual.

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

UHA authorizes out-of-network and out-of-area services as necessary to ensure the adequate services are being provided to meet members' needs. Through grievance and appeals data, UHA gets updated information via member services when patients are not able to be seen as quickly as needed. This information complements the routine annual Network Adequacy Study, which is based on CAHPS' Access to Care and satisfaction results, community needs assessments, request

for second opinions, request for out of network services, and utilization trends.

UHA has standing relationships with one dental entity and UHA monitors the work of the dental care organizations (DCO) through quarterly reporting of prior authorization, appeal, and grievance data, as well as samples of their correspondence. This information is submitted to UHA in alignment with the CCO contracted deliverable requirements, including analysis of dental data for adverse benefit determinations, appeals, and grievances. The DCO also provides utilization data and penetration rates for a transparent view of the oral health network performance. UHA monitors the DCO data and puts them on a corrective action plan if they are not meeting adequacy standards.

UHA carefully manages its contracts with behavioral health providers that provide substance abuse disorder treatment. The behavioral health providers have been delegated the process of reviewing and responding to grievances in compliance with state regulations for outpatient substance abuse, outpatient mental health, residential substance abuse, and detox programs. However, similar to the DCO delegation, data and samples are provided to UHA for monitoring and state reporting. UHA continues to handle all appeals related to substance use disorders and behavioral health. The value-based contract with Adapt provides specific incentives and penalties for demonstrating access in both mental health and SUD services to industry and internal standards. We also externally apply our network adequacy measurements (described previously) to behavioral health. Demonstration of inadequate access for behavioral health services would lead to expansion of our providers under contract.

7.5.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).

Policies and procedures have been established for the review of prior authorizations, including the requirements for adverse benefit determinations (ABD, formerly the notice of action), at UHA and by subcontractors. Staff receive training on these requirements to ensure compliance and parity, and their performance is monitored. UHA will use IRR analysis to ensure that utilization management criteria are applied consistently. All adverse determinations are completed by a medical doctor (or pharmacist for prescription drug requests). The appeal and grievance process also takes into consideration the quality and content of each ABD involved. Samples of ABD's from subcontractors are also reviewed. UHA makes continuous efforts in reconciling appropriate content to meet health literacy needs, while still providing clear written communication explaining the determination and rationale.

7.6. Coordination, Transition and Care Management

7.6.a. Care Coordination:

7.6.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, to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care.

At UHA, we believe information transparency and integration is vital to achieving the triple aim. The US spends more on healthcare than any other country, but patient outcomes are nowhere

near the best. To improve outcomes, we need the right information provided to the right people at the right time. Data integration and transparency often requires a culture shift in the health plan and provider community to ensure data is shared and used. From the inception of CCOs, UHA has promoted a culture of data integration and transparency. Our CCO built and implemented the EMR platform used by the majority of the providers in our community. EMR integration has been a major mechanism that has supported the flow of information among providers and our CCO.

UHA holds monthly IDT meetings to facilitate information sharing among all providers and community partners, including DHS. In 2020, UHA will invite DHS Medicaid-funded LTC care providers, mental health crisis service providers, home and community-based service providers to IDT meetings. This will ensure a higher level of collaboration, engagement, and flow of information between UHA and these partners to avoid duplication of services, medication errors and missed opportunities to provide effective preventive and primary care. In 2020, UHA intends to create a requirement in its PCPCH incentive program to help bridge the gap for better coordination between PCPCH and LTC Providers. UHA is still evaluating how it will effectively implement this requirement but will look for some evidence of coordination including MOUs between PCPCH and LTC Providers, medical directorships at the PCPCH, in-house visits, etc. UHA hopes higher levels of coordination will occur between the two parties with financial incentives and program requirements.

We also recognize the importance of providing data that is meaningful and actionable. Our internal staff, providers, and community partners have access to a Business Intelligence (BI) platform, Inteligenz, that provides rich analytics and reporting. Inteligenz includes a Provider Portal as well as a CCO Metrics Manager provides that rich and meaningful data, including member-level reports and higher-level population health or quality metric reports.

UHA staff and our provider network also have access to PreManage that alerts providers of hospital or ED events in real time. We are able to include notes in PreManage to inform providers of the name and contact information of the Case Manager assigned to the member. The case manager operates as the primary point of contact, coordinating the flow of information between the providers, member, and other community partners.

7.6.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.

UHA believes in having collaborative relationships with providers and the community. These relationships with providers are maintained through meaningful and routine communication, as well as accountability through written agreements and monitoring. These partnerships allow for access to and coordination with social and support services including crisis management services, and Community and self-management programs. For example, Bay Cities transportation uses flex spending to provide transportation to AA meetings, NA meetings, WIC appointments, healthy family's appointment, grocery store, prescription pickup, and court services. UHA also provides physical, mental and social support services for specific populations through the New Day (for pregnant members), New Beginning (for children), and SPMI programs. UHA actively engages community partners by participating in local coalition meetings, provider education through our quality department, and our monthly IDT meetings.

UHA's contracts with the local CMHP, Compass, to provide crisis management services as they have a long history of coordination and success with this area. The CMHP has a 24/7 crisis line that is available to all community members. This line has remained the same for close to 20 years and is well-advertised. Law enforcement agencies, community partners, members and members' families communicate with the CMHP about individuals need mobile crisis services. Protocall Crisis services receives all crisis calls after regular business hours. Protocall, law enforcement, and the local hospital (Mercy Medical Center) have access to a separate after-hours crisis number when there is a need for a mobile crisis intervention throughout Douglas County. In addition, in conjunction with the City of Roseburg, the CMHP is a sub-awardee of a 3-year grant to provide specialized co-deployment of 2 Qualified Mental Health Professionals (QMHPs) to respond to mental health calls received by dispatch 12 hours day/7 days week from the hours of 12:00 pm to 12:00 am within the Roseburg City limits and surrounding areas. A strong relationship between local law enforcement agencies and the CMHP ensures that police reports pertaining to individuals with suspected mental health problems are referred for health care follow-up. The CMHP mental health professionals additionally have been engaged with local law enforcement for the last 3 years to conduct routine ride-alongs focusing on calls with individuals with suspected mental health concerns.

To support Crisis services (Crisis Walk-ins, Crisis Calls, Mobile Crisis, Co-Deployment Crisis and Pre-Commitment Investigations) in Douglas County, the CMHP employs 6 Full-Time staff (5 QMHPs and 1 QMHA) with 4 FTE dedicated to routine Crisis work (Crisis Calls, Mobile Crisis and Pre-Commitment Investigations), and 2 FTE to Co-deployment Mobile Crisis.

7.6.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.

At UHA, we believe it is our responsibility to provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The members we serve come from culturally diverse backgrounds. We strive to provide the best care possible to all our members and patients with awareness of their unique needs related to their gender, ethnicity, race, color, language, socio-economic status, education level, age, religion, sexual orientation, and physical and mental ability. Our goal is to advance health equity at every point of contact. To this end, UHA has developed Culturally and Linguistically Appropriate Services (CLAS) tools and strategies for our organization and our provider network.

Our member services and clinical engagement teams have translation services available as needed. UHA's alternate format and Language Access Service policy is fundamental to ensuring equity in the delivery of healthcare. The goal is to reduce health disparities for UHA's limited English proficient (LEP), deaf, hard of hearing, speech impaired, and blind members. UHA periodically reviews the effectiveness of this service through a self-assessment process. We also provide certified language support services that our providers and sub-contractors can access to assist our members. Our member services department runs a weekly query to identify members with LEP so that they can be flagged for the appropriate language support services. We routinely send member materials in English and Spanish, but print materials can be provided in other languages as needed.

UHA also provides CLAS Presentations and Workshops for our providers and community partners as part of UHA's CHP. UHA has developed a training program focused on Addictions/Substance Abuse, Mental Health, and Trauma Informed Care. This program improves provider skills and knowledge to increase the effectiveness of interventions and improve engagement with patients. Specifically, this workshop helps with access by improving OHP member engagement. By first encouraging awareness of cultural differences and addressing underlying bias, we can shift to a culture of equity. Providers in our network have the tools to develop lasting relationships with members, optimize outcomes, and ensure care coordination.

7.6.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.

UHA offers both technological assistance and business processes to help manage complex patients in a uniform and consistent way.

First, UHA's case management team collaborates with providers to serve members with a wide range of healthcare needs. Providers are educated on the unique needs of Medicaid members and to be aware of the complex factors that contribute to their health. Education and outreach to providers includes information on evidence-based healthcare, clinical standards, cultural competency, and social determinants of health and health equity (SDOH-HE). All UHA providers may refer members for case management and participate in IDT meetings. IDT meetings bridge the communication gap between multiple providers and agencies working with the same patient. UHA engages providers as part of the members' care plans to streamline care, reduce duplicate work, improve outcomes, and enhance care coordination.

Second, UHA has both a BI platform and a community EHR with data that is meaningful and actionable to identify and better serve members with multiple diagnoses. Through the BI platform, each provider can access their assigned members and review diagnoses and quality metrics for their population. Providers participating in the community EHR, which is about 80% of our provider network, have access to medical records from other providers, labs, radiology, and office notes. It contains the current medication prescriptions for medication reconciliation.

7.6.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.

UHA has implemented an intensive Care Coordination and planning model in collaboration with each member's PCPCH and other service providers, such as Community Developmental Disability Programs and brokerages for Members with developmental disabilities. This ICC program effectively coordinates services and supports for the complex needs of these members. As discussed in section 7.6.a.1, UHA case managers are assigned to these complex members and act as the point person to effectively collaborate and communicate with community services and partners. UHA performs intensive care coordination (ICC) for individuals who are aged, blind, disabled, or who have high healthcare needs, multiple chronic conditions, mental illness, or substance use disorders, and either have functional disabilities, or live with health or social conditions that place them at risk of developing functional disabilities.

UHA currently holds a monthly IDT team meeting that pulls together the Case Coordinators

from the PCPCH offices, APD/AAA offices, dental provider, mental health providers, and community partners, such as home health providers. The agenda is around highly complex members brought forth by any of the entities listed above. The team reviews the current barriers and member needs and a UHA care coordinator creates a care plan and communicates with the member and providers on goals and interventions. In addition to this team meeting, UHA has monthly joint operation meetings with individual PCPCH offices who need additional services to find potential barriers and standardize communication.

UHA also utilizes EDIE/PreManage technology to help with case management. UHA case managers are able to input their contact information for individual members, giving all providers case management contact information and access to real time health information. This sharing of information will limit duplication of services and streamline transitions of care.

7.6.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.

UHA is committed to meeting state goals and expectations for care coordination focused on members with severe persistent mental health issues (SPMI) in all age groups (Children, Youth, Young Adults, Adults with SPMI, Individuals in State Custody, such as Foster care, Juvenile Justice, individuals with intellectual developmental disabilities). We have outlined the State's three goals and expectations below and included how we will meet these goals.

(1) Assignment of responsibility and accountability:

The UHA behavioral health care team, composed of intensive case management (ICM) coordinators and specialists, identify SPMI members through claims data analysis. Members are also identified through referral from PCPs, mental health providers, emergency department (ED), judicial system, DHS, foster care, self, or any other source. Once identified, the behavioral health care team flags the SPMI member in our operating system and in PreManage, ensures the member has an assigned PCP, connects the member to the appropriate resources, and tracks the member's progress. We are able to include notes in PreManage to inform providers of the name and contact information of the ICM coordinator assigned to the member. The ICM coordinator operates as the primary point of contact, coordinating the flow of information between the providers, member, and other community partners. The case manager is notified when the member presents at the ED or hospital which provides the opportunity for timely intervention, care planning, and transition of care.

(2) Individual care plans:

The behavioral health care team consists of ICM coordinators with appropriate credentials: Certified Alcohol and Drug Counselor (CADCI, CADCII), National Certified Addiction Counselor (NCACII), Qualified Mental Health Associate (QMHA), Certified Prevention Specialist (CPS), and Bachelor of Science (BS). The team also includes a case management specialist who focuses on adverse events, substance use disorder (SUD), mental health illness, physical health, and social determinants of health. Each team member has received trauma informed care training, advanced directive training, ethics training, mandatory reporting training, and cultural and linguistic awareness training. Using trauma-informed strategies and motivational interviewing, our ICM coordinators assist each member in developing a flexible,

holistic care plan to address the supportive, therapeutic, cultural and linguistic health of each member. The individual care plans developed for members reflect member, family or caregiver preferences and goals to ensure engagement and satisfaction.

(3) Communication:

Our team coordinates care with our external partners including local mental health providers (treatment & counseling), SUD treatment service providers, primary care physicians, oral health coalition, counseling services, housing assistance programs, and food assistance programs. The ICM coordinator works with discharge planners at both the inpatient and ED level to coordinate appropriate transition to behavioral health services in the community including services through the delegated community mental health providers. IDT meetings are coordinated monthly, or as needed, to address more extensive community needs for members with multiple comorbid conditions and SPMI. Community members involved in these IDT meetings include SUD treatment providers, community mental health providers including ACT team, DHS, oral health providers, probation and parole, adult or child protective services and child welfare, specialty providers, and PCPs. Treatment plan and goals are discussed with providers to better coordinate care and meet the member's needs.

As discussed in 7.6.a.3, UHA provides CLAS Presentations and Workshops for our providers and community partners to help ensure providers are effectively communicating with our members. UHA has developed a training program focused on Addictions/Substance Abuse, Mental Health, and Trauma Informed Care. This program increases the effectiveness of interventions and improves patient engagement by improving physician skills. This awareness of cultural differences and underlying bias is helping our provider network shift to a culture of equity and optimizing outcomes.

7.6.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.

In 2017, UHA established a Transitional Care (TC) department to work specifically on hospital readmission reduction. The first few months centered on care coordination and selection of an effective model that could serve as the foundation of a long-term program. In March 2018, the transitional care department launched an innovative approach for hospital readmission reduction. The UHA TC team uses three areas of focus to manage readmission risk: health coaching; care coordination; and access to provider services. This evidence-based program has been an effective strategy to coordinate care.

Additionally, UHA's ICM team coordinates care with our external partners including local mental health providers (treatment & counseling), SUD treatment service providers, primary care physicians, oral health coalition, counseling services, housing assistance programs, and food assistance programs. The ICM coordinator works with discharge planners at both the inpatient and ED level to coordinate appropriate transition to behavioral health services in the community, including services through the delegated community mental health providers. Interdisciplinary meetings are coordinated monthly, or as needed, to address more extensive community needs for members with multiple comorbid conditions, SDOH issues, SUD, and SPMI. Community members involved in these IDT meetings include SUD treatment providers, community mental health providers including ACT team, DHS, oral health providers, probation and parole, adult or

child protective services and child welfare, specialty providers, and PCPs. Treatment plan and goals are discussed with providers to better coordinate care and meet the member's needs.

Lastly, UHA is committed to investing resources in the development of a traditional healthcare workforce (THW). Utilization of THWs in Douglas County had been isolated to Adapt, who supplies Peer Support Specialists for individuals seeking SUD services. THWs are incorporated into Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), and IPS supported employment. Currently, there is a shortage of THW within Douglas County, primarily due to the lack of training resources. UHA has been working with its Innovator Agent along with local Community College to help bring a program to the community college to train and certify THWs. The hope behind this collaboration would be to expand the THW workforce in Douglas County. UHA is also looking at offering additional subsidies to local Behavioral Health providers and PCPCHs to expand the use of THWs. In 2019, UHA plans to incorporate THWs to extend the reach of UHA's care and coordination. THWs will be integrated into UHA's case management department and offer follow-up to assigned members via home visits, meetings in our transitional care clinic, or other appropriate setting. By providing life coaching, health education and social support, the THWs are an important resource to build capacity and improve care coordination.

7.6.a.8. Assignment of responsibility and accountability: The Applicant must demonstrate that each Member has a Primary Care Provider or team that is responsible for coordination of care and transitions.

(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.

Once a member is enrolled into the plan, UHA's Member Services Department contact each member to help identify a primary care provider. All newly enrolled members are assigned to a primary care provider within the first seven days of eligibility with UHA. During that conversation, the department also works with the member to identify any unmet needs. If there an immediate need for care and/or services, the Member Service Department will either assist the member or refer them to a Care Coordinator for assistance.

UHA's provider network includes multiple Patient Centered Primary Care Homes (PCPCH) which require patient assignment to a clinician or care team as part of the criteria for PCPCH recognition. Communication of member-patient assignment is made to the PCP within the first week of assignment and real-time assignment information is available online in UHA's Community Integration Manager (CIM) and BI platform. This allows the provider or care team to be aware of the assignment and prompt care initiation. Members select their own PCP, however in the event a PCP is not selected, UHA will assign a PCP to a member using the following approach:

a. PCPCH attested with the Oregon Health Authority; Tier 3 or higher.

b. PCP has a past relationship with a member as defined by the PCP who performed the plurality of visits in the last 24 months, or most recent office visit.

c. Closest open PCP office to member's home.

d. PCP that can accommodate certain member needs (e.g. age, special needs, language,

disabilities, etc.)

e. Member Services also sends out a weekly report to each provider letting them know of their assigned members, this helps inform providers of their newly assigned members for them to reach out and connect with the member. Lastly, UHA also conducts health risk screenings with each newly enrolled member within 30 days of enrollment, or within 10 days when referred for screening..

(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.

During the first week of eligibility with UHA, the Member Services department will assign every member to the most appropriate PCP who fits the known needs of the member. Member outreach is done to identify a member's needs, so the PCP assigned is a provider who can accommodate any special health care requirements. PCP assignments are also based on geographic location, a patient's cultural and linguistic needs, with patient choice being the main factor.

A Health Risk Assessment (HRA) is done within 30 days of initial eligibility with UHA (10 days by special request or referral). The assessment is attached to the member's record in CIM and tracked by report for statistics. The completed HRA information is used for care coordination activities done by UHA's Intensive Care Coordinators. The HRA will help identify members with SDOH, LGBT, language, sensory communication, and preferred format needs. The HRA is available in multilingual/alternative formats with wording of low literacy that has been approved by OHA.

UHA supports our providers who need assistance accommodating members who have cultural, language, or disability need. Providers can request assistance by contacting Member Services. Some of the resources available include free interpretive services by telephone and remote video for any requested language (including sign language), the use of a THW who acts as part of the primary care team and assists with health care navigation, and multilingual/alternative format materials to educate members about wellness and prevention resources.

7.6.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.

In 2017, UHA established a Transitional Care (TC) department to work specifically on hospital readmission reduction. The first few months centered on care coordination and selection of an effective model that could serve as the foundation of a long-term program. In March 2018, the TC department launched an innovative three-prong approach for readmission reduction. UHA's transitional care team and care coordinators are provided with annual education and attend an annual care conference on cultural awareness and linguistically appropriate services.

The target population of this program includes:

- Members with frequent admissions for management of chronic illnesses such as COPD, CHF, Diabetes, Asthma and CAD;
- Members with a LACE risk score equal to or greater than nine (i.e. a high risk of

readmission);
- Member readmitted within the last 30 days;
- Patients with SPMI or associated behavioral health conditions that complicate the management of their physical medicine needs; and
- Members with multiple SDOH issues that increase their risk of frequent hospitalization.

The UHA TC team uses three areas of focus to manage readmission risk.

1. **Health coaching** using the Care Transitions Interventions (CTI) model is the first aspect of our TC program at UHA. This model is uniquely focused on coaching patients and caregivers to develop the skills, confidence, and tools they need to assert a more active role in their care. Coleman model research revealed that patients who received CTI coaching were shown to be significantly less likely to be readmitted to the hospital and the effects were sustained for at least five months after the end of the one-month intervention period.

The model incorporates two face-to-face encounters with the patient: one during the hospitalization and a second in the home after discharge. After the home visit, the interventions continue with three follow-up phone calls at various intervals over the next three weeks. High-risk patients are identified by using a validated tool to determine 30-day readmission risk allowing the staff to focus appropriately. After medical record review, staff conducts the hospital visit, which provides an introduction of the program and sets up the intention to promote a smooth transition to the next care setting. During the face-to-face visit, multiple tasks are completed including medication reconciliation, teaching the use of a Personal Health Record (PHR), discussing self-management and addressing the social determinants of health, and coordinating care with the primary care home.

2. **Care coordination** is available for a wide variety of patients and is not limited to those in the coaching program. A mainstay of care coordination is the interaction with UHA and MMC nurse case managers and discharge planners. It is an essential element of a smooth and thorough transition to the next care setting. Work in this area includes:

- Addressing SDOH, such as homelessness, ability to communicate by phone, and facilitation of transportation to follow-up care;
- Facilitating referral to local Aging Persons and Disability for screening of multiple types of services including caregiver's resources, facility placement, and other community resources;
- Coordinating with mental health and substance use facilities in our area; and
- Assisting in scheduling follow up appointments and facilitating the establishment of a primary care medical home.

Care coordination does not stop at the hospital discharge. UHA's care coordinator continues to follow the member through each transition, such as skilled nursing facilities, home health services, substance use disorder services, behavioral health services, and oral care. UHA care coordinators attend the family care conferences and offer assistance during transitions.

3. **Access to provider services** is the third aspect of our TC program. Frequently, patients either do not have a primary care provider or do not have timely access to their provider. In these cases, TC has a nurse practitioner who can see the patient in a timely manner. Those visits focus on completing medication reconciliation and addressing any barriers to access or appropriate use of

medications. Additionally, during these visits, they work on follow-up care coordination with the member's medical home and address other urgent physical health needs.

To measure the effectiveness of this program, we have been tracking the number of all-cause readmissions. The number of readmissions decreased by 9.5% from 2016 to 2018. The all-cause readmission rate fell from 13.7% in 2016 to 12.4% in 2018. These results demonstrate the great success of this program.

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.

UHA has comprehensive systems in place to support members during care transitions. A key piece of this planning infrastructure is careful case management. Case management coordinators are notified of all admission, inpatient acute hospital, inpatient psychiatric, residential, skilled nursing facility, and psychiatric residential treatment services (PRTS) either by PA request or hospital census report. Cases are assigned to the case manager by needed specialty services. The case manager follows the patient through each level of care, receiving updates periodically from the facility for review of continued stay. Authorizations for continued stays are extended based on medical necessity and discharge planning needs.

UHA has electronic tools in place (InterQual) that helps the case managers review each case to determine the appropriate level of care. A transition of care tool is built into the EHR system, and it guides the decision on the discharge planning needs for the member. The case management coordinator assists the facility coordinators, the member, and the member's designated health care partner with each transition. Support for the transition encompasses transportation, home health services, follow-up appointments with both behavioral health or physical health providers, durable medical equipment, or long-term placement. The case managers will continue to follow the patient once they are home to ensure successful transitions. Care plans are based on the member's needs and with member and family participation. The care plans will be reviewed, at a minimum, every year.

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.

UHA has MOUs in place with AAA/APD. We hold monthly IDT meetings to discuss complex cases with community partners. APD has a case management representative at one of the local skilled nursing facilities. They attend the family care conference along with the UHA care coordinator. UHA also hosted an in-service presented by APD at UHA's community team meetings, where they provided information on covered services, time frames and processes. UHA notifies APD in a timely manner when we have a member needing assistance, usually when they are in the hospital. Care coordinators are assigned to members and identified in PreManage. Providers are able to view the name and contact information of the care coordinator assigned to the member.

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.

UHA case managers are notified of admission to care facilities through the prior authorization (PA) process, PreManage, or a census list. UHA care coordinators follows each member through each transition of care. Each member will be assigned to a care coordinator upon notification of admission. The care coordinator establishes contact with the facility to ensure coordination of transition or discharge planning. Care coordinators will make every attempt to complete a face-to-face assessment to establish a rapport with the member. When it is not possible to complete a face-to-face meeting, the care coordinator will reach out by phone to contact the member. The care coordinator will complete an assessment and create an individualized care plan with the member. Each member will be given contact information for their assigned care coordinator as well as the facility where services are being provided. UHA care coordinators will be part of the IDT process and will coordinate services in conjunction with LMHA. The standard process is to hold weekly reviews with the providers unless extenuating circumstance indicate more frequent reviews are required. Through each transition of care, the care coordinator will complete a utilization review and update the individualized care plan.

7.6.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.

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.

UHA has implemented a three-tiered system for members. The first tier consists of members that require intensive care coordination services (ICC), which is defined as members with overutilization of services (such as ED visits), chronic conditions, co-morbidities, and social determinants of health equity, such as homelessness. These members will have a case manager assigned to them and will be discussed at our twice weekly IDT department meetings with a detailed assessment and care plan. The second tier are members that require coordination of services, assistance with specialists' appointments, and connections to resources, but they do not require intensive services like the population in the first tier. The third tier are members that have a support person and are considered stabilized in their environment, such as members placed in foster care, or long-term care. These members will continue to be followed through the PreManage system, but require less active case management interventions. They will have their care plans reviewed and updated as needed on an annual basis.

Each care plan is built to meet the individuals needs of the member. The care plans list prioritized goals for a member; establish timeframes for reevaluations of goals; and provide resources that might benefit the patient, including a recommendation as to the appropriate level of care. The care plan will include continuity of care, such as assistance in making the transition from one care setting to another, and is a collaborative approach to health awareness. The care

plan includes family and/or support person participation. The guidelines used to create a care plan are as follows: the care plan should enhance the patient's treatment plan by providing a list of identified health conditions or problems with a corresponding prioritized list of interventions to meet the patient's goals. The care plan is prioritized based on Maslow's Hierarchy of needs.

Once a member with special health care needs is identified, for example a member at high risk for readmission or an adverse medical event, the case manager will complete an assessment. The assessment criteria are based on the needs of the member. UHA uses the Care Coordination module from InterQual for its assessments. The initial assessment will open screening tools based upon the member's condition. Some of the screening tools incorporated into the assessment include: Cognitive screening, MAHC 10, PHQ 9 depression screening, HRQOL, Katz activities, or TICS. Each of these tools will be available as the member answers relate to the screening need. Once the assessment is completed, the responses will generate a care plan for the member. The Case Manager will be able to add relative goals and interventions, and prioritize them to fit the member needs. The goal development in the care plan uses SMART goals: Specific, Measurable, Achievable, and Relevant Treatment goals. The case manager then can prioritize the goals, identify barriers to goal obtainment, and create interventions to meet the goals. Each goal that is created will require the member and case manager to set target dates, then each target date will be flagged in UHA's operating system for follow up. The case manager will update the care plan at each target date. To ensure the case managers are updating the care plans in a timely and efficient manner, the case management operating system will send alerts to the case manager on overdue tasks and monthly auditing will be completed by supervisor. UHA's policy is to have care plans reviewed at a minimum every year. This timeline is for members that are experiencing stabilization within the community and have completed their interventions and have met their goals.

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.

UHA uses the Health Risk Assessment (HRA) process to assess individuals for critical risk factors that trigger ICC for high needs members, including those receiving DHS Medicaid-funded LTC services. Additionally, UHA identifies members needing care coordination through referrals from providers, and claims data analytics. All UHA members are eligible for care coordination services and members will not be denied assistance at any time.

HRA surveys are mailed out to all new enrollees. Additionally, every new member enrolled in the health plan is contacted by phone within a week of enrollment and offered an opportunity to complete an HRA. If a member elects to complete an HRA, that information is recorded and sent to the Case Management Department to follow up with the member. Upon receipt of the completed HRA, UHA care coordinators will reach out to the members via phone call to offer care coordination services. These services include providing resources, assisting with appointments, or arranging transportation. The care coordinator will assess each member engaging in care coordination, and share the assessment and care plan with applicable providers.

All providers are able to refer identified members to a UHA care coordinator through a referral process. The referral and instructions for submission are located on the provider website. Providers may also call directly to the Care Coordination department for service. The Care coordinator specialist will complete the referral form and send it to a care coordinator for

screening and follow up. The care coordinator will reach out to the member within 24 hours of receiving a referral. The care coordinator will offer services and complete an assessment and care plan that will be shared with applicable providers.

In addition to the above referral process, claims data is used to identify members in need of intensive care coordination. The transitional care team uses the LACE score to identify high-risk complex members. UHA also uses the MARA score through claims data analysis to identify complex high-risk members, such as members in foster care or using Medicaid-funded LTC services. Once members are identified, they are tracked through a cohort group in PreManage, which is a program that enables the care coordinator to locate and assist members when they present to the emergency department or are admitted to the hospital. Care coordinators also attempt to contact the members by phone and will try to coordinate service through the primary care physician's office.

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.

UHA has open communication with our APD/AAA office. UHA includes local type B AAA and APD offices and DHS Medicaid-funded LTC providers in the monthly IDT meetings. These community partners can refer members to case management or care coordination. APD/AAA will share information on its long-term care consumers served with UHA as appropriate. A list of UHA members who are receiving Medicaid long-term care services is produced by the DHS central office. Both parties share information regarding high needs members. APD /AAA will share key client information with UHA when appropriate for individuals who have a UHA-developed individual care plan. This information may include things documented in the long-term care client assessment and planning system. UHA may share individual care plans, for members who have been identified as being served by the APD/AAA office, as appropriate.

Screening of members is essential for services. If members do not qualify or do not participate in receiving service through APD/AAA, UHA case managers will continue to follow the members and assist with other avenues to prevent further decline. UHA will include as many resources as needed to provide safe living environment within the limits of the member acceptance. UHA has an MOU in place that holds each party accountable for engagement in member-related services.

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.

The UHA care coordinators have a standard practice to review all care plans at least every year, or as a member's health status changes. Care coordinators can set future dates/ reminders to follow up with members including special health care needs members. Care coordination schedules regular follow up with members, and also monitor the status and outcomes of members. Through analysis of markers and goals specific to each member's circumstance, UHA is able to evaluate the success or need for a change in care plan for these members. This process will also detect a significant change in status, which is a major decline in a member's status that is not self-limiting or will generally not resolve without intervention. UHA also uses claims data analytics to review high needs members and review cases.

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.

Care plans for individuals in long-term care facilities or foster care utilizing DHS Medicaid funds receive updated care plans at least annually or when conditions change. UHA has implemented monthly IDT meetings where community partners are encouraged to attend and bring forth UHA members with complex behavioral health or medical health issues to discuss treatment plans and interventions. This provides an opportunity for community partners to discuss treatment options for members, reduce duplication of service, and create care plans that are then reviewed with the member and providers of service.

7.6.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.

Care coordinators are instructed to coordinate care for all physical, mental health, and oral health care needs. The New Day program assists pregnant members with dental care during pregnancy. Behavioral health care coordinators assist SPMI members with appointment setting and follow through with oral care. The New Beginnings program focuses on children's oral health care and sealants. UHA also assists members with dental grievances and coordinates care with the DCO case managers as needed. UHA case managers have attended appointments for complex patients as an advocate for the member when needed.

UHA will be working closely with its dental care organization (DCO) to make the experience smooth from the member perspective. UHA's DCO has strong systems of communication with all members, including welcome letters for new enrollees and ongoing multi-channel communications that inform members of dental benefits, provider assignment, and what to do in case of a dental emergency. They also follow the MORE Care model (Medical-Oral Expanded Care) for interprofessional connection to foster closed loop referrals and provider-level emphasis on the need for integration to ensure members receive whole person treatment. UHA may collaborate with its DCO to create joint informational materials, systems for warm handoffs of phone calls, and ways to share care coordination. We are confident our DCO will be an effective partner in ways to improve the member experience.

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

UHA already manages the mental health and physical health benefit in house so members experience integrated behavioral and physical health services and consolidated benefit management. Portions of the substance use disorder benefits are managed by a network provider, however UHA intends to bring that work in house in 2020. This change will allow for a seamless and integrated experience for UHA members with regards to the behavioral health and physical health services. As to oral health, UHA will be working closely with its dental care organization (DCO) to make the experience smooth from the member perspective. UHA's DCO has strong systems of member communication and care integration to ensure members receive whole person treatment, as described above.

7.6.b. Care Integration

7.6.b.1. Oral Health

a) Describe the Applicant's plan for ensuring delivery of oral health services is coordinated among systems of physical, oral, and Behavioral Health care.

The DCO's case management team works with UHA and appropriate care coordinators to coordinate care for members across disciplines. UHA is reviewing various HIE platforms to integrate physical and behavioral health and dental health information, and this process will continue in 2019. The DCO is also nearing connectivity to HIEs. Additionally, through its Everybody Brush! program, the DCO employs several EPDHs across the state who are certified trainers of the First Tooth and Maternity Teeth for Two programs, which strive to integrate basic oral health concepts into physical and behavioral health.

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.

UHA's DCO actively reaches out to its special populations to assist them in accessing preventive dental care. These special populations include: 1) foster children, 2) members with diabetes, 3) pregnant members, 4) members who have not received a dental service in the past 24 months, and 5) members that are designated by the CCO with SPMI.

Our DCO has been a leader in community-based dental care in Oregon since 2010. They provide preventive oral health services to hundreds of schools and community partner sites across the state, including 26 sites in the UHA service region. By meeting members where they are at, the DCO strives to reduce barriers to care and improve clinical outcomes. They reach those individuals who might not otherwise seek care and connect them to the system through outreach.

In addition, the DCO network's re-care systems work well to ensure members are reappointed for future preventive visits. The DCO has a goal to screen and risk assess all members and triage to care as appropriate. To facilitate these efforts in the community setting, the DCO utilizes a screening tool developed from the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey and the International Caries Detection and Assessment System (ICDAS). The screening tool is embedded into ADIN, their proprietary HIE, and uses an algorithm that auto-populates a risk-score based off the answers provided such as change in tooth structure, breakdown in enamel, or previous decay. In February of 2017, the DCO rolled-out the Risk Assessment tool in the practice setting. An on-line training is available for staff and contracted dental providers.

7.6.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:

a) Coordination with a Member's Patient-Centered Primary Care Home or PCP

To ensure that all members receive the right care, UHA requires and supports a standard of care for all contracted PCPs and PCPCH entities. This model of care fosters strong relationships with members and their families to better treat the whole person, focusing on prevention, wellness, and management of chronic conditions. As it does for all providers, UHA supports the efforts of

specialty care providers to become certified at the PCPCH level. UHA includes in contracts a requirement that providers need to communicate and coordinate care with the PCPCH, if applicable, in a timely manner using electronic health information technology.

UHA is an active user of Emergency Department Information Exchange (EDIE), which provides real-time emergency department (ED) alerts. UHA uses this tool to notify all PCPs of admissions or ED visits and discharges. On a daily basis, UHA pulls reports from EDIE/PreManage and sends these reports to each designated primary care physician to notify the PCP of the need for a follow-up appointment for these members. Our local hospital Mercy Medical Center has case workers, patient navigators, and hospitalists that communicate using these notification systems.

UHA also has a transitional team that assist our members upon discharge and helps to schedule appointments with the member's PCP for follow up care. The transitional team focuses on improving care in the inpatient setting, enhancing patient and family caregiver outcomes, and reducing costs among vulnerable, chronically ill adults admitted urgently to Mercy Medical Center. Transitional care emphasizes identification of patients' health goals, design and implementation of a streamlined plan of care, and continuity of care across settings and between providers throughout episodes of acute illness. Under this model, care is both delivered and coordinated by the registered nurse in collaboration with patients, their family caregivers, physicians, and other health team members.

The TCM supplements care provided to patients in the hospital and substitutes for care provided by professional nurses in the home setting based upon individualized member needs. This model focuses on reducing the number of unplanned readmissions. The transitional care process (described above) involves assessing a patient's risk for readmission and supporting the member through the discharge planning process to provide the post discharge medication reconciliation, and, most importantly, the scheduling of a follow-up appointment with the member's PCP within a 24- to 72-hour timeline.

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

UHA has prior authorization policies and procedures for Hospital and Specialty referrals from PCPCH and PCPs; per these policies and procedures PCPs and PCPCH do not require a prior-authorization from UHA to refer patients to Hospitals and Specialty providers. In addition, all providers are able to refer members to a UHA care coordinator through a referral process. Providers are trained on the care coordination services available and members who are referred are then assessed and assisted as described above in Section 7.6.a.

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.

When a member is admitted to the hospital, UHA is notified through various tracking and notification systems as mentioned in 7.6.b.2.a above. When a member is admitted to the hospital, our contracted hospital Mercy Medical Center agrees to cooperate with UHA's system for the coordinated discharge planning of Members, including for any necessary continuing care.

Hospitals agree to accept for admission, subject to capacity and availability, all UHA members who are admitted by qualified healthcare professionals with admitting privileges at the facility. These medical facilities or hospitals have a standard admission form that contains an

authorization for the facility to release relevant medical and financial records; and this form is completed upon member admission to the facility. For emergency admissions, the hospital or facility attempts to provide this authorization to UHA or its designee by telephone or facsimile the first working day following a member admission. UHA has a concurrent review process that requires prompt access to clinical information necessary to enable PCPs and other providers to coordinate care, including working with hospital staff to coordinate planning for services upon discharge. UHA is an active user of Emergency Department Information Exchange (EDIE). UHA uses this tool to obtain census reports and notify all PCPs of admissions or ED visits and discharges. On a daily basis, UHA pulls reports from EDIE/PreManage and sends these reports to each designated primary care physician to notify the PCP of the need for a follow-up appointment for these members.

A transition of care tool is built into the EHR system, and it guides the decision on the discharge planning needs for the member. The case management coordinator assists the facility coordinators, the member, and the member's designated health care partner with each transition. Support for the transition encompasses transportation, home health services, follow-up appointments both behavioral health or physical health providers, durable medical equipment, or long-term placement.

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.

UHA's has a Transition Care PIP in place, which is member centric, and coordinates with PCPs and PCPCH to ensure prompt post hospitalization follow-up. The three areas of focus include the Eric Coleman Care Transition Interventions (CTI) coaching model, care coordination that involves UHA and Mercy Medical nurse case managers and discharge planners, and access to provider services (i.e., PCPCH). UHA Transitional Care uses three areas of focus to manage readmission risk, and is described in detail under Section 7.6.a.9. Briefly, it involves:

1. Health coaching focuses on enabling patients and caregivers to develop the skills, confidence, and tools they need to assert an active role in their care. Members have two face-to-face encounters with the health coach: one during the hospitalization and a second in the home after discharge. Multiple tasks are completed including medication reconciliation, teaching the use of a Personal Health Record (PHR), discussing self-management, addressing the social determinants of health, and coordinating care with the primary care home. Then the member receives three follow up phone calls over the next three weeks.

2. Care coordination is available for a wide variety of patients. UHA and MMC nurse case managers and discharge planners work together to ensure a smooth and thorough transition to the next care setting.

3. Access to provider services is the third aspect of our TC program. Frequently patients do not have either a primary care provider or timely access to theirs. In those cases, TC has a nurse practitioner who can see the patient to complete medication reconciliation; address barriers; arrange follow up care at their current medical home; and address any other medical needs.

7.6.c. DHS Medicaid-funded Long Term Care Services

7.6.c.1. Describe how the Applicant will:

a) Effectively provide health services to Members receiving DHS Medicaid-funded LTC services whether served in their own home, Community-based care or Nursing

Facility and coordinate with the DHS Medicaid-funded LTC delivery system in the Applicants Service Area, including the role of Type B AAA or the APD office;

UHA has MOUs in place with the APD office and AAA. The MOU consists of expectations for each party related to interdisciplinary care teams, transition care practices, improvement on member and clinical engagement participation, health prevention and promotion, and access to member resources and responsibilities to facilitate access. In accordance with our MOU, APD and AAA provide a monthly report of UHA members receiving Medicaid-funded long-term care services and supports including key information on members' needs for assistance with activities of daily living, case management contact, and care provider contact information. UHA hosts monthly meetings to review identified members requiring interventions and a care plan is created in collaboration with all parties. The care plan may consist of both medical and non-medical information, with both long- or short-term goals as needed. Care coordinators are in contact with the assigned case managers at DHS. UHA care coordinators provide the care plan to the primary provider. UHA and AAA/APD hold each other accountable through quarterly collection of and reporting on activity measures. AAA/APD is responsible for collecting and reporting the data to APD central office. The results will be shared with UHA at a regularly scheduled team meeting and with the manager of the case management department.

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

UHA follows evidence-based best practices for transitions of care and Care Coordination at all level of care. UHA has comprehensive evidence-based systems in place to support members during care transitions, such as careful case management that follows the patient through each level of care. UHA has implemented the care coordination module from InterQual to assist care coordinators in creating a plan based on the medical needs of the member based on national standards for care transitions. The decision support system has a specific module for long-term care, and the care plan is updated per members' needs and the case manager's clinical judgment, but at least every six months. UHA's transitions of care support (detailed in Section 7.6.a.9 above) provides health coaching using the Care Transitions Interventions (CTI) model. Case management coordinators are notified of all admission, inpatient acute hospital, inpatient psychiatric, residential, skilled nursing facility, and psychiatric residential treatment services (PRTS) either by PA request or hospital census report. Support for the transition encompasses transportation, home health services, follow-up appointments with both behavioral health or physical health providers, durable medical equipment, or long-term placement.

7.6.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:

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.

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.

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).

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.

Currently UHA does not have a DHS Medicaid-funded program, however our organization is contracted with a quality and compliant skilled nursing center that offers full continuum of care to meet an individual's changing medical and healthcare needs. Rose Haven provides skilled rehabilitation and nursing care on a short- or long-term basis that addresses orthopedic conditions, prolonged illness or chronic diseases. UHA's members receive rehabilitation services at Rose Haven's complex in addition to comprehensive care that focuses on the patient. The majority of UHA's members are provided with individualized care plans that are created especially for them with both short and long-term goals to help our membership reach their maximum potential. Rose Haven also encourages patient and family involvement in the rehabilitation process because it speeds recovery and promotes successful outcomes.

UHA is conducting further research to develop a plan encompassing a DHS Medicaid program in the near future. Our goals are focused on specific approaches to the coordination of care. UHA is determined to provide industry leading outcomes through a comprehensive funded program using congregate home setting models. UHA's effort will focus on catering to the physical and emotional health of our members. Our Provider Network department will work together with our community partners and inner-interdisciplinary teams to ensure our community will meet our members' healthcare needs.

UHA's primary method of coordinating care with DHS systems is through a team-based approach. UHA has an active relationship with APD. UHA host a monthly community interdisciplinary team meeting, which includes DHS case workers. Complex members are brought forth for discussion of current barriers, and this discussion includes placement. The team reviews the case and will create a care plan to meet the member's needs. UHA care coordinators attend all care plan meetings at the local skilled nursing facilities, incudes those for long-term members. Any barriers for physical or behavioral health will be addressed at those meetings. APD is embedded within the facility, and UHA feels this streamlines members transitioning from skilled to long-term placement.

7.6.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.

7.6.d.1. How will the authorization process differ for Acute and ambulatory levels of care;

Any member who needs an acute level of care does not need a prior authorization to receive services, and this process does not change for members with Special Health Care Needs. Additionally, any member who is referred to a provider within the UHA provider Network will not require a prior authorization. UHA has a process in place for members engaged with

intensive case management services that streamlines the authorization process. UHA care coordinators will assess members with Special Health Care Needs who are engaged in ICC services, and, based on the findings from the assessment, the care coordinator will collaborate with the primary care provider to obtain referrals to needed services. The UHA care coordinator can then input and approve the referral request to remove the need for prior authorization and ensure timely access to ambulatory services. An example of this is if a member needs to be seen by an out-of-network specialist, the ICC will collaborate with the PCP to initiate a referral and process the request for services. This process decreases the amount of time that a member would need to wait to be seen by a provider.

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

To ensure that members are utilizing services appropriately, UHA assesses over- and under-utilization at two different levels of review. The first level is completed by the care coordinators during initial and ongoing assessments of members with Special Health Care Needs or other members receiving ICC services. During their assessment, they interview the member to determine which services the member is using and which services the member needs. Doing so allows the UHA care coordinator to help monitor and implement appropriate utilization of services. The second level is completed during UHA's monthly Utilization Management committee meetings. This larger scale review assesses over- and under-utilization for all services provided by UHA. Utilization trends are identified by comparing the current use of services to the previous years as well as month to month. If there is a 30% increase or decrease in utilization of a service, the Utilization Management committee will flag this area for further review and take appropriate action to improve utilization. Such actions could include the removal or implementation of prior authorization, provider or member education, network expansion, or changes in the review process for prior authorization.

7.7. Accountability

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

[redacted] Specific reports are downloaded and shared with PCPCH clinics and non-PCPCH clinics on an as needed basis and routinely on a monthly basis. Updated reports are also shared with the clinics during in-person visits. The QI department trains the clinical teams in the use of both online and offline tools. Their QI goals are to improve outcomes, optimize workflows, and build effective clinical teams.

[redacted] We can do benchmarking for national standards, as well as

internal benchmarks by contracted providers (individual mid-level to MD/DO comparisons). We can also perform utilization review by clinic and providers for procedures, diagnoses, and member demographics.

7.7.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)?

UHA's contract with its Medicare Advantage manage care organization, ATRIO, requires the Medicare Advantage plan to report on Medicare Quality Measures. UHA will not be reporting directly to NCQA or CMS on quality measurements. The organization is open to other external equality measurement, dependent on guidance from the OHA.

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

[redacted] The targets are revised by OHA on a yearly basis [redacted]

A second sub-contractor, PH Tech, performs the Authorized Services, measured on a monthly basis ("Measurement Period"), according to the following standards:

[redacted]

[redacted]

Sub-Contractors (including PH Tech and Inteligenz) have specific performance expectations built into their contracts. In addition, the following other subcontracted providers have quality components in their contracts:

- Galen Inpatient Providers
- Adapt SUD Quality Incentive Fund
- Compass Care Coordination
- Serenity Lane
- Advantage Dental
- Bay Cities NEMT

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

UHA uses the BI Platform to share quality improvement information with PCPs and PCPCH clinics. [redacted]

UHA's QI department actively reaches out to and engages providers on a range of quality topics. UHA notifies providers of changes in the population metrics; routinely generates monthly reports to give them insights into their populations; and responds quickly if any issues arise with member data. The QI department shares performance-related information with providers in the following spheres:

- [redacted]

7.8. Fraud, Waste and Abuse Compliance

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

FWA activities are based on an annual risk assessment process which incorporates relevant items from the work plans and recommendations of OIG, CMS, and the Secretary of State. Information of potential risks is also gathered from known issues; management and key stakeholder surveys; as well as through audit findings, investigations, and news. UHA's Chief Compliance Officer then scales the items for potential impacts in the risk areas of patient and member safety; reputation; finance; regulations; and operations. Issues posing the highest risk are chosen for the following year's Compliance Work Plan to proactively target FWA through auditing, monitoring, and training activities.

UHA proactively monitors for improper payments and unnecessary spending through its Claims Analyst, third-party administrator (TPA), and BI vendor. Using the TPA's claims system, both the TPA and UHA Claims Analyst are able to monitor claim submissions to prevent payment of claims that either contain errors or lack certain information for the claims to be properly processed. Further claims tools provided by UHA's BI vendor enable UHA to analyze claims data and to produce countless reports for tracking and trending utilization patterns and identifying billing outliners; these tools may also be used for prompt reactive FWA investigations. This information is then used to ensure payment integrity to detect improper payment payments.

UHA is also able to access UmpquaOneChart, which is a community EHR provided by UHA's affiliate named Physician eHealth Services (PeHS). UHA is able to leverage this relationship to access medical records during activities to identify improper payments (e.g. compliance investigation). This allows UHA to promptly and efficiently access/review medical records when research improper payments.

Additionally, UHA's Pharmacy Benefits Manager (PBM) subcontractor routinely audits pharmacies to both ensure compliance with federal and state regulation as well as to detect and prevent FWA. The PBM also provides UHA with a variety of reporting tools to detect potential FWA including inappropriate prescription utilization or prescribing and inappropriate or fraudulent dispensing by the pharmacy.

UHA also monitors for FWA through the use of Provider Trust by screening providers, vendors, and employees against Health and Human Services' Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), Excluded Parties List System (EPLS)/System for Award Management (SAM), as well as numerous State Medicaid Agencies exclusion lists.

Furthermore, UHA's Compliance Program has numerous tools and mechanisms to help identify potential improper payments. These resources are designed to bring awareness of improper payment, along with mechanisms to prevent, detect and recover such payments. Some of these resources include a hotline, FWA audits, investigations, provider audits, and a corrective action plan process. The program also ensures all levels of personnel, including executives and board members, are trained on the State and Federal FWA laws and whistleblower provisions.

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

UHA's Compliance Department's annual risk assessment process, described above (7.8.a), which creates UHA's Compliance Work Plan includes how its provider network, subcontractors and delegated entities will be monitored for potential fraud, waste, and abuse (FWA) activities. Whether looking at key performance indicators (KPIs) for monitoring purposes or performing audits (proactive or reactive), data analytics are utilized to note any atypical trends.

KPIs are used to monitor areas such as, but not limited to, member's access to care, authorization turnaround times, and claims processing. This data is then used to monitor performance and, if needed, to oversee remediation activities through UHA's corrective action plan process.

UHA's business intelligence vendor is used for data mining for potential outliers. When conducting proactive FWA audits, identified outliers are used to select the random sample to be reviewed (e.g. potential excessive prescribing of narcotics). Such audits help identify improper payments or practices that may need strengthened. Outliers found through routine data mining may also prompt investigations (e.g. significant change in usage of E/M code billing by provider). In such cases, investigations are seen through to their conclusion and followed with remediation activities appropriate to the findings.

Last, if issues are reported to the hotline regarding provider network, subcontractors, or delegated entities they are promptly investigated to their conclusion. Should FWA or other compliance concerns are discovered, UHA will initiate its corrective action plan (CAP) process. In the event additional reporting is required to the State or other regulatory bodies, as stipulated by the CCO Contract or other regulatory requirements, such reports are made in a timely fashion.

7.9. Quality Improvement Program

7.9.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.

UHA has a robust quality structure which supports the state-level CCO Health System Transformation plan (see the UHA Quality Structure diagram below). UHA's policy to achieve Health System Transformation is based on expanding the implementation of the CCO Model-of-Care, i.e. the PCPCH model. [redacted] UHA, on quarterly basis convenes the Clinical Advisory Panel (CAP) which is comprised of community providers; CAP provides feedback on how to implement adoption of clinical practice guidelines into the Model-of-Care.

7.9.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.

UHA currently offers wellness programs to our members through health-related services, such as gym memberships, yoga classes, and eating healthy cooking classes. UHA has a full self-

management curriculum, including for diabetes, and is invested in the farmer's market. UHA offers members tobacco cessation help, such as quit coaches that will help members create a personalized plan, free nicotine replacement therapy products (patches or gum), quit guides, and web and text coaching. UHA will continue to enhance current programs and plans to dedicate portions of the CCO premiums in the upcoming years to improve quality, enhance patient experience, and lower costs. UHA plans to incorporate a CDC-certified diabetes prevention program this year. The program will encourage lifestyle changes, increase wellness, improve quality of life, and reduce obesity.

UHA offers many wellness programs for employees. For stress management, employees can contact UNUM, a work-life balance employee assistance program. UHA offers reimbursement for gym memberships. UHA has recurrent challenges that encourage employees to improve lifestyle and adoption of healthy habits, such as the 25-hour challenge (25 hours of exercise in 6 weeks). UHA sponsors community exercise and activities that include health movement, walks and runs.

7.9.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.

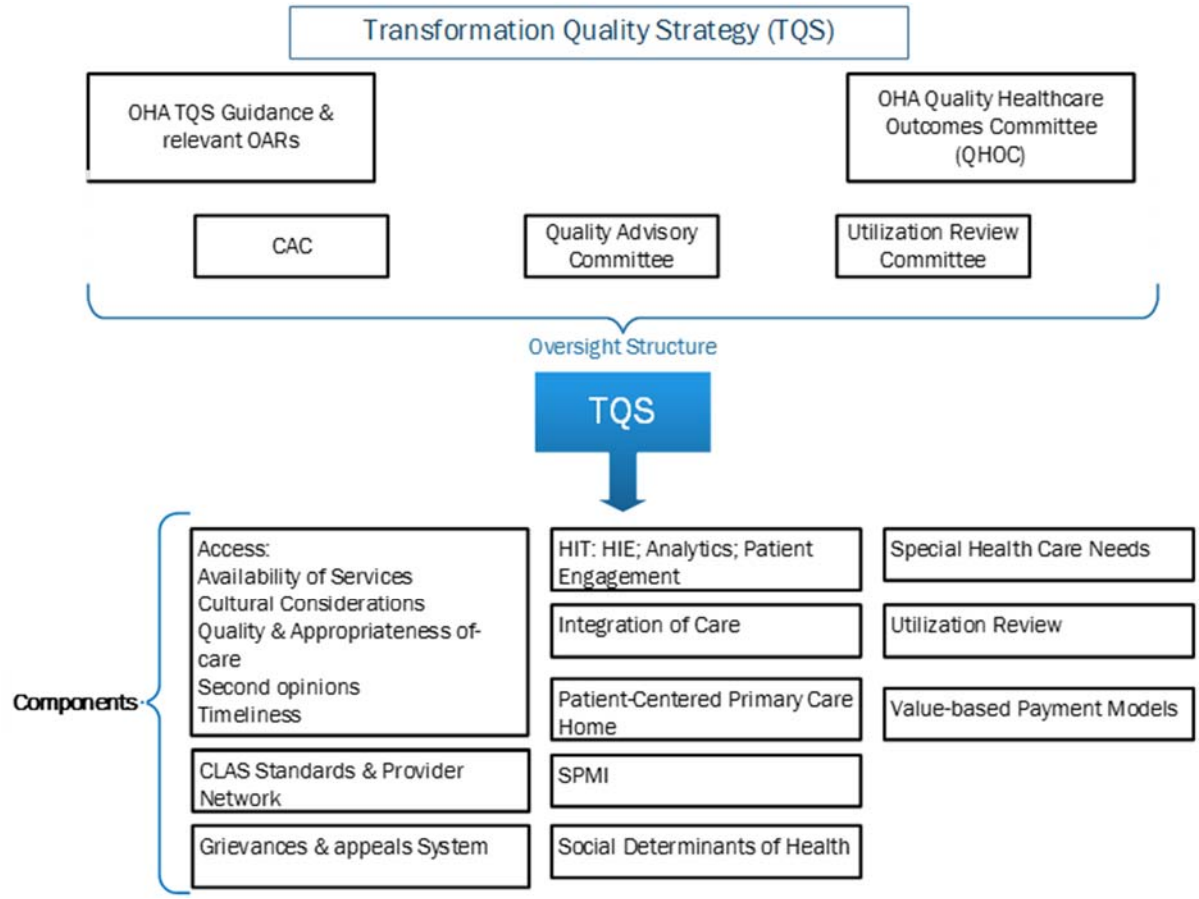
UHA's Quality Department leads the Transformation Quality Strategy (TQS) for the CCO. The Quality Department is staffed with a Quality Director with a MD qualification and 18 years of QI experience and support staff of 1 FTE Quality Improvement Specialist. The Quality Director engages with all OHA-directed quality programs, including attending the QHOC meetings (held in Salem) in-person.

[redacted] UHA's QI team ensures that all micro-systems are functioning at an optimized level; periodic system process analysis is undertaken to identify opportunities to improve workflows within and outside the EMR system.

The following QI policies ensure effective monitoring of the TQS for the CCO:

1. Transformation and Quality Strategy
2. Data Validation Process
3. Performance Measurement and Reporting Requirements
4. Over and Under Utilization
5. Freedom of Seclusion and Restraint

UHA Quality Structure



7.9.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.

UHA ensures that members who have high health care needs or who are hospitalized receive case management service to help with care coordination across all levels of care. Additionally, these high risk members are discussed at our interdisciplinary meetings which include: Primary Care Provider (PCP) or PCP Representative, Compass, Adapt, Department of Human Services (DHS), Advantage Dental, and other local agencies if applicable to members' care plans.

Referrals and prior authorizations are tracked using our authorization and claims system, CIM (which is described above in Section 7.2.a). Each member has their own chart that tracks each of their authorization requests, which are reviewed by the Utilization Review Coordinators. When a coordinator reviews a request for an out-of-network hospitalization or skilled nursing facility, the member's information is given to a case management coordinator (CMC) to provide continuity of care through the different levels of care. Case management coordinators are notified of all admission, inpatient acute hospital, inpatient psychiatric, residential, skilled nursing facility, and psychiatric residential treatment services (PRTS) either by PA request or hospital census report. Cases are assigned to the case manager by needed specialty services. The case manager follows the patient through each level of care, receiving updates periodically from the facility for review

of continued stay. Authorizations for continued stays are extended based on medical necessity and discharge planning needs.

7.10. Medicare/Medicaid Alignment

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

No, UHA is not under any sanctions by CMS.

7.10.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?

UHA currently has an ownership stake and is affiliated with ATRIO Health Plan.

7.11. Service Area and Capacity (not counted towards overall page limit)

7.11.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.

UHA is applying for all:

- **Douglas County**: Entire service area, with no cap on number of members served.

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

UHA intends to serve the entire county of Douglas County. UHA intends to serve the entire population in Douglas County with no cap of membership.

Service Area Table

County (List each separately)	Maximum Number of Members, Capacity
Douglas County	N/A

7.12. Standards Related To Provider Participation

7.12.a. Standard #1 - Provision of Coordinated Care Services

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.

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.

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.

7.12.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.

Whether it is Geriatric Specialists like Dr. Preeti Satyanarayana and Dr. Hennie Abrio at Internal Medicine and Geriatrics, Endocrinologists like Patrick Clyde at Evergreen Family Medicine, or Pediatricians like Dr. Beth Gallant at North River Pediatrics, UHA has a wide and varied network to handle special needs such as aging, chronic conditions, or pediatrics. UHA has clinics in the network that are able to communicate with members across 20 non-English languages (including sign language). Additionally, the UHA network has a wide array of specialists, including Allergy, Asthma, Gastroenterology, Orthopedics, Pulmonary, Sleep, Heart, Vascular, Kidney, Podiatry, Internal Medicine, Geriatrics, Pediatrics, Hypertension, Urology, Oncology, Dermatology, etc.

Adding to the physical health network, UHA has a full range of oral health services provided by its DCO partner, Advantage Dental. This includes DDS's, DMD's, Endodontics, etc.

Lastly, to serve a wide variety of Behavioral Health and Substance Use Disorder needs, UHA has a thriving relationship with Adapt, located in Roseburg, in the heart of Douglas County, that has Behavioral Health and Substance Use Disorder specialists ranging from Marital and Family professionals to Clinical Psychiatrists to Prescribing MDs.

All these providers work in partnership with UHA to provide a team of Coordinated Care Professionals to serve the members of Douglas County.

7.12.c. Standard #3 – Publicly funded public health and Community mental health services

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.

Publicly Funded Health Care and Service Programs Table

Name of publicly funded program	Type of public program (i.e. County Mental Health Department)	County in which program provides service	Specialty/Sub-Specialty Codes

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).

Please see the attached **Publicly Funded Health Care and Service Programs Table**.

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

Currently, UHA's Director of Marketing and Communications is a member of the board for the Douglas Public Health Network (DPHN). This relationship allows us to play an active role in establishing services that are specific to the needs of our community and provide us the opportunity to receive information from DPHN that we can integrate into our application process. Additionally, UHA has been collaborating with the local CMHP, Compass, to articulate the many ways in which the two organizations work together when caring for mutual members. They have been an active partner in developing this coordinated Application and together the two organizations have worked to describe to OHA our current capacities for behavioral and mental health services, as well as actively partner in the expansion taking place in the CCO 2.0 iteration. Finally, UHA has ongoing close relationships with FQHCs and RHCs (see Section 7.3.a). Over 77% of primary care is provided to UHA members either through FQHCs, RHC, or tribal clinics. To ensure our members are encouraged to use our many community-based partners, UHA has taken several measures to contract with professionals who will improve outcomes and reduce disparities. We are focused on community involvement and our service delivery. They have informed our RFA response and will be key partners moving forward.

7.12.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.

UHA is contracted with our CMHP to provide behavioral health services to most of our members in need of such services. UHA also uses other organizations to increase the options and availability of behavioral health services for our members. Our contract with our CHMP includes the specifics of our Care Coordination fee to ensure they have the financial means to support the CMHP infrastructure. It also has the expected responsibilities of each organization, and the services provided by the behavioral and mental health providers.

For members receiving behavioral health service, the CHMP is contracted to provide Intensive Case Management to assist members with transitions from or admissions to a residential level of care, care coordination of residential services and supports, and management of community-based specialized services such as Systems of Care. The Intensive Case Management also aims to lower the rate of recidivism by helping members establish with a mental health provider instead of using the ER for treatment. Additionally, the CHMP provides a crisis intervention team that works with the Douglas County Justice Department to facilitate a rapid response to members in the community experiencing a mental health crisis. As demonstrated above, UHA has a long and successful relationship with its CMHP and believes all of the elements associated with ORS 414.153(4) are captured in the current contract between both organizations. However, prior to 1/1/2020, UHA and Compass will update its current arrangement to reflect any needed changes.

7.12.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: We do have signed agreements with the CMHP.

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

Please describe your experience and ability to provide culturally relevant Coordinated Care Services for the AI/AN population.

At UHA, we believe it is our responsibility to provide effective Coordinated Care Services as individual employees and an organization within the context of the cultural beliefs, behaviors, and needs presented by our members and their communities. The internal and external customers we serve come from culturally diverse backgrounds. We strive to provide the best care possible to all our members and patients with awareness of their unique needs related to their gender, ethnicity, race, color, language, socio-economic status, education level, age, religion, sexual orientation, and physical and mental ability. To this end, every employee and contractor must complete an annual cultural competency training, and our provider network is held to this same standard.

Providing culturally competent and relevant care for members of American Indian or Alaskan Native (AI/AN) Tribes is a high priority at UHA. UHA has contracted with Cow Creek Health & Wellness Center (CCH&WC) to provide primary care services pursuant to a compact to carry out programs of the Indian Health Service (IHS) under the Indian Self Determination and Education Act (IDEAA), 25 USC § 450 et. seq. CCH&WC is dedicated to the health and welfare of all citizens of Douglas County and strives to deliver culturally competent and trauma-informed care to any member of federally recognized AI/AN Tribes that choose to receive their care through the CCH&WC Clinics. As a member of the UHA provider network, CCH&WC will accept any Medicaid enrollee assigned to CCH&WC. All CCO members have their choice of providers but we are confident that if any member of an AI/AN Tribe requests culturally competent care, CCH&WC will be ready to offer primary care, behavioral health, child and adult psychiatry, and health and nutrition education. This is reflected in the increase in CCH&WC utilization from 2017 to 2018. Members receiving physical and mental health services from CCH&WC more than doubled from 2017 to 2018. For more details, see the SDOH-HE Attachment 10.

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

7.12.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.

Last Name of Provider	First Name of Provider	Facility Name	County
Basham	Derwood	Cow Creek Health & Wellness Center	Douglas
Dachepally	Rashmitha	Cow Creek Health & Wellness Center	Douglas
Freeman	Thomas	Cow Creek Health & Wellness Center	Douglas
Groshong	Aric	Cow Creek Health & Wellness Center	Douglas
Hargraves	Julie	Cow Creek Health & Wellness Center	Douglas

Last Name of Provider	First Name of Provider	Facility Name	County
Henderson	Hugh	Cow Creek Health & Wellness Center	Douglas
Lamb	Amy	Cow Creek Health & Wellness Center	Douglas
Lee	Kevin	Cow Creek Health & Wellness Center	Douglas
Leonard	Ross	Cow Creek Health & Wellness Center	Douglas
Schmieding	Ashley	Cow Creek Health & Wellness Center	Douglas
Simmons	Carolyn	Cow Creek Health & Wellness Center	Douglas
Barnstable	Mark	Cow Creek Health & Wellness Center	Douglas
Bentley	Lauren	Cow Creek Health & Wellness Center	Douglas

7.12.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.**

UHA is proud to be the second CCO in the state to contract with a tribal organization. Cow Creek Health & Wellness Center (CCH&WC) is an Indian Health Care Provider, located on sovereign Tribal lands of the Cow Creek Tribe in Roseburg, Oregon. UHA has enjoyed a strong, collaborative relationship with CCH&WC for years. The CCH&WC Clinic Director recently attested to the strength of this relationship and described the challenges that can arise during CCO contracting: "It is unusual to have a Tribal Health Facility fully contracted with a Coordinated Care Organization. With notable exceptions, CCOs are woefully unaware of Tribal needs, issues and concept of sovereignty." UHA recognized that sovereignty is of the utmost importance. It has been hard-won and is fiercely guarded. Additionally, UHA remained patient and diligent during the sometimes-lengthy contract proceedings. The CCH&CW Clinic Director states: "[UHA's] awareness of the issues and absolute willingness to practically address them in a timely, even accelerated, manner was exceptional. From our perspective [UHA's provider contracting team members] were the superstars who made this happen and are the model that should be used by other CCOs."

CCH&WC is the only Tribal 638 facility in Douglas County. Thus, we have not experienced any non-participating Tribal facility issues. We do not require referral or prior authorization for IHS or Tribal facility services. UHA will fervently protect and respect our member's right to culturally competent care as we continue to demonstrate this successfully with CCH&WC. While awaiting contract execution, any non-participating Tribal 638 facility claims would be automatically paid at DMAP rates to eliminate barriers for our members.

7.12.f. Standard #6 – Pharmacy Services and Medication Management

7.12.f.1. Describe Applicant's experience and ability to provide a prescription drug benefit as a Covered Service for funded Condition/Treatment Pairs.

UHA's prescription drug benefit, formulary (i.e. drug list), and utilization management program

are designed to comply with our CCO contract and all applicable OARs including OAR 410-141-3070. The UHA formulary is designed by our local Pharmacy and Therapeutics (P&T) committee to provide medically-appropriate and cost-effective drugs used to treat funded condition/treatment pairs in accordance with the Prioritized List of Health Services. Our utilization management criteria are also designed to ensure medications are used in accordance with all applicable Health Evidence Review Commission (HERC) guidelines. UHA, formerly DCIPA, has been a contractor in the Oregon Health Plan since 1994. We have locally administered our prescription drug benefit since the inception of OHP prescription drug coverage and the Prioritized List of Health Services.

7.12.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.**

UHA's formulary is designed and managed in compliance with OAR 410-141-3070. It is our operational standard that members are allowed access to products not on our formulary through the prior authorization process. We ensure that there is a pathway to coverage for all drugs covered by the Medicaid Drug Rebate Program as required by Section 1927 of the Social Security Act.

- **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.**

In alignment with OAR 410-141-3070, UHA's prescription drug formulary is designed to include products from each funded therapeutic class to ensure the availability of covered drugs with minimal prior authorization requirements. Additionally, we have included at least one over-the-counter (OTC) product in each therapeutic class, if available. Our local P&T committee reviews the formulary, in entirety, annually to ensure this requirement is met. Our P&T committee is composed of local providers. We do not delegate this function to our Pharmacy Benefit Manager (PBM) because we believe it is important to have input from our local providers who understand the unique needs of our provider and patient community. Minimizing prior authorization barriers is a priority of the committee. For example, we use more seamless UM controls, like step therapy, whenever possible to minimize prior authorization barriers.

- **Development of clinically appropriate utilization controls.**

UHA's prescription drug formulary and associated utilization management (UM) controls are designed and implemented to promote rationally, clinically appropriate, safe, and cost-effective drug therapy. Formulary and UM control decisions are made by our P&T committee and are based on scientific evidence and economic considerations to select medications with the best value. When making formulary and UM decisions, our P&T committee uses evidence-based medicine and aligns with national clinical practice guidelines.

- **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.**

UHA's P&T Committee is composed of actively practicing physicians and pharmacists and was developed to establish a drug list (formulary) and drug policies based upon peer-reviewed, clinical literature and evidence-based practice guidelines from national and/or international professional organizations. This internal committee has external participants; it meets at least quarterly and operates in accordance with all applicable state and federal regulations. The committee evaluates available evidence-based research using a transparent process. This informs drug policies to promote safe and effective use of high value medications for Douglas County members we serve. Additionally, the UHA P&T Committee fulfills Drug Use Review (DUR) regulatory requirements. The committee, in its DUR capacity, ensures prescriptions are medically appropriate, and not likely to result in adverse effects.

When performing drug class reviews, we refer to the Oregon P&T committee review as a basis for our review. We supplement that base with local prescribing trends, testimony from local providers, and pharmacoeconomic information specific to our CCO. We also add additional data or information as necessary to provide a robust review to our committee. In the event a drug class review is not available from the Oregon P&T, internal staff drafts the review and monograph using a systematic, evidence-based process. We also review the fee-for-service (FFS) preferred drug list and UM criteria to align when prudent.

7.12.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.

UHA's Pharmacy Benefit Manager (PBM), MedImpact, manages the pharmacy network under our supervision. Our network has over 54,000 chain and independent pharmacies nationwide. In Oregon, UHA members have access to nearly 600 pharmacies. The locations of the pharmacies meet the access needs of the CCO.

We provide our participating providers and pharmacies our formulary and information about how to make requests for drugs not on our formulary or that require prior authorization. We provide notice of updates made to our network or formulary within 30 days of a change including additions of a new drug or removal of a previously listed drug.

7.12.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 MedImpact, our contracted network pharmacies are electronically linked for real-time claims adjudication. MedImpact 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 that we use 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.

Electronic coordination of benefits (eCOB) occurs at the point of sale as well. 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 will return 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 then the secondary electronic claim is processed, and the pharmacy is paid. For eCOB to work most effectively, UHA provides the appropriate COB eligibility information, and network pharmacies must be willing or contractually obligated to participate. The ability for a pharmacy to participate can be dependent on the capabilities of the pharmacy's claim submission software. The eCOB program is fully compliant with NCPDP 5.1 standards for claim submission; however, some pharmacies are still unable to participate due to constraints.

7.12.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.

At UHA, we believe it is important to have local control and management whenever possible to ensure the unique needs of our community are met. We know and care about our members and we have formed strong, collaborative relationships with our provider community. For this reason, we do not delegate prior authorization review or customer service functions to our PBM, MedImpact. We handle all member and provider calls as well as prior authorizations. Staff in both member services and pharmacy services are trained to effectively and expeditiously field calls. UHA has pharmacy staff, including a pharmacist and pharmacy technicians, on-call 24 hours a day, 365 days a year to ensure prior authorization requests are reviewed within 24 hours. This means the administrative and clinical review of the request, coverage decision, effectuation and notification all occur within 24 hours. In 2018, UHA processed of 99.6 percent of prior authorizations within the 24-hour turnaround time.

MedImpact handles pharmacy calls 24/7 but does not handle member or provider calls during or after business hours. For Emergencies, MedImpact will enter a five-day override, only after the plan's business hours, if the pharmacy states that it is an emergency. Specific to natural disasters, MedImpact 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.

7.12.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 following pricing is based on the Post First Databank (FDB) roll-back AWP values provided by Medispan. If UHA is awarded the contract, MedImpact will continue to use the most current Medispan AWP available at the time a claim is adjudicated for payment. [redacted]

- [redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted] f awarded the CCO 2.0 contract, this agreement will be amended to require payment of 100% of the rebates, discounts, incentives or other credits from manufacturers with respect to utilization of any rebate-eligible drugs filled for members on which a rebate is paid. This payment is including, but not limited to, any rebate administration fee or other fees paid by the manufacturer or an aggregator. Rebates are negotiated based on MedImpact's entire book of business.

[redacted] MedImpact has agreed to remove P4P from our contract for the CCO 2.0 amendment, if requested.

- **The dispensing fees associated with each category or type of prescription (for example: generic, brand name, mail order, retail choice 90, specialty).**
  - [redacted]
  - [redacted]
  - [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.**

[redacted] The latter administrative fee is reported quarterly and reconciled annually.

7.12.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;**

Yes, UHA works with FQHCs. Specifically, we contract with Umpqua Community Health Center (UCHC) and Oregon Health & Sciences University (OHSU) to provide 340B services.

- **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;**

UHA does not own or operate the FQHCs and does not have regulatory authority over the facilities. The funding goes towards keeping the facilities open and operational. The 340B program was created to allow covered entities to purchase drugs at an affordable rate in order to

provide patients with affordable access to these medications as well as to maintain the comprehensive services they provide to their vulnerable patients. In addition to providing better access to medications for patients in medically underserved communities, the savings from the 340B Program also result in an enhancement of all preventive and primary care services provided by FQHCs.

- **How the Applicant is evaluating the impact of these adjunctive programs whether they are generating positive outcomes.**

UHA has a close and collaborative relationship with UCHC. We are engaged with the staff that manage the 340B program and have open dialogue and discussion of the programs provided and the positive outcomes provided to our members. The savings achieved from purchasing medications at reduced prices allow health centers to use more of their limited resources to expand services for those in need of care. UCHC's uninsured and underinsured patient demographic is approximately 80 percent of its total patient population and the savings received from the 340B support that patient population by providing sliding scale and financial adjustments for patient visits. UCHC provided hundreds of thousands of dollars in patient assistance for FY17-18 from this program. The savings also supports patient debt dissolution, enables UCHC to open additional clinic sites for outlying communities; allows for additional services for mental health services and free community clinics such as smoking cessation and diabetes education. These services would not be possible without the savings received from the 340B program.

We contract with OHSU's 340B hemophilia program. 39 percent of their patient population are Medicaid beneficiaries. Funds generated by their 340B program allow them to increase the outreach, and breadth of services beyond just the patients who receive medication, providing additional support for family members and caregivers. Without 340B funds they would not be able to provide the following comprehensive services:

- Staff supported and services offered to patients: Pediatric and Medical hematology; Pathology; Nursing; Medical assistants; Social work; Physical therapy; Psychology; Nutrition; Genetic counseling; Research; Administration; and Hemophilia pharmacy.
- Clinical services: Comprehensive and acute hemophilia care; Adult women with bleeding and clotting disorders (in collaboration with the Center for Women's Health); Young women's hematology (Spots, Dots, and Clots in collaboration with the Center for Women's Health); Pediatric stroke clinic in collaboration with pediatric neurology; and Pediatric sickle cell (in collaboration with pediatric hematology-oncology).
- Additional Services: Pain Specialist; Pediatric Dental consultation; Home Nursing; Education Specialist; Support of additional wraparound services; 24/7 on call hematologist; and 24/7 on call hemophilia pharmacy.
- Comprehensive Outreach Clinics: Full comprehensive team travels to provide clinic in the Medford, Eugene, Bend, and Hermiston.
- Additional Educational Programs Supported: Peak Teen Program, which is educational learning on how to transition to adulthood and living with a bleeding disorder; First Steps / Steps for Living, which is geared towards parents and young families on how to cope, deal and work with their bleeding disorder diagnosis; Camp for 8 to15 year old patients, self-infusion and self-care, independence with bleeding disorders; Parents Empowering

Parents, which is a workshop for additional support of raising children with bleeding disorders, focused on the parents; Women's Conference for women with bleeding disorders education; and Infusion Clinics that teach patients and families to self-infuse to treat their bleeding disorder at home and out of emergency rooms.

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

In close collaboration with providers including those who are part of a Patient Centered Primary Care Home (PCPCH), UHA plans to pilot a pharmacist-based telephonic Medication Therapy Management (MTM) program in 2019. The objectives of this program are to improve medication adherence, lower costs, fill gaps in care as established by national consensus guidelines, and address medication safety concerns for the members enrolled in the program. This program targets members at risk for drug-related problems (DRPs), including those taking multiple medications, with multiple chronic conditions, with poor medication adherence, or with high medication costs. The program is a high-touch, patient-centered program designed to manage medication therapy and optimize population health outcomes. Members will be enrolled in the program through referral by the provider, referral by a UHA care manager, referral by pharmacy staff, and through targeted claim analytics. Once members are enrolled in the program, potential DRPs are triaged for resolution opportunities through targeted patient, provider and/or caregiver outreach. Members will be offered a one-on-one comprehensive medication review with an experienced MTM clinical pharmacist.

After evaluating the results of this pilot program, UHA may expand the program to include a pharmacist in the PCPCH as part of the care team.

7.12.f.9. Describe Applicant's ability to utilize E-prescribing and its interface with Electronic Health Records (EHR).

UHA's PBM partner, MedImpact, has an electronic solution to furnish providers with formulary, benefit and medication history information to support prescribing accuracy and efficiency. As the result of CMS's requirements for providers to access EHRs and/or e-Prescribing applications, MedImpact developed MedPrescription®. MedPrescription provides physicians and other healthcare providers with "pre-prescribing" services. These services include patient-specific prescription eligibility, medication history and basic formulary information for consenting patients in both inpatient and outpatient settings. The exchange of pre-prescribing essential intelligence between physicians and MedImpact enables physicians to write an informed prescription at the point of care.

MedPrescription interfaces with Surescripts, MedImpact's e-prescribing connectivity vendor, to deliver these valuable pre-prescribing services to UHA physicians. Physicians can access patient-specific information securely using their practice's e-prescribing technology of choice. The e-prescribing technology has passed the certification requirements of the e-prescribing connectivity vendor. MedPrescription's IT flexible infrastructure supports any connectivity vendor provided the vendor conforms to industry standards.

7.12.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.

UHA has been honored to serve Douglas County since before the inception of the CCO model. UHA has designed an evidence based Preferred Drug List (PDL) and associated Utilization

Management (UM) criteria to ensure the right member gets the right drug at the right time for the right price. Our preferred drug list is publically posted and easily accessible on our website. UHA will also post our prior authorization (PA) criteria on our website, which is accessible to members, providers, and the general public. We wholeheartedly support efforts to allow easy access to these materials publically, and will comply with providing both the PDL and associated PA criteria in other formats or through other distribution channels as specified by the Oregon Health Authority (OHA).

7.12.g. Standard #7 – Hospital Services

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

UHA has the ability to deliver hospital services locally, however at times the hospital may refer patients to specialists in Eugene or OHSU because of medical complexity. UHA will make arrangements with our contracted hospitals which are in Lane County if our members cannot be treated locally. UHA is currently contracted with PeaceHealth Sacred Heart Medical Center at Riverbend, and Peace Health Sacred Heart Medical Center University District. UHA does not have any standing contracts with out-of-state hospitals. UHA will make single case arrangements for members if they need to receive care out of state.

In addition, federal and state requirements to have providers enroll with the Oregon Health Authority has presented some challenges for our members that we are actively addressing. When a member receives services from a non-enrolled provider either inside or outside of our state, they may be subsequently get billed directly for the services after the CCO claim rejects. This could put our members in a position that may further jeopardize their financial stability, such as being sent to collections and negative impacts to their credit score. The future of our members and avoiding additional challenges is our top priority. To prevent these problems, UHA proactively outreaches to providers via mail, fax, and telephone to facilitate encounter-only enrollment and enable claim payments. This approach ensures that the patients will not be faced with challenges or the hardship of getting billed for a covered service.

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

Patients are screened in the emergency department (ED), either by the staff Psychiatrist, Tele, Psych or by the crisis unit from our contracted behavioral health provider, and then diverted to the appropriate level of care. UHA's hospital contract requires that standards are applied equally to all referrals; UHA will design a survey tool to monitor compliance with the contract. UHA's Medical Director and Case-Management Directors have monthly meetings with their hospital counterparts to review the scope and amount of services rendered to CCO members.

7.12.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.**

UHA is a fundamentally data-driven organization. We believe that data transparency on the use of health services can help identify avoidable ambulance, ED, and urgent care utilization and the reasons behind it. Measuring and reporting on overutilization can help reveal how and why patients are using these services unnecessarily. The desired result is that through improved communication and information sharing, UHA case managers, hospitals, and providers will be empowered to provide higher quality care to patients, identify patients at risk for hospital admission or readmission, reduce burdensome duplication of services, and ultimately reduce reliance on costly emergency services through better coordination of care.

The UHA Case Management team uses a variety of reporting tools to identify members who are potentially over-utilizing emergency services. One of these tools, PreManage, alerts us of hospital or ED events in real time. This information is supplemented with data from EMR reports and Inteligenz CCO Metrics Manager, a business intelligence platform that provides rich analytics and reporting. CCO Metrics Manager provides member-level reports that provide demographic information, SPMI flags, emergency services claim data including date(s) of service and diagnoses, and last PCP visit information. These tools are not only available to internal CCO staff, but also to our provider network. Once identified, these members are tracked by case management, and enrolled into our ED Diversion Program, as discussed below.

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

Coordinated care is essential to providing appropriate services to our members, and UHA focuses on managing utilization of emergency services. To this end, UHA has created an ED Diversion Program. A team composed of ICM Coordinators, Case Management Specialists, Community Health Workers (CHW), Provider Relations, Quality Improvement, and Decision Support manages this program. Each member of the team has received trauma informed care training, advanced directive training, ethics training, mandatory reporting training, and cultural and linguistic awareness training. This team is focused on coordinating care, reducing utilization of emergency services, and improving outcomes. Additionally, UHA has assigned an ICM to work specifically with members utilizing the ED at MMC in Roseburg. The primary role for the ED Diversion Program is to coordinate care among community agencies and UHA providers for these members and help them find the appropriate medical services. This program aims to:

1. Decrease the frequency of ED visits for those members with 10 or more visits per year.
2. Increase outpatient Primary Care utilization for those members who have high ED utilization.
3. Increase our Emergency Department ICM’s coordination with community agencies serving the populations identified as frequenting the MMC Emergency Department. This goal is measurable by monitoring the number of referrals to or consultation with community resources by our UHA Intensive ED Care Manager and by monitoring the number of agencies that we are working with in the communities we serve.

Care Management staff uses the reports discussed previously to identify SPMI members and members who have used the ED 10 or more times within the year. The team contacts the member

to create a relationship and engage the member in the ED Diversion project. Once engaged, they are followed by an ICM. Using trauma-informed strategies and motivational interviewing, the ICM assists each member in developing a flexible, holistic care plan and coordinating:

- Timely and appropriate scheduling or referrals to needed services including PCP, behavioral, oral health, or addiction medicine follow-up;
- Root-cause analysis to determine the reason for inappropriate ED use;
- Identification of barriers and proactive problem-solving;
- Identification and elimination of redundancy of services; and
- Ensuring communication with the family and their care team.

Our team coordinates care with our external partners including local mental health providers (treatment & counseling), SUD treatment service providers, primary care physicians, oral health coalition, counseling services, housing assistance programs, and food assistance programs. The ICM works with discharge planners at both the inpatient and ED level to coordinate appropriate transition to behavioral health services in the community including services through the delegated community mental health providers. IDT meetings are coordinated monthly, or as needed, to address more extensive community needs for members with multiple comorbid conditions and SPMI. Community members involved in these IDT meetings include SUD treatment providers, community mental health providers including ACT team, DHS, oral health providers, probation and parole, adult or child protective services and child welfare, specialty providers, and PCPs. Treatment plan and goals are discussed with providers to better coordinate care and meet the member's needs.

Starting next year, UHA will have Traditional Health Workers who will assess social determinants of health and address barriers including transportation, food, housing, and domestic violence. They can assist the member in peer-delivered support by collaborating with providers and using community resources to provide the member with needed services. They will work with the ICM to improve outcomes, and address barriers to the integration of care by collaborating with behavioral, physical, and oral health providers. They can help ensure patients receive the right care at the right time and in the right place.

This program has been quite successful. To determine the success of this program, we have been monitoring ED and outpatient PCP utilization (number of visits normalized by CCO enrollment). We would expect ED utilization to decrease and PCP utilization to increase if the program is effective. We have seen a 10% decrease in ED utilization in the past two years. We have also seen a 2.5% increase in PCP utilization over the same period. These results show the success and efficacy of this program. Using continual process improvement to fine-tune this program and by adding additional team members, we expect to continue to improve these numbers.

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

- **Adverse Events**
- **Hospital Acquired Conditions (HACs).**

To protect Medicaid beneficiaries and the Medicaid program, UHA ensures non-payment for Provider-Preventable Conditions, including adverse events and hospital acquired conditions (HACs) as referenced in 42 CFR 447.26(b). UHA's prior authorization review process monitors for diagnosis/procedure codes submitted for potential HACs. Additionally, UHA's claims payment system has edits in place to exclude payment for HACs and the claims audit review

process includes monitoring claim denials for HACs. UHA will not pay for any Provider-Preventable Conditions that meet the following criteria: has been found, based upon a review of medical literature by qualified professionals, to be reasonable preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the member; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a member, surgical or other invasive procedure performed on the wrong body part, surgical or other invasive procedure performed on the wrong member.

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

UHA covers medical inpatient hospital admissions when services are rendered at an in-network facility or have an approved prior authorization. Payment of claims are subject to applicable eligibility, coverage, referral, authorization, notification, and medical necessity requirements. Claims for members who are readmitted for inpatient services within thirty days of the original inpatient discharge for the same or related condition for which they were treated during the original admission may be reviewed by the Chief Medical Officer (CMO) for appropriateness and medical necessity. If it is determined that the member is being treated for the same or a related condition as the original admission, the readmission can be retracted.

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

In 2017, UHA established a Transitional Care (TC) department to work specifically on hospital readmission reduction. The first few months centered on care coordination and selection of an effective model that could serve as the foundation of a long-term program. In March 2018, the TC department launched an innovative three-prong approach for readmission reduction. The target population of this program includes:

- Members with frequent admissions for management of chronic illnesses such as COPD, CHF, Diabetes, Asthma and CAD;
- Members with a LACE risk score equal to or greater than nine (i.e. a high risk of readmission);
- Member readmitted within the last 30 days;
- Patients with SPMI or associated behavioral health conditions that complicate the management of their physical medicine needs; and
- Members with multiple social determinants of health issues that place them at increased risk for frequent hospitalization.

The UHA TC team uses three areas of focus to manage readmission risk.

1. **Health coaching** using the Care Transitions Interventions (CTI) model is the first aspect of our TC program at UHA. This model was selected because it is uniquely focused on coaching patients and caregivers to develop the skills, confidence, and tools they need to assert a more active role in their care. Coleman model research revealed that patients who received CTI coaching were shown to be significantly less likely to be readmitted to the hospital and the effects were sustained for a minimum of five months after the end of the one-month intervention period. The model incorporates two face-to-face encounters with

the patient: one during the hospitalization and a second in the home after discharge. After the home visit, the interventions continue with three follow up phone calls at various intervals over the next three weeks. High-risk patients are identified by using a validated tool to determine 30-day readmission risk allowing the staff to focus appropriately. After medical record review, staff conducts the hospital visit, which provides an introduction of the program and sets up the intention to promote a smooth transition to the next care setting. During the face-to-face visit multiple tasks are completed including medication reconciliation, teaching the use of a Personal Health Record (PHR), discussing self-management, addressing the SDOH and coordinating care with the primary care home.

2. **Care coordination** is the second aspect of our TC program. Care coordination includes efforts for a wide variety of patients and is not limited to those in the coaching program. A mainstay of care coordination is the interaction with UHA and hospital nurse case managers and discharge planners. It is an essential element of a smooth and thorough transition to the next care setting. Work in this area includes:
    - Addressing the social determinates of health such as homelessness, ability to communicate by phone, and facilitation of transportation to follow up care;
    - Facilitating referral to local Aging Persons and Disability for screening of multiple types of services including caregiver's resources, faculty placement and other community resources;
    - Coordinating with mental health and substance use facilities in our area; and
    - Assisting in scheduling follow up appointments and facilitating the establishment of a primary care medical home.
3. Access to provider services is the third aspect of our TC program. Frequently, patients either do not have a primary care provider or do not have timely access to their provider. In these cases, TC has a nurse practitioner who can see the patient in a timely manner. A focus of those visits is to complete medication reconciliation and address any barriers to access or appropriately use medications. Another area of focus is follow-up care coordination with the member's medical home. Additionally, other urgent physical health needs are addressed during these visits.

To measure the effectiveness of this program, we have been tracking the number of all-cause readmissions. The number of readmissions decreased by 9.5% from 2016 to 2018. The all-cause readmission rate fell from 13.7% in 2016 to 12.4% in 2018. These results demonstrate the great success of this program.

7.12.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.

The strategies discussed above under 7.12.g.2 and 7.12.g.5 also apply to dual eligible beneficiaries. These members are eligible for both the ED Diversion program and the TC program. Additionally, we have ATRIO case managers embedded in the UHA office to coordinate care with other members of the care management team. A portion of our biweekly IDT team is dedicated to coordinating care for our dual eligible members.

Name of publicly funded program	Type of public program (i.e. County Mental Health Department)	County in which program provides service	Specialty/Sub- Specialty Codes
Douglas Public Health Network	Public Health Administration	Douglas	286 - Public Health
Umpqua Health Harvard	Rural Health Centers	Douglas	085 - Rural Health - Clinic/Center
Umpqua Health Newton Creek	Rural Health Centers	Douglas	085 - Rural Health - Clinic/Center
CMG East dba Evergreen Family Medine	Rural Health Centers	Douglas	085 - Rural Health - Clinic/Center
Compass Behavioral Health	Community Mental Health Program	Douglas	092 - Community Mental Health Program
Umpqua Community Health Center - Roseburg	FQHC	Douglas	096 - FQHC - Clinic/Center
Umpqua Community Health Center - Glide	FQHC	Douglas	096 - FQHC - Clinic/Center
Umpqua Community Health Center - Myrtle Creek	FQHC	Douglas	096 - FQHC - Clinic/Center
Umpqua Community Health Center - Sutherlin	FQHC	Douglas	096 - FQHC - Clinic/Center
SouthRiver Community Health Center	FQHC	Douglas	096 - FQHC - Clinic/Center
Adapt (via its Board of Director)	Local Mental Health Authority	Douglas	446 - Local Mental Health Authority

Attachment 8 — Value-Based Payment Questionnaire

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,

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 be given 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:
    - Payment differential and/or range across the PCPCH tier levels during year CY 1 (2020);

- Payment differential and/ or range by PCPCH tier levels over CY 2 (2021) through CY5 (2024); and
- 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:

- 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;
- 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
- Report implementation plans for the two care delivery areas that will start in 2021; and
- 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

Please see the attached Data Template VBP Lowest Enrollment Viability Data for a detailed estimate of the percent of VBP spending for the *lowest* Enrollment viability threshold.

Please see the attached VBP Highest Enrollment Data Template for a data-driven spending estimate for the *highest* Enrollment threshold that the UHA network can absorb.

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.

UHA current invests [redacted] into PCPCH. With regards to future growth, the organization will commit to [redacted]

Applicants must submit the following details:

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

UHA utilizes a [redacted] The Patient-Centered Primary Care Home ("PCPCH") providers are eligible to receive PCPCH incentives from our Improved Patient Experience Program Funding within our CCO Value-Based Care Program. PCPCHs are health care clinics that have been recognized by the OHA for their commitment to providing high quality, patient-centered care.

Criteria. UHA will pay a PCPCH incentive to all Primary Care Home providers who meet the following criteria:

PCPCH Recognition. The OHA has defined five levels of PCPCH tier recognition and 11 must-pass measures that the Provider must meet in order to be recognized as a PCPCH at any level. Beyond the 11 must-pass measures, each additional measure is assigned a point value. The total points accumulated determines a Provider's overall tier of PCPCH recognition by OHA.

PCPCH Tier	Accumulated Points	Minimum Standards
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65 - 125 points	+ All must-pass standards
Tier 3	130 – 250 points	+ All must-pass standards
Tier 4	255 - 380 points	+ All must-pass standards
Tier 5 (5 STAR)	255 – 380 points	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

Member Assignment. To qualify for the PCPCH incentive in any given month, [redacted]

Limited Restrictions. Providers may only have restrictions to member assignment limited to criteria for age, geography and gender that are consistent with Provider's scope of practice and the same as the criteria used by Provider for all other populations (e.g., an age restriction of 17 or younger for a pediatrician).

Incentive Qualifications. Providers will not be eligible for the PCPCH payment if they [redacted]

Incentive: In year 1, UHA at a minimum will incentivize qualifying PCPCHs at the following levels:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

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

At its heart, the PCPCH model of care fosters strong relationships with Members and their families to better treat the whole person. PCPCHs reduce costs and improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions. UHA supports this model and is committed to supporting the efforts of PCPCH providers.

Because Douglas County is considered rural, and a low-diversity county by the State, UHA does not apply factors such as Rural, Urban or social complexity because they do not apply to our population. UHA currently has a strong PCPCH concentration and its intended approach is to continue to support the infrastructure needs for PCPCH, [redacted].

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

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

The VBP program is based on progress made to attain the highest tier of the Model-of-Care (MOC) [PCPCH]; the MOC standards provide safeguards against adverse impacts of the VBP by emphasizing Culturally Linguistically Appropriate Services (CLAS). UHA follows OHA's quality accountability metrics established for CCOs to monitor Provider performance; this is a contractual requirement. OHA's performance metrics do not take into account risk associated with patient mix. UHA traditionally evaluate performance against their historical rather than national benchmarks. The primary reason for this is UHA recognizes that its population is unique and that national benchmark do not necessarily incorporate all of the health inequities. To assess performance, UHA has established a Utilization Review committee that evaluates provider performance through a budgetary and historical look back. This provides strong safeguards in that we are evaluating performance through the lenses of our unique population compared to national standards.

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

UHA is currently modeling a new VBP that will be eligible for providers [redacted]

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

UHA tracks the number of members terminated from care (fired) along with reason for the termination. Also, UHA has a policy which does not allow contracted providers to terminate a member due to reasons that are not compliant with applicable state and federal regulations. UHA's Member Services monitors provider compliance with the policy and reports any non-compliance to the Compliance department [which imposes administrative sanctions if appropriate, see policy] and the Contracting department [provides provider education to resolve the issue]. Additionally, UHA is able to track to the provider level the number of requests and reasons for member reassignment. This information is tracked, analyzed, and also reported to UHA's Network Performance Committee to identify trends with certain providers requesting member reassignment, or whether members are requesting reassignment due to provider conduct. The Network Performance Committee then recommends actions that should be taken which could include provider education, restricting member assignment, contract termination, etc.

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.

[redacted]

C.5. Provide a detailed plan for how the Applicant will achieve 70% VBP by the end of 2024, taking into consideration the Applicant's current VBP agreements. The plan must include at a minimum information about:

a. The service types where the CCO will focus their VBPs (e.g. primary care, specialty care, Hospital care, etc.)

[redacted]

b. The LAN categories the CCO will focus on for their payment arrangements (e.g. mostly pay for performance, shared savings and shared risk payments, etc.)

[redacted]

General Instructions

"Model_descriptions" tab.
Include payments associated with VBPs on an incurred basis (as opposed to a paid basis). If any payment arrangements have a specified quality incentive payment, estimate the size of the payment for calendar year 2020
Include all payments to providers or contracted entities for which the payment aligns with one or more of the HCP-LAN categories for VBP. See the "HCP-LAN Framework" tab for definitions of the categories.
Arrangements without any quality component should be listed under fee-for-service, category 3N, or category 4N on the "Data_template" tab.
contract that includes a shared savings arrangement with a pay-for-performance component - such as a quality incentive pool - then you should put the total value of the annual contract in Category 3A for shared savings because 3A (shared savings) is more advanced than 2C (pay-for-performance).
showing how your CCO will meet the 20% minimum VBP threshold for 2020.
You are required to complete at least one "data_template" tab. Completing more than one is optional.
For additional guidance, see the RFA and other resource documents such as the VBP categorization document.

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **Umpqua Health Alliance, LLC**
REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, excluding contracts that are exclusively FFS": Enter the sum of all contracts by VBP category. These totals reflect the entirety of the contract, even if a portion of the contract is based on fee-for-service. For multi-model contracts that span multiple VBP categories, attribute all payments for that contract to the most advanced category. Column f "Total dollars paid for provider contracts and/or arrangements": Enter the sum of all contracts that are not VBPs because they are wholly fee-for-service arrangements or have no link to quality.

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	[redacted]

a	b	c	d	e	f
Value-Based Payment Category	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS**	**Non-Value-Based Payment Category**	**Examples (lists not exhaustive)**	**Total dollars paid for provider contracts and/or arrangements**
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	[redacted]	Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	[redacted]
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	[redacted]	3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	[redacted]
2C Pay-for-Performance	bonuses for quality	[redacted]	4N: Capitated payments not linked to quality	capitation payments with no connection to quality	[redacted]
3A Shared Savings	savings shared with contracted entity	[redacted]			
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	[redacted]			
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	[redacted]			
4B Comprehensive Population-Based Payment	global budgets	[redacted]			
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	[redacted]			
All VBP Sub-total		$ [redacted]	**Total payments**		$ [redacted]
VBP 2C or higher sub-total		$ [redacted]	**Percent of payments that are VBP 2C or higher**		[redacted]

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **Umpqua Health Alliance, LLC**
REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, excluding contracts that are exclusively FFS": Enter the sum of all contracts by VBP category. These totals reflect the entirety of the contract, even if a portion of the contract is based on fee-for-service. For multi-model contracts that span multiple VBP categories, attribute all value-based payments to the highest, most advanced category.
Column f "Total dollars paid for provider contracts and/or arrangements": Enter the sum of all contract that are not VBPs because they are wholly fee-for-service arrangements or have no link to quality.

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	UHA currently has quality components in many of its contracts; in 2020 79% of contract payments will include a LAN Tier 2C or higher.

a	b	c	d	e	f

Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	
4B Comprehensive Population-Based Payment	global budgets	
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	
	VBP Sub-total	$ -

Non-Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arrangements
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	$ -
Percent of payments that are VBP	#DIV/0!

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME:

REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, excluding contracts that are exclusively FFS": Enter the sum of all contracts by VBP category. These totals reflect the entirety of the contract, even if a portion of the contract is based on fee-for-service. For multi-model contracts that span multiple VBP categories, attribute all value-based payments to the highest, most advanced category.
Column f "Total dollars paid for provider contracts and/or arrangements": Enter the sum of all contract that are not VBPs because they are wholly fee-for-service arrangements or have no link to quality.

Optional - describe any relevant details about your predicted VBPs - using terminology from LAN categories - for 2020. (50 words or less)	

a	b	c	d	e	f

Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	
2C Pay-for-Performance	bonuses for quality	
3A Shared Savings	savings shared with contracted entity	
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	
4B Comprehensive Population-Based Payment	global budgets	
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	
	VBP Sub-total	$ -

Non-Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arrangements
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	

Total payments	$ -
Percent of payments that are VBP	#DIV/0!

Describe the kinds of services/providers/populations your CCO focuses on for VBPs (e.g. primary care, maternity care, hospital-based care, oncology, etc.). Briefly list as many as are applicable. Limit your

Enter the per-member-per-month dollar amount you intend to pay clinics participating in the Patient Centered Primary Care Home (PCPCH) progra
If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount.

PCPC Tier	PMPM (or range) dollar amount
Tier 1 clinics	
Tier 2 clinics	
Tier 3 clinics	
Tier 4 clinics	
Tier 5 clinics	

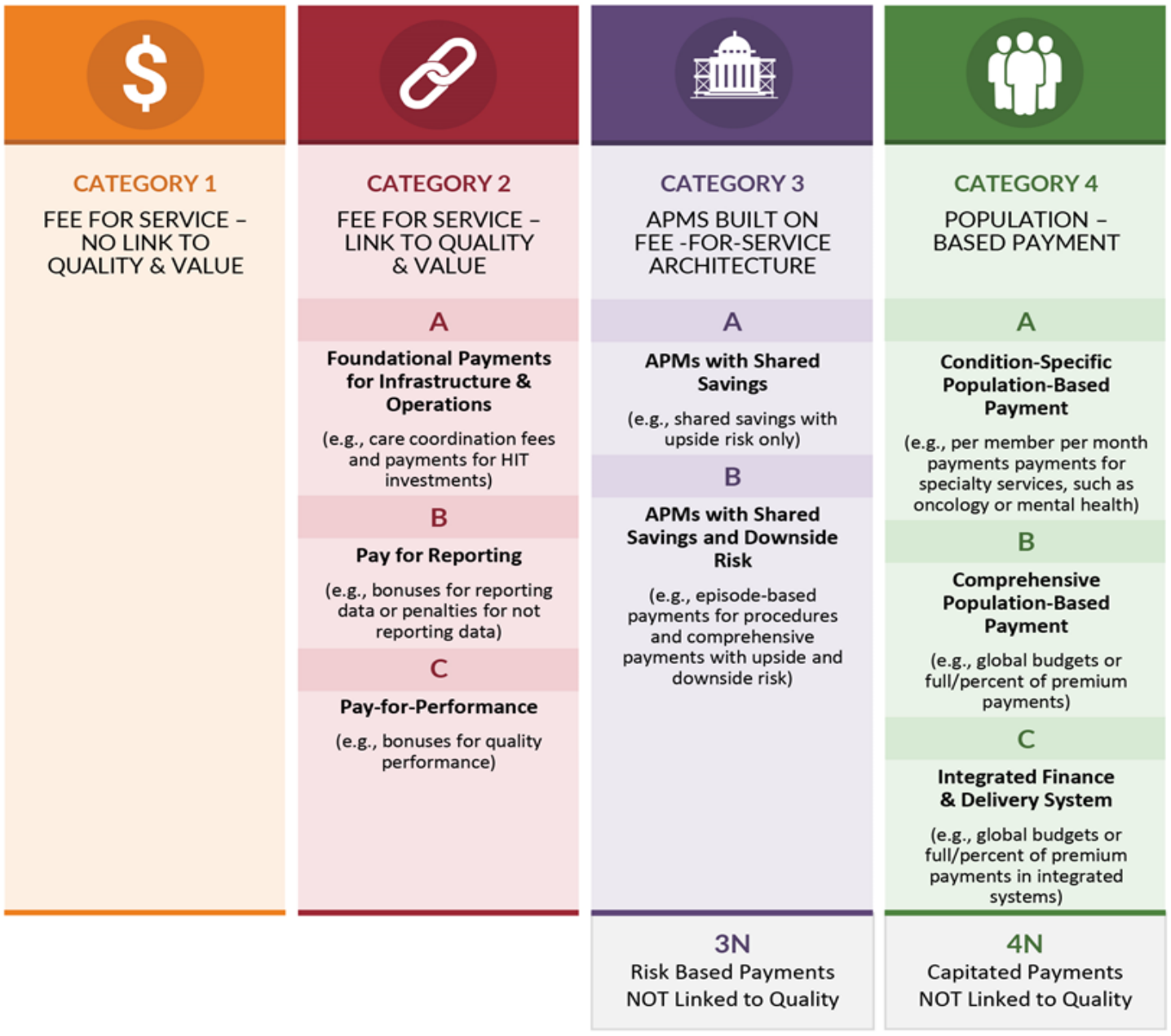
Instructions: Fill in the cells that are shaded yellow in this worksheet. For questions on terms see the Definitions tab.

Types of VBP (Subcategories)

A	B	C	D	E
Question	**LAN APM Category**	**APM Types - Subcategories**		**Brief description of:** A) Type of providers/services involved; AND if applicable B) contracts with multiple APMs, where plan determined 'dominant APM' and C) future APM payments based on performance in this period not reflected here, such as future shared savings/risk arrangements. Please describe if and how these models take into account racial and ethnic disparities. Please also describe how models have considered individuals with complex health care needs.
		Select all that apply by putting an X in Column C in each applicable row		
Which types of APM payment models were in effect during any portion of the payment period?	**2A**		Foundational spending to improve care	
	2B		FFS plus Pay for Reporting (no penalties, upside only)	
	2C		FFS plus Pay for Performance (no penalties, upside only)	
	2C		FFS plus Pay for Performance (potential for penalties)	
	2C		FFS plus Pay for Performance (potential for incentives and penalties)	
	3		FFS-based Shared Savings	
	3		FFS-based Shared Risk	
	3 or 4*		Procedure-based Bundle/Episode Targets or Payments	
	3 or 4*		Condition-Specific Bundle/Episode Targets or Payments	
	3*		Population-based Targets (not condition-specific)	
	4*		Population-based Payments (condition-specific)	
	4		Full or % of Premium Population-based Payment (prospective payment)	

* = whether these APMs are in Category 3 vs. Category 4 depends in part on whether the provider payments are made using a FFS architecture with retrospective reconciliations (3) or made prospectively based on subcapitated payments/budgets. See "Definitions" worksheet for more details.

https://hcp-lan.org/groups/apm-refresh-white-paper/



Definitions

Category 2A (Foundational Payments for Infrastructure & Operations)	Foundational spending to improve care , e.g., care coordination payments, PCPCH payments, and infrastructure payments.
Category 2B (Pay for Reporting)	Payments for reporting on performance measures.
Category 2C (Rewards for Performance)	Pay-for-performance (P4P) rewards to improve care, such as provider performance to population-based targets for quality such as a target HEDIS rate.
Category 2C (Penalties for Performance)	Pay-for-performance (P4P) penalties where providers miss target rates on select performance measures.
Category 3A (Shared Savings)	Providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets if quality targets are met. Cost target may be for a comprehensive set of services (total cost of care) or for a limited episode/bundle.
Category 3B (Shared Risk)	Providers have the opportunity to share in a greater portion of the savings that they generate against a cost target or by meeting utilization targets if more quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.
Category 4A (Partial Capitation or Episode-Based Payment)	Providers receive prospective-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice (e.g., partial capitation or episode).
Category 4B (Comprehensive Population-Based Payment)	Providers receive prospective population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care for a comprehensive set of services that covers all of an individual's health care.
Category 4C (Integrated Finance and Delivery System)	Payments to a highly-integrated finance and delivery system.

General Instructions

"Model_descriptions" tab.
Include payments associated with VBPs on an incurred basis (as opposed to a paid basis). If any payment arrangements have a specified quality incentive payment, estimate the size of the payment for calendar year 2020
Include all payments to providers or contracted entities for which the payment aligns with one or more of the HCP-LAN categories for VBP. See the "HCP-LAN Framework" tab for definitions of the categories.
In order for a payment arrangement to qualify as a value-based payment, there must be a quality component. Arrangements without any quality component should be listed under fee-for-service in the "data_template" tab.
contract that includes a shared savings arrangement with a pay-for-performance component - such as a quality incentive pool - then you should put the total value of the annual contract in Category 3A for shared savings because 3A (shared savings) is more advanced than 2C (pay-for-performance).

For additional guidance, see the RFA and other resource documents such as the VBP categorization document.

CCO RFA DATA COLLECTION - VALUE-BASED PAYMENTS

CONTRACTOR/CCO NAME: **Umpqua Health Alliance, LLC**
REPORTING PERIOD: **1/1/2020 - 12/31/2020**

Definitions: Column c "Total dollars paid for provider contracts and/or arrangements, excluding contracts that are exclusively FFS": Enter the sum of all contracts by VBP category. These totals reflect the entirety of the contract, even if a portion of the contract is based on fee-for-service. For multi-model contracts that span multiple VBP categories, attribute all payments for that contract to the most advanced category. Column f "Total dollars paid for provider contracts and/or arrangements": Enter the sum of all contracts that are not VBPs because they are wholly fee-for-service arrangements or have no link to quality.

Optional - describe any relevant details about your actual VBPs - using terminology from LAN categories - for 2020. (50 words or less)	[redacted]

a	b	c	d	e	f

Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arangements, excluding contracts that are exclusively FFS
2A Foundational Payments for Infrastructure & Operations	care coordination fees and payments for HIT investments	[redacted]
2B Pay for Reporting	bonuses for reporting data or penalties for not reporting data	[redacted]
2C Pay-for-Performance	bonuses for quality	[redacted]
3A Shared Savings	savings shared with contracted entity	[redacted]
3B Shared Savings and Downside Risk	episode-based payments for procedures and comprehensive payments with upside and downside risk	[redacted]
4A Condition-Specific Population-Based Payment	capitation payments for specialty services	[redacted]
4B Comprehensive Population-Based Payment	global budgets	[redacted]
4C Integrated Finance & Delivery System	payments to a highly-integrated finance and delivery system.	[redacted]
	All VBP Sub-total	[redacted]
	VBP 2C or higher sub-total	[redacted]

Non-Value-Based Payment Category	Examples (lists not exhaustive)	Total dollars paid for provider contracts and/or arrangements
Fee for service payments	All contracts and/or payment arrangements that are exclusively fee for service	[redacted]
3N: Risk-based payments not linked to quality	payments with upside and downside risk but no connection to quality	[redacted]
4N: Capitated payments not linked to quality	capitation payments with no connection to quality	[redacted]
	Total payments	[redacted]
	Percent of payments that are VBP 2C or higher	[redacted]

Describe the kinds of services/providers/populations your CCO focuses on for VBPs (e.g. primary care, maternity care, hospital-based care, oncology, etc.). Briefly list as many as are applicable. Limit your

Enter the per-member-per-month dollar amount you paid clinics participating in the Patient Centered Primary Care Home (PCPCH) program
If the PMPMs vary for a given tier, you may enter a range. Otherwise, enter a single dollar amount.
In the "Average PMPM" column, enter the average PMPM payment for each tier, weighted by enrollment. If you paid one tier 1 clinic $1.50 PMPM and another tier 1 clinic $2.00, and the first clinic had three times the number of members attributed as compared to the second clinic, then the average weighted PMPM would be $1.625. ($1.50 x 0.75 + $2.00 x 0.25 = $1.625). The weighting may be calculated using number of members or number of member months.

PCPC Tier	PMPM (or range) dollar amount	Average PMPM dollar amount
Tier 1 clinics		
Tier 2 clinics		
Tier 3 clinics		
Tier 4 clinics		
Tier 5 clinics		

Instructions: Fill in the cells that are shaded yellow in this worksheet. For questions on terms see the Definitions tab.

Types of VBP (Subcategories)

A	B	C	D	E
Question	**LAN APM Category**	**APM Types - Subcategories**		**Brief description of:** A) Type of providers/services involved; AND if applicable B) contracts with multiple APMs, where plan determined 'dominant APM' and C) future APM payments based on performance in this period not reflected here, such as future shared savings/risk arrangements. Please describe if and how these models take into account racial and ethnic disparities. Please also describe how models have considered individuals with complex health care needs.
		Select all that apply by putting an X in Column C in each applicable row		
Which types of APM payment models were in effect during any portion of the payment period?	**2A**		Foundational spending to improve care	
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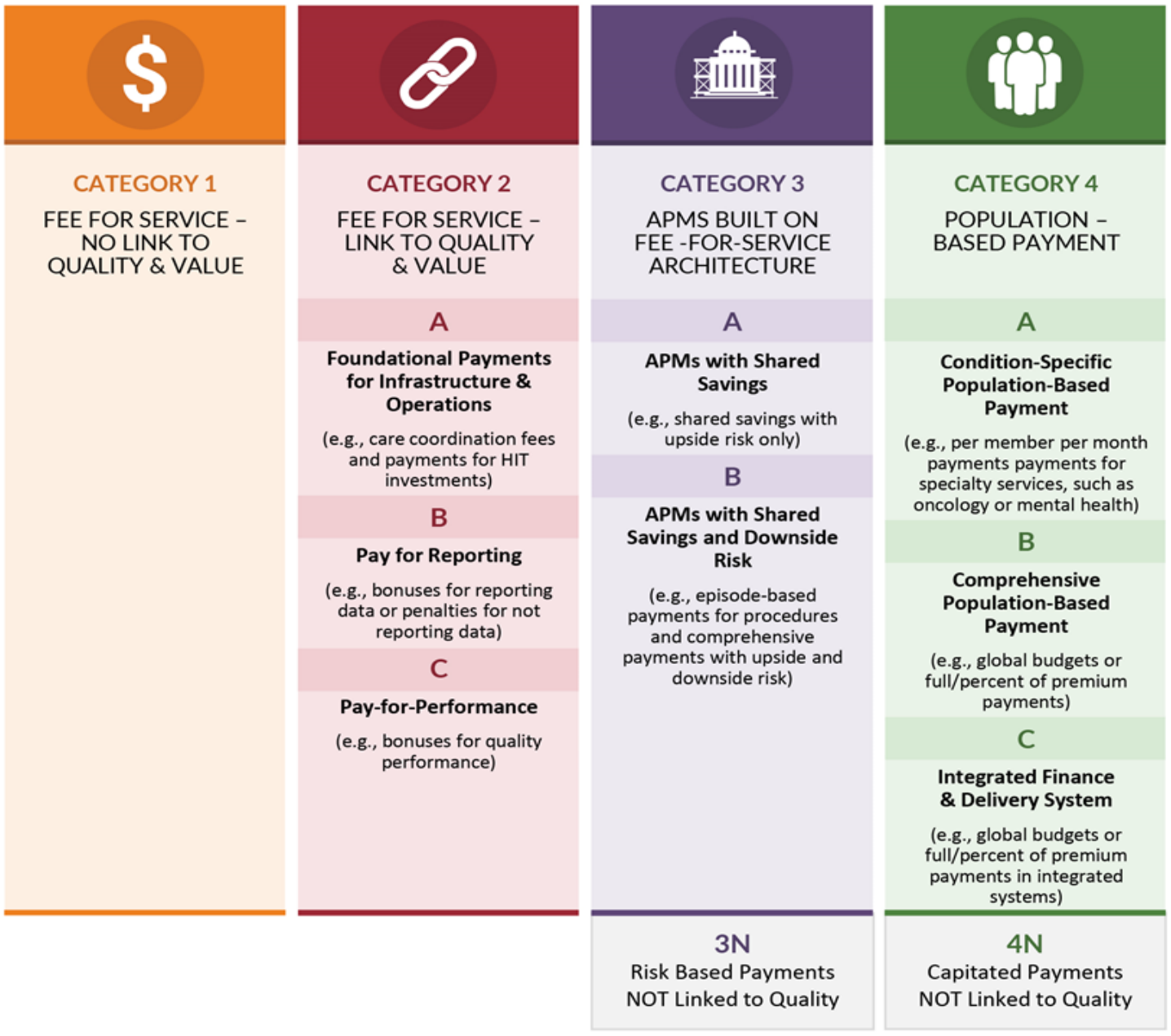
	2C		FFS plus Pay for Performance (no penalties, upside only)	
	2C		FFS plus Pay for Performance (potential for penalties)	
	2C		FFS plus Pay for Performance (potential for incentives and penalties)	
	3		FFS-based Shared Savings	
	3		FFS-based Shared Risk	
	3 or 4*		Procedure-based Bundle/Episode Targets or Payments	
	3 or 4*		Condition-Specific Bundle/Episode Targets or Payments	
	3*		Population-based Targets (not condition-specific)	
	4*		Population-based Payments (condition-specific)	
	4		Full or % of Premium Population-based Payment (prospective payment)	

* = whether these APMs are in Category 3 vs. Category 4 depends in part on whether the provider payments are made using a FFS architecture with retrospective reconciliations (3) or made prospectively based on subcapitated payments/budgets. See "Definitions" worksheet for more details.

https://hcp-lan.org/groups/apm-refresh-white-paper/



Definitions

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Category 4B (Comprehensive Population-Based Payment)	Providers receive prospective population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care for a comprehensive set of services that covers all of an individual's health care.
Category 4C (Integrated Finance and Delivery System)	Payments to a highly-integrated finance and delivery system.

Decision Support Deliverables Master List

		Time Frame						
Code	Request	Weekly	Bi-weekly	Monthly	Quarterly	Annually	Deliverable Specifics	Primary
[redacted]								

Abr.	Definition
EOM	End of Month
EOQ	End of Quarter
NLT	No Later Than

Attachment 9 — Health Information Technology

Introduction

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

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

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:

- 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.
- 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:

- 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.

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.

A. HIT Partnership

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

UHA will sign the MOU as a participant of the HIT Commons and adhere to its terms, paying annual HIT Commons assessments according to the fee structure. UHA does not expect to encounter obstacles to signing the 2020 HIT Commons MOU. While UHA doesn't currently have a representative filling one of the seats on the HIT Commons, UHA has worked to become more engaged as part of the HIT Commons.

As mentioned above, UHA has become more involved as a member of the HIT Commons. Examples of this include:

- Putting forth a nominee to serve on Health Information Technology Oversight Council (HITOC)
- Becoming an active member of Oregon's state-run Health IT Advisory Group (HITAG), including sending a representative to Portland to give a presentation on Health Information and Management Systems Society (HIMSS) in 2018.
- Joining and attending meetings for the following committees: Clinical Quality Metrics Registry (CQMR), Metrics TAG and the ED Disparity Metric Workgroup.

B. Support for EHR Adoption

B.1 Evaluation Questions

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. (recommended limit 5 pages)

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

UHA already has a highly effective strategy for encouraging Electronic Health Record (EHR) adoption by its providers and has exceptionally high rates of EHR adoption in its network. UHA maintains a list of contracted providers and the EHR system each provider is using. Over 97% of in-network physical health providers are already using an EHR, suggesting that UHA's strategy and initiatives have contributed to a high level of EHR adoption.

UHA has a long history of providing a subsidized EHR to the community providers to support increased EHR adoption rates. As early as 2005, UHA helped build and deploy a cutting-edge community wide health information network using a one chart model. Each member has a single health record that is accessed, shared and updated by all participating area physicians and healthcare providers.

Due to a strong leadership and community presence, UHA experienced tremendous success with its implementation of this community EHR model. In fact, during the first few years, UHA was able to deploy the community EHR to about 80% of the physical health providers in the area, including both primary care and specialty practices. Strong relationships and a teamwork approach enable UHA to work with local, state and federal agencies to achieve advanced communications and data sharing that benefits both providers and their patients with better continuity of care.

UHA works closely with the local hospital (Mercy Medical Center) to support clinical data feeds to the community EHR system. This information includes labs, x-ray, and imaging results that automatically flow into the EHR in real-time as soon as the procedures are performed at the hospital. UHA partnered with the hospital and other community providers to implement a community wide health information exchange (HIE). This exchange allows providers to share clinical information between disparate EHR systems, including medications, problems, allergies, and visit notes. Through these local partnerships, health care providers benefit from improved utilization of health-related resources and services, permitting an exceptional quality of care for their patients.

[redacted] UHA will continue to actively engage with community providers and find ways to integrate other data sources into the

EHR workflow.

UHA will partner with the Office of Health Information Technology (OHIT) to establish a realistic initial target for EHR adoption, focusing on each provider type (physical, behavioral, and oral health). Further, UHA will establish 5-year targets for EHR expansion beyond the first year, based upon current EHR adoption rates and opportunities.

Table 9.1. Draft EHR Adoption Milestones and Timeline

EHR Adoption – Physical Health		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	EHR Inventory List	X															
Milestone	Establish 5-year Targets for expansion		X														
Activity	Physician Engagement			X		X				X				X			
Activity	Monitor Program and Support Adoption																
			Targeted completion date														
			Ongoing effort														

The Milestones and associated activities for EHR Adoption are described below:

- **EHR Inventory List**: UHA will develop an inventory list to understand the current penetration of physical health EHRs in use in the provider network.
- **Establish 5-Year Targets for expansion**: UHA will work in collaboration with OHIT to develop realistic EHR adoption goals for the provider network.
- **Physician Engagement**: UHA will provide an initial engagement each year with the provider network with the goal of providing guidance to the provider network during their EHR adoption process.
- **Monitor Program and Support Adoption**: UHA will monitor progress throughout each year and will provide additional guidance as needed to assist the provider network in adoption an EHR.

As technology evolves, UHA continues to look for new and innovative ways to support the community physicians and their EHR use. UHA will continue its effective collaboration with local physicians and the UHA Board of Directors to make the technology meaningful and useful for both patients and providers. UHA will continue to track EHR usage and EHR Certification level for contracted providers. As part of the CCO Metrics and Incentive Program, the CCO will create yearly EHR adoption targets with the end-goal being as complete an adoption as possible among physical, behavioral, and oral health providers. These EHRs will meet the latest Office of the National Coordinator (ONC) certification standards that are achievable based on the practice area. Additionally, UHA will work with each of the provider offices to ensure their patients can

access their health information electronically via an EHR portal. Each of these two transformational expectations will be supported by metrics. Lastly, UHA will set up reports on targets for percentage of providers adopting and using 2015 Certified EHR technology, broken out by provider type.

UHA will continue to support contracted providers by offering an EHR subsidy and aid with the adoption and implementation strategies of a certified EHR. UHA will also work on educating providers as to the value and benefits of using an EHR system.

B.1.b. How will Applicant support increased rates of EHR adoption among contracted Behavioral Health Providers ? (Evaluation Question)

UHA will continue to support the community providers, including behavioral health providers. Most contracted providers are already using a certified EHR system, with several providers that are currently using the community EHR system supported by UHA. UHA will work with OHA to set reports on realistic targets for percentage of providers adopting and using EHRs, broken out by provider type (physical, behavioral, and oral). Behavioral health providers are included in our reports and targets for percentage of providers adopting and using 2015 Certified EHR technology. While behavioral health providers in our network are not at the near 100% EHR adoption rates of our physical health providers, UHA can expand EHR use among behavioral health providers using many of the same highly successful approaches, such as close provider community collaboration, provider education, and assessing and addressing barriers.

Table 9.2. Draft Behavioral Health EHR Adoption Milestones and Timeline

EHR Adoption – Behavioral Health		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Environmental Scan	X															
Milestone	Assess Barriers to EHR Expansion		X														
Activity	Provider Engagement & Adoption Support			X		X				X				X			
Activity	Monitor Program																
			Targeted completion date														
			Ongoing effort														

The Milestones and associated activities for Behavioral Health Providers' EHR Adoption are described below:

- **Environmental Scan**: UHA will conduct an assessment of the current penetration of behavioral health EHRs in use in the provider network and develop an inventory list of behavioral health providers' EHR use.
- **Assess Barriers to EHR Expansion**: UHA will assess the unique barriers to EHR adoption among behavioral health providers and compile them into a report that will

enable UHA to analyze opportunities for improvement.

- **Provider Engagement & Adoption Support**: UHA will provide an initial engagement each year with the provider network with the goal of providing guidance during their EHR adoption process. Our analysis of EHR barriers will help inform this effort.
- **Monitor Program:** UHA will monitor progress throughout each year and will provide additional guidance as needed to assist the behavioral provider network in EHR adoption.

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

UHA will provide oversight and work directly with our contracted DCO on oral health provider adoption of EHRs. The contracted DCO is finalizing and implementing a policy and procedure to track all providers Electronic Health Record (EHR) Vendor, Software, Version, and if it meets CERHT. Data collection has already begun in some areas and will be completed in March, 2019. The DCO has also drafted a policy to be distributed to all contracted providers that encourages all providers to adopt, implement, and utilize 2015 Certified EHR Technology. We will monitor and support this progress as outlined in the timeline below.

Table 9.3. Draft Oral Health EHR Adoption Milestones and Timeline

EHR Adoption – Oral Health		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Baseline Dental EHR Use in DCO Network	X															
Milestone	Establish 5-year Targets for expansion		X														
Milestone	Engagement with DCO			X		X				X				X			
Milestone	Monitor Program and Support Adoption																
			Targeted completion date														
			Ongoing effort														

The Milestone and associated activities for EHR Adoption in the DCO Network are as follows:

- **Baseline Dental Electronic Health Record Use in DCO Network**: UHA will receive an inventory list from the contracted DCO to better understand the current penetration of oral health EHRs in use in the oral health provider network.
- **Establish 5-year Targets for expansion**: UHA will work in collaboration with OHIT to develop realistic Dental EHR adoption goals for the provider network.
- **Engagement with DCO**: UHA will engage each year with the goal of providing guidance to the oral health provider network during their Dental EHR adoption process.

- **Monitor Program and Support Adoption:** UHA will monitor progress throughout each year and will provide additional guidance as needed to assist the provider network in Dental EHR adoption.

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?

UHA will work with their contracted providers to remove barriers to EHR adoption and use. By leveraging internal technical expertise, UHA will take the role of active liaison between providers and the EHR vendors. Barriers include:

- Cost of an EHR system
- Complexity / Learning a new system
- Lack of local IT support for smaller provider offices
- Current IT support at the provider office not experienced with EHR systems
- Physicians close to retiring from practice
- Lack of a common Health Information Exchange (HIE)
- Variability in EHR Vendors across the marketplace
- Changing regulatory requirements

UHA currently offers an EHR subsidy program to substantially lower the cost for providers to adopt and use an EHR system through a turn-key solution provided by a local team of highly skilled IT support professionals directly employed by UHA. This solution includes EHR implementation support, application support and training, as well as a complete set of technology solutions. The current solution offered by UHA includes access to a local HIE that is used by the local hospital and many providers in the area. Although not all providers participate in the HIE, UHA is actively engaged with several provider groups to assist them in joining the HIE. This includes technical assistance and provider education on the benefits of an HIE. UHA will continue working with community providers and also explore other HIE solutions as they become available.

UHA will continue to engage with provider offices to encourage EHR adoption and all the benefits it has to offer. UHA's plan for EHR implementation support and expansion across the three major provider types (physical, behavioral and oral) was described above. The following timeline describes the activities specific to EHR Adoption Barriers.

Table 9.4. Draft Activities to Address EHR Adoption Barriers

EHR Adoption – Barriers		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Annual Review of EHR Subsidy Program	X			X				X				X				X
Milestone	Develop Technology Assistance Opportunities		X				X				X				X		
Activity	Provider Engagement			X				X				X				X	
Activity	Monitor Program and Support Adoption																
			Targeted completion date														
			Ongoing effort														

The Milestones and associated activities for addressing Barriers to EHR Adoption are described below:

- **Annual Review of EHR Subsidy Program -** UHA will review its subsidy program on a yearly basis, to ensure it is providing cost relief to potential EHR adoptees.
- **Develop Technology Assistance Opportunities -** UHA will investigate and develop opportunities to provide training and support for providers. In this way, UHA will attempt to mitigate some of the complexity and support barriers that are often faced by providers attempting to adopt an EHR.
- **Provider Engagement**: UHA will engage with providers to communicate new and different Technology Opportunities as they are developed.
- **Monitor Program and Support Adoption**: UHA will continuously monitor the EHR barriers to ensure that any new barriers are identified and addressed.

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?

Behavioral health providers have many of the same challenges as physical health providers. However, there are additional barriers they will have to overcome because behavioral health EHRs are more fragmented and have less interoperability functionality. Also, additional legal restrictions for sharing mental health and substance abuse information make it more difficult to use an EHR that is primarily designed for physical health. Finally, EHR costs can be more challenging in these practices.

Many of UHA's behavioral health providers have access to EHRs as part of a health system using the PCPCH model, which includes behavioral health in its larger model of care. We have learned through our PCPCH practices that behavioral health providers have different needs for EHR use. For example, behavioral health providers need to ensure that privacy is maintained surrounding substance use treatment, even when an EHR system enables the sharing of health

records. In addition, recording behavioral health diagnoses and treatment notes are not always well supported in current EHR technology, and many behavioral health providers are individual or very small practices making it challenging for them to adopt EHRs due to cost and infrastructure needs. UHA plans to evaluate a path forward with the providers in our network and also assess new EHR technology that better meets the needs of behavioral health providers as it becomes available.

B.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?

As mentioned above, UHA works closely with its DCO to support oral health providers in adoption of Dental EHRs. The DCO expects the largest EHR adoption barrier to be oral health providers that do not wish to change practice management software due to cost, time, and the immediate effect on their patients during the transition. UHA's DCO will encourage and support its providers in their upgrades to 2015 Certified EHR Technology by supplying resources and offering anecdotal information regarding past experience. If the DCO is not meeting its targeted percentage of providers, UHA would begin a corrective action process if necessary. However, our contracted DCO's largest office already has the highest number of members assigned in the UHA Region of all PCDs, and these offices do utilize a 2015 Certified EHR Technology.

B.2. Informational Questions

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

No assistance is needed from OHA at this time.

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.

UHA is currently collecting data on EHR use through the provider questionnaire as part of the credentialing process. UHA will continue to develop an internal tracking and reporting mechanism while leveraging existing software solutions (e.g. Provider Credentialing database).

Table 9.5. Draft EHR Use Data Milestones and Timeline

DATA COLLECTION PLAN		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q4	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Review system requirements for data collection	X															
Milestone	Update software with required fields	X															
Milestone	Distribute provider questionnaire	X				Ongoing through Provider Credentialing											
Milestone	Launch behavioral health provider questionnaire			X		Ongoing through BH Provider Credentialing											

DATA COLLECTION PLAN		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q4	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Initial Physical and BH Data Collection	X		X			Ongoing Data Collection										
Milestone	Produce Phys. Hlth EHR adoption and usage reports		X				X				X				X		
Milestone	Produce BH EHR adoption and usage reports				X		X				X				X		
Milestone	Set Target - OHIT Collaboration		X														
			Targeted completion date														
			Ongoing effort														

The Milestone Details for collecting data on EHR use and setting targets are described below:

- **Review system requirements for data collection:** UHA will plan to make system changes to ensure that the EHR adoption data can be tracked.
- **Update software with required fields:** UHA will take the System Requirements and modify the system to capture the relevant EHR adoption information.
- **Distribute provider questionnaire:** As part of the existing provider credentialing process, the Provider Questionnaire will be distributed and UHA will ensure that data about EHR usage will be captured.
- **Collect Initial Data:** Data will be collected and stored in the Provider Credentialing database. This includes both physical and behavioral health data.
- **Produce EHR adoption and usage reports:** Once the data is collected, UHA will produce adoption and usage reports, which will be the basis for actions targeted at increasing future adoption.
- **Set Target - OHIT Collaboration:** UHA will partner with The Office of Health Information (OHIT) to establish a realistic initial target for Electronic Health Record (EHR) adoption and 5-year targets for EHR expansion.

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.

UHA's plans to collect data on EHR use is completely integrated with our data collection and analysis of physical health providers' use of EHR systems. For both analyses, UHA can use the provider questionnaires with the same data collection methods as described above. However, anticipating that the data we collect from behavioral health providers will be more complex than that of physical health providers, we have shifted the timelines to give us more time to prepare and implement this data collection and analysis. See the timeline above.

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.

UHA's DCO has a similar approach to collecting data on Dental EHR use from its oral health providers. By the end of March 2019, UHA's DCO will have implemented a survey process for all contracted providers to complete so that the DCO have the information on their current EHR use. When dental providers are notified that they need to complete the survey, they will also be sent the DCO's policy on Dental Electronic Health Record Systems. Providers will be required to report this information starting in April, 2019, and report on this item quarterly to maintain up-to-date information. The DCO's plan is to establish the baseline by CCO/Region from the data collected. They plan to use the Minnesota Method to increase the percent of adoption each year as a DCO. Within the DCO's Enterprise Resource & Planning software (ERP), they are able to track all EHR Information provided by our contracted providers for reporting and follow up purposes. UHA will work closely with our DCO to ensure targets are being met and Dental EHR adoption rates are improving.

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.

CCOs must work to increase the number of physical, behavioral, and oral health Providers with access to HIE that supports Care Coordination.

In addition, CCOs must ensure their contracted Providers have access to timely Hospital event notifications.

C.1 Evaluation Questions

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 a narrative as well as a roadmap that includes activities, milestones and timelines.

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.

UHA currently offers Health Information Exchange (HIE) access as part of its subsidized EHR offering. Additionally, UHA is an active user of Emergency Department Information Exchange (EDIE), which provides real-time ED alerts. Additionally, UHA continues to explore ways to expand HIE capabilities to providers.

UHA uses EDIE/PreManage to assist the Care Coordinators in locating and identifying members with high utilization. UHA has set-up specific cohort groups in PreManage identifying members by SDOH-related diagnoses. For example, all members that have SPMI have been loaded into a group and UHA receives an email alert any time they present to the ED or hospital. This system will send an email alert to the assigned care coordinator that he or she has a member in the ED or in the Hospital. Also, the faculty at the hospital has direct access to the case manager. All of the members that are actively engaged with Case Management will have their contact information in Pre-Manage/EDIE. UHA also uses this tool to notify all PCPs of admissions or ED visits and discharges. On a daily basis, UHA pulls reports from EDIE/PreManage and sends these reports to each designated primary care physician to notify the PCP of the need for a follow-up appointment for these members.

UHA will establish targets for provider usage of HIE information and Hospital Notification data. UHA will be guiding physicians in the HIE Onboarding program, providing support to clinics that want to join an HIE, and ensuring clinics either have access to PreManage or have access to the related ED data.

Table 9.6. Draft HIE Support for Physical and Behavioral Health Timeline

HIE AND PREMANAGE SUPPORT		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q4	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Review system requirements for data collection	X															
Milestone	Update software with required fields	X															
Milestone	Distribute provider questionnaire	X				Ongoing through Provider Credentialing											
Milestone	Initial Data Collection	X					Ongoing Data Collection										
Milestone	Produce HIE adoption and usage reports		X				X				X				X		
Milestone	Set HIE Adoption Targets - OHIT Collaboration		X														
Activity	Provider Engagement			X													
Activity	PCP access to PreManage				X												
Activity	Monitor program and support adoption																
			Targeted completion date														
			Ongoing effort														

The Milestone Details for Collecting data on HIE Use and setting targets are as follows:

- **Review system requirements for data collection:** UHA will plan to make system

changes to ensure that the HIE adoption data can be tracked.

- **Update software with required fields:** UHA will take the System Requirements and modify the system to capture the relevant HIE adoption information
- **Distribute provider questionnaire:** As part of the existing provider credentialing process, the Provider Questionnaire will be distributed and UHA will ensure that data about HIE usage will be captured.
- **Initial Data Collection:** Data will be collected and stored in the Provider Credentialing database.
- **Produce HIE Adoption and Usage Reports:** Once the data is collected, UHA will produce adoption and usage reports, which will be the basis for actions targeted at increasing future adoption.
- **Set Target - OHIT Collaboration:** UHA will partner with The Office of Health Information (OHIT) to establish a realistic initial target for Health Information Exchange (HIE) adoption and 5-year targets for HIE expansion.
- **Provider Engagement**: UHA will engage with providers to communicate the benefits of joining an HIE
- **PCP Access to PreManage**: UHA will work with contracted primary care providers to ensure they have access to the PreManage system.
- **Monitor Program and Support Adoption:** UHA will continuously monitor the HIE adoption rates and PreManage access and ensure any new barriers are identified and addressed.

C.1.b. How will Applicant support increased access to HIE for Care Coordination among contracted Behavioral Health Providers?

UHA will support its Behavioral Health Providers in gaining access to an HIE. The first step to increasing access for UHA's contracted behavioral health providers is developing a true understanding of their current EHR and HIE usage. UHA will increase awareness with the Behavioral Health Providers of the State's HIE onboarding process. With the complete information about HIE barriers and usage rates, UHA can decide the best form of outreach and assistance, which could include learning forums, written communications, or individual vs. organizational outreach. We plan to partner with our Behavioral Health Providers to assist them through the process of being a member of an HIE. This includes individual outreach to help guide the providers through the HIE selection process and available options. UHA will continue to provide technical assistance to providers that participate in the community based EHR system that is currently offered by UHA.

C.1.c. How will Applicant support increased access to HIE for Care Coordination among contracted oral health Providers?

UHA is partnering with a DCO that believes oral health is an essential component into whole person care. Therefore, our contracted DCO strives to work across disciplines to improve oral health and overall health. UHA and our DCO also realize that for successful integration to occur, provider types across disciplines need to be able to effectively communicate and share health information about common members. Therefore, the DCO has created a specialty Health

Information Exchange (HIE), ADIN, that allows dentists to share patient records regardless of what practice management system they use. When built in 2010, the focus of ADIN was to connect dental providers within the DCO network. It has since developed into a sophisticated HIE with the ability to connect dental practices to the community health record via HL7 enabled direct connections. ADIN is also a bridge between multiple sources of data including the Emergency Department Information Exchange (EDIE and PreManage). Additionally, the DCO is nearing connectivity to Unite Us and Reliance eHealth HIEs.

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.

UHA's focus is going to be on expanding primary care Providers' ability to use of the PreManage system to receive hospital event notifications. Hospitals in Oregon have adopted the Emergency Department Information Exchange (EDIE), which provides real-time alerts. ED physicians have subsequently reported finding significant value in receiving these notifications, which in addition to providing information about utilization, may include information about providers and care managers involved in the care of the patient, relevant patient background, and brief care recommendations.

PreManage is a complementary product to EDIE that allows hospital event information (ED and Inpatient admissions and discharges) to be sent real time to health plans, CCOs, and provider groups on a real-time basis for specified member or patient population. The intended result is that through improved communication and information sharing, hospitals, providers and health plans would be able to provide higher quality care to patients, identify patients at risk for hospital readmission, reduce burdensome duplication of tests, and ultimately reduce reliance on costly EDs through better coordination of care.

UHA's Clinical Engagement Department utilizes PreManage to monitor emergency department and inpatient admissions and discharges. PreManage allows users to create reports and notifications, such as ED utilization. Currently, the CCO is investigating ways to provide the EDIE information to its providers, regardless of their technology state and usage level. UHA is also looking at offering EDIE/PreManage subscription to its provider community. UHA can also provide assistance for setting up patient cohorts and with configuring notifications for Admissions, Discharge and Transfers.

The notifications may prompt case managers or other staff to reach out to the member and relevant providers, usually the primary care provider (PCP), to improve timely follow-up after discharge. The resource supports reduction of re-admission rates, improved care coordination, and improved PCP involvement. UHA aims to participate in the discharge process and will assist with coordination, such as behavioral and oral health provider involvement.

Additionally, UHA offers an HER solution that is currently connected to Tiani HIE. The system also has a direct interface with Mercy Medical Center. Lastly, the organization is also talking with Reliance eHealth to add connectivity to their HIE into the organization's EHR. Umpqua Health and Reliance eHealth are also working together to bring the HIE onboarding program into Douglas County to further connect other EHRs to an HIE.

C.1.e. How will Applicant ensure access to timely Hospital event notifications for

contracted Behavioral Health Providers?

UHA is in the process of contracting with Vituity, who provides psychiatric telepsych services within EDs. When a member presents in the ED, staff from Vituity will evaluate patients who come into the ED for a behavioral health-related problem. Vituity will then offer telepscyhiatry as an intervention, with hopes of stabilizing the member. Once that service is performed, Vituity will then notify the CMHP via a phone call to their crisis intake line. This ensures that once the members receives the telepsychiatric services, and discharges from the ED, that there is a community presence to follow up on the member. Additionally, UHA's Case Management Department also utilizes EDIE and also receives daily census reports from the hospital for all admissions, including ones related to behavioral health needs. Case Managers then notify the patients' providers of hospital admissions when the member is identified by either the transitional care team or the case managers.

C.1.f. How will Applicant ensure access to timely Hospital event notifications for contracted oral health Providers?

Along with UHA's utilization of PreManage, the DCO, Advantage Dental Services, was an early adopter of the PreManage/EDIE system and has had a direct connection since September 2015. This connection allows Advantage to know in real time when members are accessing the ED for non-traumatic dental concerns. The DCO's Case Management team follows up with members (on average 4 or 5 days) after they accessed the ED. Case Management educates the member on emergency dental protocol and tries to get them scheduled with their provider within 14 days. After two call attempts, the DCO then follows up with a cling mailer that outlines in plain language the steps to take for emergency dental care.

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.

UHA case managers use the PreManage on daily basis. Our technical team is able to set up cohort groups for a particular group of patients. For example, any identified SPMI member is flagged in a pre-Manage Cohort group, so that anytime this member is being seen in the Emergency department or has been admitted to a hospital, the assigned case manager gets an email alert. The Case manager then reviews the EHR for case management services or transitional care services.

We also notify PCP members per a PreManage report that their assigned member has been registered at the ED or admitted to the hospital. This report allows the PCP time to schedule the required follow up appointment after discharge. It has greatly improved transition of care; 80% of the members were seen post-hospitalization by their primary care physicians, which greatly reduces the change of readmission.

UHA also offered an EHR solution that it can use internally to identify and further understand hospital events. The EHR that is available to UHA's Care Coordination team is connected to Tiani HIE, in which UHA's Care Coordination team can readily access hospital information associated with a hospital event. Lastly, UHA is also talking with Reliance eHealth to find opportunities to integrate Reliance's HIE into UHA's Care Coordination and BI platforms.

C.2. Informational Questions

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

OHA can provide information about HIE adoption, specifically around the use of the HIE Onboarding program. Helpful information would describe the onboarding program itself, how the State covers the onboarding cost, and any technical assistance the State offers in regards to HIE onboarding. It would also be helpful to have a better understanding of HIE adoption throughout the State.

Armed with this information, UHA can work in partnership with OHIT to develop realistic targets for adoption within its provider network.

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.

By continuing the current dialogs with the HIEs available in the state, and by using surveys, UHA will actively collect data on HIE use among its physical health Providers. In partnership with OHIT, UHA will work to set realistic HIE targets for its provider network and continue to offer guidance and support to the providers to ensure HIE targets are met. Our data collection process is described in Section C.1.a above along with the related milestones and activities.

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.

By continuing to use provider surveys, UHA will actively collect data on HIE use among its Behavioral Health Providers. In partnership with OHIT, UHA will work to set realistic HIE targets for its provider network and continue to offer guidance and support to the providers to ensure HIE targets are met.

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.

UHA's dental provider will track all providers' EHR vendor, software, version and if it meets CEHRT. Once a baseline is established, the DCO will set improvement targets in alignment with UHA to incrementally achieve 100% adoption of at least 2015 CEHRT.

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.

D.1. Informational Questions

D.1.a. If Applicant will need technical assistance or guidance from OHA on HIT for VBP,

please describe what is needed and when.

UHA will evaluate need for technical assistance or guidance from OHA on HIT for VBP and communicate with OHA should a need be identified.

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?

UHA's Quality and Decision Support teams have completed the Technical Assistance training program related to SDOH data use, offered by the OHA. Since the training, these two technical teams have made good progress on helping UHA better leverage SDOH data for population health improvement. As part of this training, CCOs were provided SDOH data for their pediatric populations; UHA has analyzed the OHA-provided data files and has identified the process to match this data with claims. UHA has shared the county level SDOH [aggregate] data with its CAC and received positive feedback related to data sharing with community providers.

UHA is in the process of developing policies and procedures to help identify children who would benefit from further assessments based on the initial SDOH data set. We hope to pilot new programs, leveraging SDOH data, to deploy and test interventions that will increase member engagement at the Primary Care level.

D.1.c. What are some key insights for population management that you can currently produce from your data and analysis?

[redacted]

UHA's BI software environment has enabled staff to arrive at several population insights. [redacted]

UHA's pharmacy director reviews prescription claim information to identify high costs or high utilization drugs being prescribed for our members, in order to research possible alternative medications that are as clinically effective but lower costs. Providers can then be educated by UHA's Quality Improvement department or practice guidelines can be created through UHA's Clinical Engagement department to both inform providers and lower pharmacy costs.

Another area UHA reviewed was detox program services and recidivism rates for UHA's assigned members. Through claims review, UHA examined local substance use disorder programs for length of detox stay and compared those to national averages. This enabled UHA to outreach to providers to align programs closer to national averages. It had the added benefit of

identifying members who had multiple detox episodes in a multi-year look back. UHA could then bring additional wrap-around and case management services to these identified members to improve patient outcomes. When a patient adheres to a program intervention, it further decreases their long-term cost trend with lowered medical necessity in the short-term and decreased medical complications for the member's long-term health.

Monthly, UHA utilizes our data to convene a Utilization Committee to review trends across provider specialty (taxonomy) types and places of service. Current utilization by cost, claims, units, and distinct members are reviewed with a three-year lookback comparison. Any under- or over- utilization is further investigated until a reasonable conclusion is found as to why the variances have occurred. For example, an increase in Ambulatory Surgical Centers (ASC) was recognized. Upon review, it was determined that recent contracting changes had expanded our network capacity and certain types of surgeries had shifted from hospital settings to ASCs, generating lower costs per procedure and available capacity for our members. Just as over-utilization is reviewed, under-utilization is researched. Decreases in certain specialty types has occurred as local specialists have retired or moved out of our rural area. Recognition of these events guides our network development staff to contract or identify alternative specialist providers for our members, as well as working with local entities with recruiting more specialists to our area.

UHA is also in the process of evaluating additional tools for risk satisfaction and identification of waste in the system. With the information, UHA would then look to incorporate some of those data elements into provider contracts for further VBP arrangements.

These analyses are but a few examples of the insights that UHA has been able to produce within our BI environment. The flexibility of our systems allows broad queries of member and claim information, with the ability to drill down deeper to the claim detail level to produce conclusions that guide our staff within UHA to make data-driven decisions.

D.2. Evaluation Questions

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.

UHA's consistent utilization of HIT has allowed them to develop VBP arrangements within their provider network that [redacted]

[redacted]

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;

The addition of Value Based Payment arrangements began in 2017 through the [redacted]

2. Accurate and consistent information on patient attribution; and

[redacted]

[redacted]

3. **Identification of specific patients who need intervention through the year, so the Providers can take action before the year end.**

[redacted]

esides ad-hoc reporting capabilities, we also have the flexibility to develop and implement new reports as new reporting requirements or regulations are implemented.

D.2.c. Describe other ways the Applicant plans to provide actionable data to your Provider Network.

[redacted] We provide information through ad-hoc requests as needed. Furthermore, we meet internally every month to discuss areas of interest, which includes analyzing over-utilization and high cost providers.

Additionally, UHA provides information following the close out of a reporting period for the CCO Quality Metrics. [redacted]

[redacted]

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.

UHA' Quality Department provides detailed information to providers on using the Business Intelligence tools, especially the Provider Portal, which providers can use to check daily for performance on CCO incentive measures. UHA's Quality Department has developed a training plan with the objectives of: 1) Improving performance in outcomes; 2) Optimizing clinic workflows; and 3) Building Effective Clinical Teams. The training Portfolio includes updated tools to be used both online and offline. The portfolio comprises EMR workflow guides, Provider Portal Guides, CCO Measure Binder, and PCPCH Recognition Guide.

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 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. (D.2.e.1.)

Population Health: We will continue our current utilization, cost, and member risk analyses which help us manage costs and provide services effectively to our population. [redacted]

While UHA currently has a robust Quality and BI platform, it also is currently researching other options to add into its population health management and quality metrics process. The hope is to add additional attributes into it systems to further improve provider care methodologies, outcomes, while eliminating waste and inefficiencies.

Table 9.7. Draft Population Health Management Health Timeline

POPULATION HLTH MILESTONES		Year 1				Year 2				Years 3-4				Year 5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone	Care gaps report enhancements		X														
Milestone	Develop new VBP arrangements			X													
Milestone	Implement new VBP arrangements				X												
Activity	Track/monitor VBP arrangements																
Activity	Refine VBP arrangements																
			Targeted Completion Date														
			Ongoing Effort														

The Milestone Details for developing VBP arrangements with providers are as follows:

- **Care gaps improvement:** UHA will review the existing reporting system for identifying care gaps and will continue to develop more sophisticated metrics by using risk stratification methods. These metrics will be used to focus on areas where UHA can improve health and control costs.
- **Develop new VBP arrangements:** Using newly developed metrics including [redacted]
- **Implement new VBP arrangements:** UHA will modify its provider contract structure to incorporate these new VBP arrangements.
- **Monitor and Refine VBP Arrangements:** UHA will monitor VBP modifications and refine VBP arrangements as necessary to improve outcomes and control cost.

Provider Support: [redacted]

[redacted]

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)?

UHA currently utilizes multiple [redacted]. UHA intends to utilize this report as part of future VBP arrangements.

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.

1. Data sources:

[redacted] UHA's Decision Support Department periodically performs audits to verify data integrity and makes any necessary corrections as needed.

2. Data storage:

UHA has a Third-Party Administrator (TPA) who processes physical health claims and a

Pharmacy Benefit Manager (PBM) for pharmacy claims. Our Dental Care Organizations (DCO) process dental claims and submit encounter data to our TPA.

Our BI vendor, Inteligenz, receives feeds from our TPA (which include DCO encounter data) and our PBM to a cloud-based server. This enterprise data warehouse allows UHA to query our data by any data point on a claim (See the Enrollment, Eligibility, and Encounter Data Diagram on Page 28).

3. Tools:

a. What HIT tool(s) do you use to manage the data and assess performance?

[redacted]

b. What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?

UHA's Decision Support department is responsible for any routine or ad-hoc reporting required across department activities [redacted]

- [redacted]
- [redacted]
- [redacted]

.

4. Workforce:

UHA has a Decision Support department with the primary responsibility of data oversight and reporting. This department has grown from one staff member to a Director and three Data Analysts in the past two years. This growth in long-term staffing has been driven by the necessity of internal staff with the technical and analytic capabilities to glean insights from UHA's data as well as integrate internal performance metrics and value-based payment (VBP)

methodologies.

The Director manages staff workflows and leads the department. The three Data Analysts have backgrounds in economics, finance, and accounting. The Data Analysts generate the various routine and ad-hoc reports. There is gap list reporting for providers, clinical performance for UHA's clinics, quality improvement reporting from incentive measure performance to coding reviews, and population reporting for community members (with scrubbing and/or grouping to eliminate PHI risks). Decision Support also generates ad-hoc reporting based on departmental needs. An UHA manager may reach out to the DS department with a request and the Data Analyst staff will work with them to determine exactly what data points are required to capture the information for their request. The Data Analyst would produce a specification sheet in order to query UHA's data to capture all relevant data points for the manager's request.

UHA DS staff also trains internal staff on using BI tools, especially the Provider Portal which is an Inteligenz interface that internal and external individuals can use to check daily on provider performance on incentive measures and how the overall plan is performing. Decision Support staff is available to provide detailed information to providers and trains Quality Improvement and Network Development staff on the Provider Portal so they can provide updates when they have provider interactions or are out on office visits with our provider network. Providers or their support staff can be granted access to view their individual assigned member performance on each incentive measure, download gap lists for measures, and view flags for new members who have been assigned to them or have become eligible in a new metric. This interface is updated nightly which each night's claim information for claims received by UHA's TPA.

Most DS reporting is done in an OLAP cube interface through our Inteligenz platform. Online analytical processing (OLAP) allows multi-dimensional analytical queries, thus allowing our Data Analyst to pull in various claim data points to generate reporting. Our BI partner does much of the coding, but the Data Analyst staff has the capacity to generate custom SQL queries if the need arose.

Moving forward, UHA has budgeted for additional training for the Decision Support department to attend conferences and educational opportunities to expand staff knowledge base, especially in regards to quality and outcome metrics to improve our internal reporting. UHA also supports educational reimbursement for our staff for their continued education.

Just as we have expanded this department over time, UHA is open to ramping up staffing to accommodate any additional reporting or analysis needs that may be required with any expansion in service areas. We are constantly improving automation to free up Decision Support resources to generate more reporting and data analysis.

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?

On a monthly basis, UHA delivers a [redacted]

6. Effectiveness:

How will you monitor progress on your roadmap and the effectiveness of the HIT supports implemented or to be implemented?

Monitoring of UHA's roadmap will be done through engagement with PeHS, UHA Decision Support Department, and UHA's Project Manager.

UHA brought on a full-time IT Business Development Manager in the 2018 calendar year with extensive IT management and project implementation experience. His role is to work with department directors as they implement new HIT supports or updates. The effectiveness of each support implemented will be done through our Decision Support department, with input from the departments initiating new applications.

For instance, we recently integrated InterQual for use by our Clinical Engagement Department. This HIT tool uses standardize evidence-based practices to determine the appropriate level of care of service. For example, in hospital inpatient services, does the member meet inpatient criteria and or are they ready for discharge. If a member is ready for discharge, it analyzes what level of service should they be discharged to, such as skilled nursing facility home with home health or home with outpatient follow-up. To ensure this product is being utilized properly by the staff, we have implemented Inter-Rater-Reliability testing through InterQual. Our process will be to test staff semi-annually. During the utilization review, the impact of the InterQual integration compared to prior period trends for length of stay, episode costs, and inpatient readmissions to determine the effectiveness of patients' continuity of care after inpatient discharge.

When new HIT supports are identified, UHA's IT Business Development Manager, Director of IT, and Decision Support work in conjunction with department managers during the

implementation phase. Subsequent monitoring is done by the Decision Support department.

Any progress made in regards to UHA's roadmap with be reported internally through our Quality Advisory and Operational Advisory Committees, to further guide implementation efforts through the CCO 2.0 period.

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?

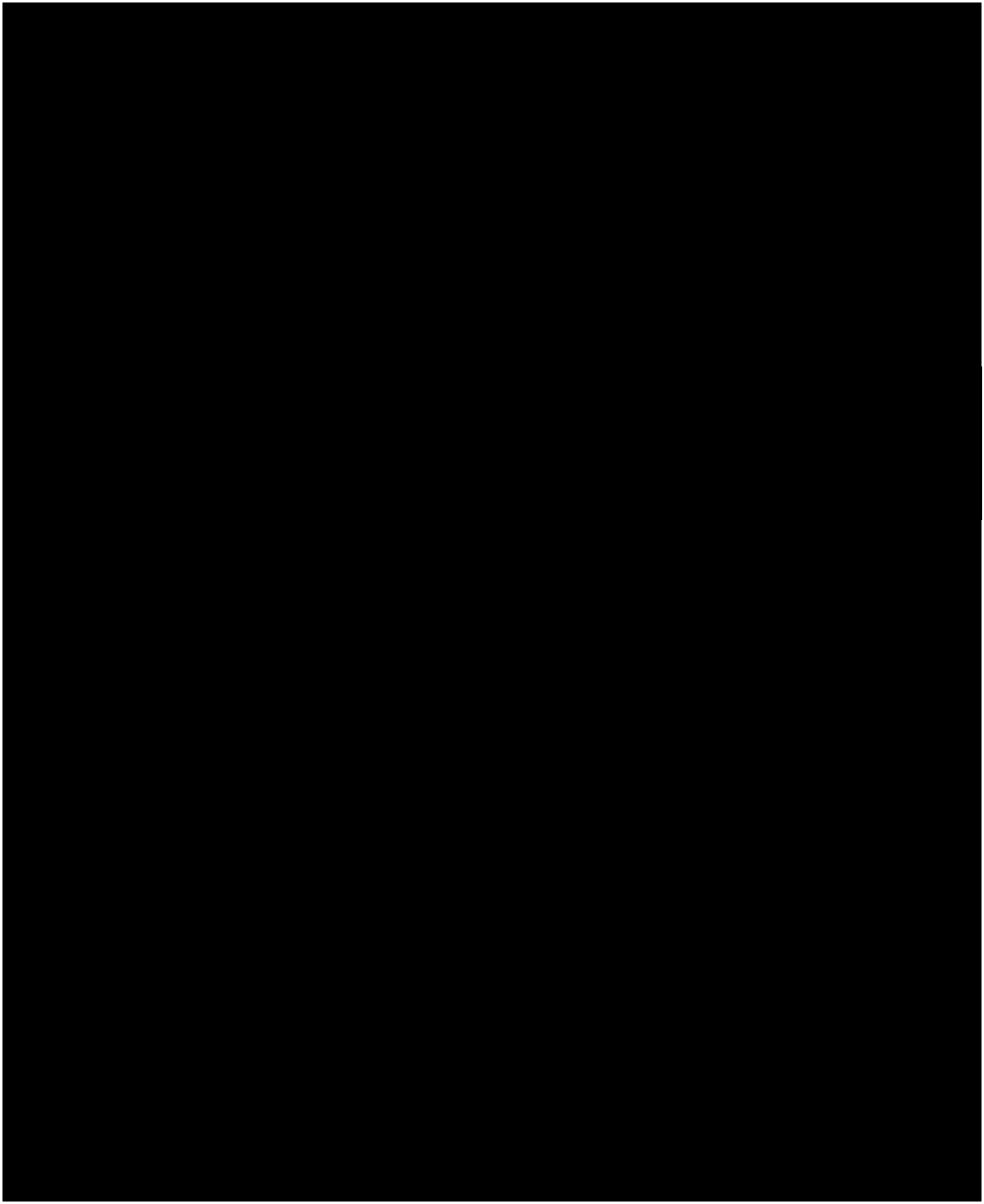
UHA's Decision Support department already has the capacity and tools to implement a multitude of VBP arrangements. Therefore, we feel well-prepared to support CCO 2.0 VBP structures, as well as providing information and reporting to those contracted providers with periodic updates on current performance levels.

Over the past several years, UHA has already integrated VBP arrangements into our contracts. For 2017, 70% of UHA's contracts contained VBP arrangements and that percentage increased to 79% for 2018. Whenever these VBP arrangements contain outcome or performance-based metrics, the Decision Support department works in conjunction with our Contracting department to validate metric specifications so that expectations are clear to the contracted provider and the Decision Support department can generate performance updates periodically per the contract language.

One area of opportunity moving forward is the integration of further EHR data points that do not appear in claims information or the current data feeds that UHA receives. The majority of current UHA members are assigned to providers who utilize two different EHR programs. UHA already has integration with one EHR and is currently working on the second EHR. With any additional expansion or provider conversions to other EHR programs, UHA will continue to have our IT Business Development Manager and IT staff working on solutions to integrate these EHR data sources.

UHA is in the process of adding systems to identify efficiencies and waste, such as analytics capabilities. This upgrade will afford UHA the ability to add VBP arrangements based on episode performance and potentially avoidable costs.

Enrollment, Eligibility, and Encounter Data Diagram



UMPQUA HEALTH

CORPORATE POLICY & PROCEDURE

	Policy Name: Grievances
Department: Clinical Engagement	Policy Number: CE01
Version: 7	Creation Date: 7/9/2008
Revised Date: 8/14/18	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health – Transitional Care

Signature: F Douglas Carr, M.D.

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 8/25/2018

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3230 through 410-141-3255, and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, appeals, hearings, and member services.

PURPOSE

To provide all members with a meaningful, confidential process to file a grievance.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR §438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within

the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal: A request by a UHA member or a member's representative to review an adverse benefit determination. For purposes of this policy, an appeal also includes a request by OHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

Grievance: A UHA member's or a member's representative's expression of dissatisfaction to UHA or to a practitioner about any matter other than an adverse benefit determination.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make OHP related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For Members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Authority (OYA), the Member Representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

	Policy Name: Grievances
Department: Clinical Engagement	Policy Number: CE01
Version: 7	Creation Date: 7/9/2008
Revised Date: 8/14/18	Review Date:

PROCEDURES

1. UHA provides members with written information regarding the grievance process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (see also policy MS3-Member Rights);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service;
    e. When UHA extends the timeframe of a service authorization, or fails to meet the required timeframe; and
    f. At any time upon request.
2. UHA will provide members with oral information regarding the grievance and appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
3. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA Member Services for assistance.
4. UHA will ensure members that all information concerning a member's grievance will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance, have a right to use this information, without a signed release from the member, for purposes of:
        i. UHA resolving the grievance;
        ii. For purposes of maintaining the appropriate logs; and/or
        iii. For health oversight purposes by OHP.
    b. If UHA must release any information related to the grievance to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. Without a signed authorization, some information cannot be released which may restrict UHA's investigation.
5. A member grievance may be received in writing or orally. Any time a member expresses dissatisfaction or concern they are informed of their right to file a grievance and how to do so. UHA, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.

6. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to grievances. Upon receipt of a grievance, UHA obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.
7. UHA will acknowledge receipt of a grievance to the member within 5 working days, as part of the notifications below.
    a. Each grievance is investigated and resolved as expeditiously as the member's health condition requires and within the following timeframes:
        i. For standard disposition of a grievance, within five working days from the date of receipt, UHA will make a decision and notify the member; or
        ii. Notify the member in writing that a delay of up to 30 calendar days from the date of receipt is necessary to resolve the grievance. If a delay is needed to resolve the grievance UHA shall specify the reasons the additional time is necessary.
8. UHA ensures that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3230 MCE Grievance and Appeals System General Requirements.
9. UHA will ensure that any staff or consulting experts making decisions on the grievance are:
    a. Not involved in any previous level of review or decision making nor a subordinate of such individual;
    b. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall also make decisions pertaining to a grievance regarding denial of expedited resolution of an appeal or involves clinical issues; and
    c. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
10. If UHA's failure to meet a required timeframe for review precipitated the grievance, UHA will work with the member and provider(s) to coordinate care and address the original request as appropriate.
11. A written response will be provided whether the member filed their grievance orally or in writing. The notice of grievance resolution shall:
    a. Address each aspect of the member's grievance and the reason for UHA's decision.
    b. Comply with OHA's formatting and readability standards in OAR 410-141-

3300 and 42 CFR §438.10. UHA shall write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.

c. The process for members who are dissatisfied with the disposition of a grievance to present their grievance to the DHS Client Services Unit or OHA's Ombudsman.

12. All grievances are placed in Clinical Engagement's quarterly grievance log. This log is reviewed quarterly for quality improvement purposes and submitted to the State to review as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO contract deliverables.
13. Data from grievances may also be utilized to identify and report, as needed, trends impacting members, UHA, its subcontractors, or its participating providers. Information may also be reported to the Clinical Advisory Panel.
14. In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, UHA reviews and reports to the OHA, as outlined in the CCO contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.
15. Grievance documentation shall be accurately maintained in a manner accessible to the state and available to CMS upon request for ten (10) years (CO23 – Record Retention & Destruction Policy).

Delegated Entities

1. If UHA delegates the grievance process to a subcontractor, it must:
    a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3025 through 410-141-3255;
    b. Monitor the subcontractor's performance on an ongoing basis;
    c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
    d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Delegated subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. Grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.

CORPORATE POLICY & PROCEDURE

	Policy Name: Health Related Services
Department: Clinical Engagement	Policy Number: CE02
Version: 5	Creation Date: 03/17/2015
Revised Date: 2/20/17, 3/07/19	Review Date:
Line of Business: ☐ All	
☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health - Transitional Care
Signature:  Approved By: Michael A. von Arx, Chief Operating Officer	Date: 3/8/2019

POLICY STATEMENT

Umpqua Health Alliance (UHA) provides non-covered services under the Oregon Health Plan (OHP) intended to improve care delivery and overall member and community health and well-being through flexible services and community benefit initiatives, consistent with Oregon Administrative Rules (OAR) 410-1471-3000 (38) and 410-141-3150.

PURPOSE

To promote the efficient use of resources and address members' social determinants of health to improve health outcomes, alleviate health disparities, and improve overall community well-being consistent with OAR 410-141-3000 and the UHA Coordinated Care Organization (CCO) contract.

RESPONSIBILITY

Clinical Engagement, Marketing, and Finance

DEFINITIONS

Community Benefit Initiatives: Community-level interventions that include members, but are not necessarily limited to only members, and are focused on improving population health and health care quality.

Flexible Services: Cost-effective services offered to an individual member to supplement covered benefits.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	In progress			

	Policy Name: Health Related Services
Department: Clinical Engagement	Policy Number: CE02
Version: 5	Creation Date: 03/17/2015
Revised Date: 2/20/17, 3/07/19	Review Date:

Health-Related Services (HRS): Non-covered services under OHP intended to improve care delivery and overall member and community health and well-being. Health-related services include flexible services and community benefit initiatives. See OAR 410-141-3000 (38).

PROCEDURES

Overview

1. UHA's Health-Related Services are provided to meet the needs of members and the communities. These must meet the following criteria:
    a. Be designed to improve health quality.
    b. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements.
    c. Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members.
    d. Be based on any of the following:
        i. Evidence-based medicine.
        ii. Widely accepted best clinical practice.
        iii. Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.
2. Expenditures and activities that may not be included as an activity that improves health care quality are:
    a. Those that are designed primarily to control or contain costs.
    b. Those that otherwise meet the definitions for quality improvement activities but that were paid for with grant money or other funding separate from revenue received through the CCO contract.
    c. Those activities that may be billed or allocated by a provider for care delivery and that are, therefore, reimbursed as clinical services.
    d. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 codes sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.

e. That portion of the activities of health care professional hotlines that do not meet the definition of activities that improve health quality.
f. All retrospective and concurrent utilization review.
g. Fraud prevention activities.
h. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
i. Provider credentialing.
j. Costs associated with calculating and administering individual member incentives.
k. That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Flexible Services

1. Requests may be made to UHA for flexible services through a form on the external website, email, or phone. Some types of requests may require specific documentation that cannot be provided by phone. The request should address the following:
    a. Alternative funding resources.
    b. Care plan.
    c. Improvement of outcomes, or prevention of deterioration.
    d. Cost-savings.
    e. Sustainability.
2. Consistent with the requirements above, UHA will review the request and any submitted documentation to confirm the following are met:
    a. Lacking billing or encounter codes.
    b. Health related.
    c. Consistent with the member's treatment plan as developed by the member's primary care team and documented in the member's medical records.
    d. Likely to be cost-effective alternative to covered benefits and likely to generate savings.
    e. Likely to improve health outcomes and prevent or delay health deterioration.
    f. Payer of last resort – no other community resource is capable of providing the service.
3. If a flexible services request is denied, a notification letter is sent to the member (and requesting provider if applicable) providing the determination and the member's right to

file a grievance in response to the outcome consistent with OAR 410-141-3151 (12). Appeal and hearing rights do not apply to HRS requests.

Community Benefit Initiatives & Health Information Technology

1. For community benefit initiatives, UHA has utilized its Community Advisory Council (CAC) to administer and allocate funds in accordance with UHA's Community Health Improvement Plan (CHIP).
    a. The CHIP Program allows UHA's CAC to identify the community needs and fund the community benefit initiative portion of the health related services.
    b. The CHIP Program application identifies who is eligible to apply, how to apply for funding, and the process on how the funds are awarded.
2. Health Information Technology (HIT) may also be considered if meeting meaningful use requirements necessary to accomplish the activities consistent with 45 CFR 158.151, to promote clinic community linkage and/or referral processes or support other activities as defined in 45 CFR 158.150.

Reporting

1. HRS are reported in accordance with the CCO contract and 42 CFR 438.8 Medical Loss Ratio (MLR).
2. All requests are recorded under the following categories consistent with OAR 410-141-3150 (4):
    a. "Training and education" for health improvement or management, including, but not limited to, classes on healthy meal preparation, diabetes and self-management curriculum.
    b. "Care coordination," navigation, or case management activities not otherwise covered under State Plan benefits, including, but not limited to, high utilizer intervention programs.
    c. "Home and living environment" items or improvements not otherwise covered by 1915 Home and Community Based Services authorities, including, but not limited to, non-Durable Medical Equipment (DME) items to improve mobility, access, hygiene, or other improvements to address a particular health condition such as an air conditioner, athletic shoes, or other special clothing.
    d. "Transportation" not covered under State Plan benefits, including, but not limited to, transportation for non-medical purposes.

e. Programs to improve community or public health, including, but not limited to, farmers' market in a "food desert," workforce development.
f. Community Health.
g. "Housing Supports" related to social determinants of health, including, but not limited to, temporary housing or shelter, utilities, or critical repairs.
h. "Food/Social Resources" assistance, including, but not limited to, supplemental food, referral to job training or social services.
i. "Other" non-covered services that comport with the definition of health-related services in OAR 410-141-3000.

CORPORATE POLICY & PROCEDURE

	Policy Name: Appeals and Hearings
Department: Clinical Engagement	Policy Number: CE20
Version: 8	Creation Date: 7/09/2008
Revised Date: 8/14/18, 4/1/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health – Transitional Care

Signature:

F Douglas Carr, M.D.

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 4/1/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3230 through 410-141-3255, and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, member grievances, and member services.

PURPOSE

To provide all members with an appropriate means to appeal an adverse benefit determination.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR §438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within

the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal: A request by a UHA member or a member's representative to review an adverse benefit determination. For purposes of this policy, an appeal also includes a request by OHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

Grievance: A UHA member's or a member's representative's expression of dissatisfaction to UHA or to a practitioner about any matter other than an adverse benefit determination.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make OHP related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the Member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian. For the purpose of this policy, references to "member" may also include "member representatives."

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

	Policy Name: Member Appeals and Hearings
Department: Clinical Engagement	Policy Number: CE20
Version: 8	Creation Date: 7/09/2008
Revised Date: 8/14/18, 4/1/19	Review Date:

PROCEDURES

Appeals

1. A member that disagrees with an adverse benefit determination may file an appeal. UHA provides members with written information regarding the appeal and hearing process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (see also policy MS3-Member Rights);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service; and
    e. At any time upon request.
2. UHA will provide members with oral information regarding the appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
3. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA Member Services for assistance.
4. A member or a subcontractor or provider with the member's written consent who disagrees with an adverse benefit determination or is contesting the failure of UHA to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals may file an appeal with UHA.
5. UHA has one level of appeal for members, and members shall complete the appeals process with UHA prior to requesting a contested case hearing.
6. For standard resolution of an appeal and notice to the affected parties, UHA shall establish a timeframe that is no longer than 16 days from the day UHA receives the appeal:
    a. UHA will acknowledge the receipt of an appeal to the member in writing for standard resolutions.
    b. If UHA fails to adhere to the notice and timing requirements in 42 CFR §438.408, the member is considered to have exhausted UHA's appeals process. In this case, the member may initiate a contested case hearing;
    c. UHA may extend the timeframes from this rule by up to 14 days if:
        i. The member requests the extension; or
        ii. UHA shows to the satisfaction of the Authority, upon its request, that there is need for additional information and how the delay is in the member's interest.
    d. If UHA extends the timeframes, but not at the request of the member, it shall:
        i. Make reasonable efforts to give the member prompt oral notice of the delay; and
        ii. Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to

file a grievance if the member disagrees with that decision.

7. For expedited resolution of an appeal, UHA completed the review in a timeframe that is no longer than 72 hours after receipt when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-120-1860.
8. The review timeframe for an expedited review may be extended by up to 14 days if:
    a. The member requests the extension; or
    b. UHA shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.
9. If UHA extends the expedited timeframes not at the request of the member, then it will:
    a. Make reasonable efforts to give the member prompt oral notice of the delay;
    b. Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
    c. Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860.
10. The adverse benefit determination notices and Appeal and Hearing Request form (OHP 3302) provides information on member's rights and the process for appealing:
    a. If after filing an oral appeal, a member or the provider on the member's behalf does not submit a written appeal request within the appeal timeframe, the appeal shall expire;
    b. UHA shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;
    c. UHA does not need to notify the member if it has already made attempts to assist the member in filling out the necessary forms to file a written appeal.
11. UHA, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
12. A member or the provider on the member's behalf may request an appeal either orally or in writing directly to UHA for any notice or failure to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by UHA:
    a. UHA shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an

expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;

b. The member shall file the appeal with UHA no later than 60 days from the date on the notice.

13. UHA will ensure members that all information concerning a member's grievance or appeal will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance or appeal, have a right to use this information for purposes of UHA resolving the grievance or appeal, for purposes of maintaining the appropriate logs, and for health oversight purposes by OHP, without a signed release from the member.
    b. If UHA must release any information related to the grievance or appeal to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. UHA's investigation may be restricted and information will not be released without a signed authorization.
14. UHA ensures that the individuals who make decisions on appeals follow all requirements in OAR 410-141-3230 MCE Grievance and Appeals System General Requirements:
    a. Ensure staff and any consulting experts making decisions on the appeal are: Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
    b. Decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
15. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to appeals. Upon receipt of the appeal, the coordinator:
    a. Obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.
    b. Investigates and resolves as expeditiously as the member's health condition requires and within the timeframes stated above for standard and expedited appeals.
    c. Provides members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

d. Informs members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. UHA informs members of this sufficiently in advance of the resolution timeframe for appeals.

16. UHA will ensure that any staff or consulting experts making decisions on the grievance are:
    a. Not involved in any previous level of review or decision making nor a subordinate of such individual;
    b. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall also make decisions pertaining to a grievance regarding denial of expedited resolution of an appeal or involves clinical issues; and
    c. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
17. UHA must continue the member's benefits while an appeal is in process if all the following are met:
    a. The member files the appeal or administrative hearing request within 10 calendar days of the adverse benefit determination.
    b. The appeal involves the termination, suspension, or reduction of a previously authorized services.
    c. The services were ordered by an authorized provider.
    d. The original period covered by the original authorization has not expired; and
    e. The request for continuation of benefits is filed on or before the later of the following:
        i. Within 10 calendar days of UHA sending the notice of adverse benefit determination; or
        ii. The intended effective date of UHA's proposed adverse benefit determination.
18. If at the member's request UHA continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
    a. The member withdraws the appeal or hearing; or
    b. The member does not request a hearing within 10 days from the when UHA mails the notice of appeal resolution to the member; or
    c. A hearing decision adverse to the member is made; or
    d. Until OHA issues an appeal decision adverse to the member; or
    e. The authorization expires or authorization service limits are met.

19. UHA will provide members a copy of their case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the adverse benefit determination. UHA provides the case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.
20. The member will be notified in writing with a notice of appeal resolution consistent with the notice requirements of 42 CFR §438.404 and OAR 410-141-3240, and the Authority's formatting and readability standards in OAR 410-141-3300, 42 CFR §§ 438.408, and 438.10. This includes but is not limited to the following content and format:
    i. The results of the appeal resolution.
    ii. The date of the appeal resolution.
    iii. Written in language sufficiently clear that a layperson could understand the notice and make an informed decision (about appealing and following the process for requesting a hearing if applicable).
21. If the original adverse benefit determination is upheld, a notice is also mailed with the Appeal and Hearing Request Form (OHP 3302) explaining that they may file a hearing within 120 calendar days of the date of the adverse benefit determination. A request for an OHA administrative hearing made without previous use of the appeal procedures may be forwarded to UHA to review as an appeal prior to the hearing.
    a. If UHA had reinstated or continued the member's benefits pending the appeal, the benefits must be continued pending an administrative hearing.
    b. If a portion of the request was overturned, UHA would also indicate in the notice details of those services that had a favorable outcome.
22. If the original adverse benefit determination is overturned, UHA will issue a notice of appeal resolution within the required timeframes and must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date of notice reversing the determination. the UHA must promptly correct the adverse benefit determination taken up to the limit of the original request or authorization.
23. In the case that UHA fails to adhere to notice and timing requirements, the member is deemed to have exhausted the appeals process and may initiate a hearing.
24. The Appeal and Hearing Request Form (OHP 3302) is available on the OHA website, at Member Services, UHA's Clinical Engagement Office, and can be mailed to the member upon request.
25. UHA's participating providers are provided information about the Grievance System at the time they enter into a contract with UHA via provider orientation and training (PN6 – Provider Orientation & Training). This information is also available on the UHA website under the Provider Handbook section.

26. If a member expresses that they need assistance in filling out any forms, they can be assisted by Member Services, a grievance coordinator, or a case manager. Interpreter services may be arranged by UHA upon request. Member Services also has access to a TTY/TTD to assist.
27. All appeals shall be documented in writing on the quarterly report log and an appeal chart must be created. The quarterly report log is submitted to the State as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO contract deliverables.
28. Appeal trends may be reported to the Clinical Advisory Panel (CAP).

Administrative Hearings

1. A member may request a contested case hearing with the Authority after receiving notice that UHA notice of action/adverse benefit determination is upheld or, in the case of UHA failing to adhere to the notice and timing requirements in 42 CFR §438.408, the Authority may consider that the member has exhausted the appeals process and may initiate a contested case hearing.
2. If the member files a request for an appeal or hearing with the Authority prior to the member filing with UHA, the Authority shall transfer the request to UHA and provide notice of the transfer to the member.
3. OHA must receive the member's hearing request within 120 days of the date shown on the Notice of Appeal Resolution.
4. If the member requested that UHA continue or reinstate services while the appeal was pending, benefits must be continued pending the administrative hearing until one of the following:
    a. The member withdraws the administrative hearing request;
    b. 10 calendar days have passed after UHA notice of appeal resolution was issued and the member failed to request continuation of benefits;
    c. A final order is issued to a member with an adverse resolution to that member; or
    d. The time period or service limits of a previously authorized service have been met.
5. OHA will review the administrative hearing request and verify that the member was a UHA member at the time the adverse benefit determination was taken and whether the hearing request was timely.
    a. Should UHA receive the administrative hearing request, UHA will date stamp the request with the date of receipt and transmit that request to OHA including a copy of the member's adverse benefit determination or notice of appeal resolution, as applicable, immediately.
6. Once OHA receives a valid administrative hearing request they will send a copy of the hearing request to UHA.
7. UHA shall cooperate with providing relevant information required for the hearing

process to OHA on all administrative hearings within 2 business days. This includes expedited hearings.

8. Information regarding the member used for administrative hearings is handled in confidence.
    a. OHA, the member or their representative, UHA, and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the administrative hearing have a right to use this information for purposes of resolving the administrative hearing without a signed release from the member.
    b. OHA may also use this information for health oversight purposes and for other purposes authorized or required by law.
    c. The information may also be disclosed to the Office of Administrative Hearings and the administrative law judge assigned to the administrative hearing and to the Court of Appeals if the UHA member seeks judicial review of the final order.
    d. OHA will ask the member to authorize a release of information regarding the administrative hearing to any other individual.
9. The hearing will be scheduled through the Office of Administrative Hearings. Parties to the administrative hearing shall include UHA, the member and the member's representative.
10. A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.
11. The Authority shall issue a final order or the Authority shall resolve the case ordinarily within 90 days from the date UHA receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing request.
12. For reversed appeal and hearing resolution services:
    a. For services not furnished while the appeal or hearing is pending. If UHA or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, UHA shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
    b. For services furnished while the appeal or hearing is pending. If UHA or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, UHA or the state shall pay for those services in accordance with the Authority policy and regulations.
13. Should the administrative hearing decision uphold UHA's adverse benefit

determination, UHA may recover the cost of service furnished to the member while the hearing is pending.

Documentation and Quality Improvement

1. UHA shall have a grievance chart for each grievance and appeal. The chart should include record of the review/investigation, resolution, written decisions, and copies of correspondence. UHA shall retain documentation of appeals for the term of ten years to permit evaluation (CO23 – Record Retention & Destruction Policy).
2. Each appeal and grievance shall be documented in the appropriate log. The quarterly report and grievance log shall be consistent with OHA requirements of the Exhibit I of CCO contract deliverable.
3. All written decisions and copies of all correspondence with all parties to the appeal. The grievance coordinator is responsible for monitoring both appeals and grievances for completeness, accuracy, and timeliness of documentation, compliance with policies and procedures, and compliance with Oregon Health Plan Rules.
4. All quarterly reports are reviewed by the CAP.

Delegated Entities

1. If UHA delegates the grievance and appeal process to a subcontractor, it must:
    a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3025 through 410-141-3255;
    b. Monitor the subcontractor's performance on an ongoing basis;
    c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
    d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Delegated subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. Notice of appeal resolutions will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.

CORPORATE POLICY & PROCEDURE

	Policy Name: Adverse Benefit Determinations
Department: Clinical Engagement	Policy Number: CE21
Version: 2	Creation Date: 8/14/2018
Revised Date: 4/1/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health – Transitional Care

Signature: F Douglas Carr, M.D.

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 4/1/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) issues written notification to members when it has made or intends to make an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3230 through 410-141-3255, and 42 CFR §438.400 through 438.424. This policy is applied in conjunction with the policies for prior authorizations, grievances, appeals, hearings and member services (i.e. Member Handbook).

PURPOSE

To provide all members with opportunity to appeal an adverse benefit determination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR §438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under

§438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeal: A request for review of an adverse determination, action or as it relates to an adverse benefit determination issued by UHA.

Grievance: A UHA member's or a member's representative's expression of dissatisfaction to UHA or to a practitioner about any matter other than an adverse benefit determination.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make OHP related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through person's familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

PROCEDURES

1. UHA issues a written notification approved by OHA for an adverse benefit determination (ABD), for any of the following:
    a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner, as defined by the State.
    e. The failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

f. For a resident of a rural area with only one managed care organization, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

2. The ABD notifies the member and requesting provider in writing by meeting the notice requirements of 42 CFR §438.404 and OAR 410-141-3240 by including the Appeal and Hearing Request Form (OHP 3302) and including the following:
    a. Date of the notice;
    b. UHA's name, address, and telephone number;
    c. Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
    d. Member's name, address, and member ID number;
    e. Service requested or previously provided and the adverse benefit determination UHA made or intends to make, including whether UHA is denying, terminating, suspending, or reducing a service or denial of payment;
    f. Date of the service or date service was requested by the provider or member;
    g. Name of the provider who performed or requested the service;
    h. Effective date of the adverse benefit determination if different from the date of the notice;
    i. Whether UHA considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services;
    j. Clear and thorough explanation of the specific reasons for the adverse benefit rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:
        i. The item requiring prior authorization but not authorized;
        ii. The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-000;
        iii. The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;
        iv. The service or item received in an emergency care setting that does not qualify as an emergency service;
        v. The person is not a member at the time of the service or not a member at the time of the requested service;
        vi. Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;
        vii. Prior approval not obtained (except as allowed in OAR 410-141-3140); or

viii. UHA's denial of member's disenrollment request and findings that there is no good cause for the request.

3. The ABD and attached Appeal and Hearing Request Form (OHP 3302) also explain the following to the member:
    a. The member's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
    b. Circumstances under which an appeal process can be expedited and how to request it.
    c. The member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of continued services.
    d. The member's right to have benefits continue pending the resolution of the appeal [to be entitled to continuing benefits, the member shall complete a UHA appeal request or an Authority contested case hearing request for continuing benefits no later than: (A) The tenth day following the date of the notice of action/adverse benefit determination or the notice of appeal resolution; and (B) The effective date of the action proposed in the notice, if applicable].
    e. The member's right to request a hearing.
4. The notice must comply with the OHA's formatting and readability standards in OAR 410-141-3300 and 42 CFR §438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal.
5. UHA provides notice of an ABD expeditiously as the member's condition requires within state-established timeframes for authorization requests consistent with OAR 410-141-3225:
    a. For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:
        i. The member, the member's representative, or provider requests an extension; or
        ii. UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.
    b. For notice of actions/adverse benefit determinations that affect services previously authorized, UHA shall mail the notice at least ten days before the date the adverse benefit determination takes effect:

i. UHA shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service;
ii. UHA may extend the 72-hour time period up to 14 days if the member requests an extension or if UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest.

c. If UHA extends the 14 calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services, it must:
   i. Give the enrollee written notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision.
   ii. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
d. UHA mails the notice of adverse benefit determination by the date of the action when any of the following occur:
   i. The recipient has died.
   ii. The enrollee submits a signed written statement requesting service termination.
   iii. The enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
   iv. The enrollee has been admitted to an institution where he or she is ineligible under the plan for further services.
   v. The enrollee's address is determined unknown based on returned mail with no forwarding address.
   vi. The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
   vii. A change in the level of medical care is prescribed by the enrollee's physician.
   viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
   ix. The transfer or discharge from a facility will occur in an expedited fashion.
   x. Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an adverse benefit determination. A notice of action/adverse benefit determination shall be issued on the date the timeframe expires.
e. UHA mails the notice of adverse benefit determination at least 10 days before the date of action, when the action is a termination, suspension, or reduction of

previously authorized Medicaid-covered services. UHA may mail the ABD as few as five (5) days prior to the date of action if the agency has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.

6. UHA will give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.
7. UHA maintains a record of each ABD, appeal, and grievance in a manner accessible to the state and available upon request to the Centers for Medicare & Medicaid Services. Records shall be retained for ten years (CO23 – Record Retention & Destruction Policy).
8. In addition to the content of the ABD and the Appeal and Hearing Request Form (OHP 3302), members may also access information regarding their rights to an appeals, hearing, and grievance on the UHA website and in the member handbook.
9. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA member services for assistance.

Delegated Entities

1. If UHA delegates the prior authorization, appeal, or grievance process to a subcontractor, it must:
    a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3025 through 410-141-3255;
    b. Monitor the subcontractor's performance on an ongoing basis;
    c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
    d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Delegated subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. Adverse benefit determination, notice of appeal resolution, and grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.

STANDARD OPERATING PROCEDURE

Title: CLI- Interpreter Services	
Department: Member Services	
Related Policy Title: Interpreter Services	Related Policy Number: MS5
Version: 1	Creation Date: 03/15/2018
Revised Date:	Review Date:

PURPOSE
To train and instruct UHA staff on how to utilize services provided by CLI.

SCOPE
To assist members who need interpretive services. UHA is required to provide interpretive services and alternate formats to its members per OAR 410-141-0280.

RESPONSIBILITY
Umpqua Health Management, LLC

DEFINITIONS
CLI – Certified Languages International
UHA – Umpqua Health Alliance
OAR – Oregon Administrative Rule

PROCEDURES
Upon receiving a call from a non-English speaking member or member representative:

1. Explain to member, as best you can, that you are getting an interpreter.
2. On your phone, select the “more” button and then the “confrn” button.
3. Dial 1-800-225-5254
4. When the operator answers, tell the operator:
    a. You are calling from either Umpqua Health
    b. Your customer code is 38536
    c. Language that you need interpreted
    d. You will be asked if what department you are calling from. You will tell them either Umpqua Health Alliance, Clinical Engagement, Umpqua Health Harvard, Umpqua Health Newton Creek
    e. You will then be asked to give your password (each department has their own)
5. You will also be asked your phone number and name. The operator will connect you with an interpreter.
6. Let the interpreter know that you will add the member to the line
7. Add member by selecting the “confrn” button again.

8. Explain to member that the interpreter is on the line. The interpreter usually introduces him/herself.
9. Proceed with call.

If you need to add an additional person to the line (example - ENCC):

10. Do not transfer the call, it will disconnect the interpreter
11. Remain on the line
12. Select the "confrn" button. This will place both parties on hold.
13. Dial the number person you wish to add to the call.
14. Advise them that they are joining a three way call with a member and an interpreter.
15. Select the "confrn" button again to connect all three parties (not counting yourself).
16. Remain on the call until it is concluded.
17. Thank the interpreter for their assistance
18. End the call.

When placing a call to a non-English speaking member.

1. Dial 1-800-225-5254
2. When the operator answers, tell the operator:
    f. You are calling from DCIPA Management, LLC
    g. Your customer code is 38536
    h. Language that you need interpreted
    i. You will be asked if you calling from Umpqua Health Alliance (say **yes**)
    j. Your phone number, name and office name (Umpqua Health Alliance).
3. Dial the member's phone number.
4. When the member answers, add the interpreter by selecting the "confrn" button again.
5. Proceed with call.
6. When finished, thank the interpreter for assistance.

CORPORATE POLICY & PROCEDURE

	Policy Name: Policies and Workflows – Drafting and Distribution
Department: Compliance	Policy Number: CO25
Version: 5	Creation Date: 9/24/2014
Revised Date: 9/15/2016, 1/18/2017, 11/28/17, 2/27/18	Review Date:

Line of Business: ☒ All

☐ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health – Transitional Care

Signature:

Approved By: Michael A. von Arx, Chief Operations Officer Date: 4/12/2018

Approved By: Board Oversight Compliance Committee Date: 4/12/2018

POLICY STATEMENT

Umpqua Health's Family of Companies is governed by many regulatory, contractual, and organizational requirements. Accordingly, Umpqua Health utilizes policies to communicate and demonstrate its commitment to satisfy those requirements.

PURPOSE

The purpose of this policy is to define the steps by which Umpqua Health policies are created, revised, reviewed and distributed. This policy outlines the development process to ensure consistency, collaboration, and education of the policies that govern Umpqua Health.

RESPONSIBILITY

Umpqua Health Executive Team, Policy Committee Members.

DEFINITIONS

Creation Date: Date when policy was first created.

Policy Administrator: Individual who assists in reminding due date(s) of policies, and facilitate the publication of policies implemented.

Policy Committee: Multi-departmental committee that reviews and approves policies collectively to ensure all operational areas are considered before approval.

Policy: A document that typically outlines on a high level, steps taken to satisfy a contractual, regulatory, or organizational requirement.

Policy Number: Naming convention of policies. First two letters of a department name, followed by a number (should be done in sequential order with other department policies).

	Policy Name: Policies and Workflows – Drafting and Distribution
Department: Compliance	Policy Number: CO25
Version: 5	Creation Date: 9/24/2014
Revised Date: 9/15/2016, 1/18/2017, 11/28/17, 2/27/18	Review Date:

Revised Date: Date(s) of when a policy has had revisions. Multiple dates can be listed to demonstrate revision history (e.g. 1/1/2015, 6/1/2015, 1/1/2016, etc.).

Revised Policy: A current policy that has substantial changes made to it. Substantial changes include, but are not limited to, edits to the "Purpose," "Responsibility," "Definition," or "Procedures" sections.

Review Date: Date(s) of when a policy has been reviewed and no substantial changes, beyond the updating of the header, were necessary. Multiple dates can be listed to demonstrate revision history (e.g. 2/15/2014, 1/1/2016, etc.).

Reviewed Policy: A current policy that was looked over and no substantial changes were made, other than the appropriate edits to the policy's header.

Standard Operating Procedure (SOP): A set of formalized step-by-step instructions to aid staff in carrying out internal complex routine operations.

Version: Denotes the number of times a policy has been reviewed and/or revised.

Workflows: An internal department document that outlines the specific steps taken to meet a policy.

PROCEDURES

General Requirements

1. All Umpqua Health policies are required to be reviewed every two years, or when changes are made, whichever is sooner (CCO Contract, Exhibit B, Part 8, Section 1 (f)). Exceptions to this rule include:
    a. Grievance System policies for Umpqua Health Alliance are required to be revised and/or reviewed annually (CCO Contract, Exhibit B, Part 3, Section 5 (a)).
    b. Fraud and Abuse policies for Umpqua Health Alliance are required to be revised and/or reviewed annually (CCO Contract, Exhibit B, Part 8, Section 14 (b)).
2. Generally, all policies should reference the applicable regulation or contract requirement that the policy is designed to support.
3. Policies are required to be in the appropriate template and format (See attachment).
4. The Policy Administrator will provide assistance in tracking and providing notice when policies are due for revision, however the responsibility for timely revision falls solely on each department's member of the Policy Committee.

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5. Each department's Executive Team member shall be responsible in signing their department's policies. In the event of a vacancy of an Executive Team member, Umpqua Health's Chief Executive Officer shall be the signee of the impacted department's policies.

New Policy

1. If a department determines that there is a need for a new policy, the department is expected to draft the new policy using the guidelines addressed above.
2. The department must engage with other departments for feedback in the event there is departmental crossover.
3. It is expected that all applicable regulations and contractual requirements are appropriately cited.
4. The department is to coordinate with other departments who oversee other organizational documents (e.g. Member Handbook, Provider Handbook, Employee Handbook, etc.) to ensure the new policy is reflected in those documents as well.
5. The department's Policy Committee member shall provide the draft policy to the Policy Committee Chair, at least one week prior to the Policy Committee meeting date. Polices submitted less than one week prior will be reviewed at the following month's meeting. Any exception to this well be considered on a case by case basis.
    a. The Policy Committee Chair will disseminate the draft policy to the Policy Committee members no later than three days prior to the Policy Committee.
6. At the Policy Committee, the department representative will present the new policy to the Committee who will be tasked to provide feedback. The Committee can take the following actions:
    a. Reject the new policy.
    b. Accept new policy, as is.
    c. Accept new policy with suggested changes.
7. Once a policy has been accepted by the Policy Committee, the Executive Team Member overseeing that department will sign the policy into place.
8. Signed copies will be sent to the Policy Administrator to load onto Umpqua Health's intranet site for distribution.
9. New policies will need to be distributed to the individuals impacted by the policy. Distribution should occur no later than 30 days after a policy has been executed.

Revised Policy

1. Sixty days (60) prior to the revisions date of a policy, the Policy Administrator will notify the appropriate department's Policy Committee member.
2. The department will make a determination as to whether the policy needs to be revised, or simply reviewed.

   a. If a policy just needs to be reviewed, departments are expected to follow the "Reviewed Policy," section.
3. If it is determined that the policy needs to be revised, the department's Policy Committee member, or designee, will make the necessary changes to the policy, using track changes as a means for the Policy Committee to identify the changes.
4. Departments are encouraged to solicit feedback from other departments in the event the policy crosses over to another department.
5. Departments are expected to update any regulatory citations for accuracy purposes.
6. Once the policy has been revised, the department is also expected to notify appropriate departments on the changes if the changes impact other organizational documents. These documents will need to be updated to reflect the new policy:
   a. Example: It would be expected that the Provider Handbook and/or the Member Handbook be revised to reflect the changes in the policy.
   b. Example: The Employee Handbook may be revised in the event a revised Human Resources' policy is changed.
7. The department's Policy Committee member shall provide the revised policy to the Policy Committee Chair, one week prior to the Policy Committee meeting date.
   a. The Policy Committee Chair will disseminate the revised policy to the Policy Committee members no later than three days prior to the Policy Committee.
8. At the Policy Committee, the department member will present the new policy to the Committee who will provide any feedback. The Committee can take the following actions:
   a. Reject the new policy.
   b. Accept new policy, as is.
   c. Accept new policy with suggested changes.
9. Once a policy has been accepted by the Committee, the Executive Team Member overseeing that department will sign the policy into place.
10. Signed copies will be sent to the Policy Administrator to load on to Umpqua Health's intranet site for distribution.
11. All revised policies must be distributed to the individuals impacted, no later than 30 days after a policy has been executed.

<u>Reviewed Policy</u>

1. When a policy is reviewed and there are no changes, the policy is not required to be presented to the Policy Committee. Departments must verify that the policy has not changed since its last update. Changes that need to be considered include:
   a. Changes in process since last version.
   b. Changes in contractual/regulatory requirements and/or citations.
   c. Changes in terminology, names, systems, etc.

	Policy Name: Policies and Workflows – Drafting and Distribution
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2. Departments are required to update the reviewed policy header to reflect the following:
    a. New version number.
    b. Review date.
    c. New signature.
3. Once changes have been made, the department is to submit the reviewed signed policy to the Policy Administrator and advise to archive the previous version.
    a. The Policy Administrator will load the reviewed policy on to Umpqua Health's intranet site for distribution.

Policy Distribution

1. All policies will be housed on the Umpqua Health's intranet site, managed by the Policy Administrator.
2. Individual departments are expected to provide the signed copy of the policies to the Policy Administrator for uploading on to the intranet site.
3. Departments are solely responsible in ensuring that applicable individuals within their department review any new or revised policies (certain exceptions may be considered).

Workflows

1. Departments may create their own workflows to support a process that is governed by a policy.
    a. Internal workflows should be documented using the Umpqua Health Standard Operating Procedures (SOP) template.
2. Workflows should be used only for internal purposes and are not governed by this policy.
3. SOPs may be signed into action by the department director or executive.

CORPORATE POLICY & PROCEDURE

	Policy Name:
Department:	Policy Number:
Version:	Creation Date:
Revised Date:	Review Date:
Line of Business: ☐ All ☐ Umpqua Health Alliance ☐ Umpqua Health - Harvard ☐ Umpqua Health - Newton Creek ☐ UHA Community Activities ☐ Professional Coding and Billing Services	☐ Umpqua Health Management ☐ Physician eHealth Services ☐ Umpqua Health Network ☐ ACE Network ☐ Umpqua Health – Transitional Care
Signature: Approved By:	Date:

POLICY STATEMENT

PURPOSE

RESPONSIBILITY

DEFINITIONS

PROCEDURES

CORPORATE POLICY & PROCEDURE

	Policy Name:
Department:	Policy Number:
Version:	Creation Date:
Revised Date:	Review Date:

STANDARD OPERATING PROCEDURE

Title:	
Department:	
Related Policy Title:	Related Policy Number:
Version:	Creation Date:
Revised Date:	Review Date:
Signature: Approved By:	Date:

PURPOSE

SCOPE

RESPONSIBILITY

DEFINITIONS

PROCEDURES

RFA Community Engagement Plan

Tables should be completed in the format provided below and submitted with Applicant's Community Engagement Plan (narrative).

Table 1: Stakeholders to be included in the community engagement process			
All applicants must complete this full table. Applicants may add rows as needed.			
Part 1a. List stakeholder types to be included in the engagement process. Applicants must include, at a minimum, plans to engage the following stakeholder types: OHP consumers, community-based organizations that address disparities and the social determinants of health ("SDOH-HE"), providers (includes physical, oral, behavioral, providers of long term services and supports, traditional health workers and health care interpreters), Regional Health Equity Coalitions (if present), early learning hubs, local public health authorities, local mental health authorities, other local government, and tribes. Add rows as needed.	**Part 1b.** List specific agencies, organizations and individuals, based on the stakeholder types identified in Part 1.a, with which the applicant will engage. Add additional rows under the stakeholder type as needed.	**Part 1b.** Describe why each listed agency, organization and individual was included.	**Part 1b.** Describe how Applicant plans to develop, maintain or strengthen relationships with each stakeholder and maintain a presence within the community.
OHP consumers (list in first column below)			
OHP Consumers	CAC Members: OHP Consumer representatives constitute the majority of the CAC membership	CAC members are a vital component to UHA operations. Our CAC members are crucial partners in creating the community health assessment and community health improvement plan, as well as overseeing the funding of projects and programs that aim to address our community health improvement plan.	UHA plans to maintain the relationship with our current CAC through monthly CAC meetings, regular communications with UHA staff, having the CAC Chair and Vice Chair serve on the UHA Board, and involving the CAC in decisions about funding efforts for projects that impact focus areas identified in UHA's CHIP and social determinants of health. UHA will strengthen this relationship by establishing a seat on the UHA Board for a CAC member who is also a UHA member.

RFA Community Engagement Plan

Community-based organizations that address disparities and SDOH-HE (list in first column below)			
Community-based organizations	Battered Persons' Advocacy	Battered Person's Advocacy aids individuals experiencing trauma.	UHA has worked with Battered Persons' Advocacy since UHA became a Coordinated Care Organization on projects that address Adverse Childhood Experiences and Trauma Informed Care. UHA will continue to partner with BPA through several means, including possibly funding projects and programs and inviting BPA personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	CASA of Douglas County	CASA of Douglas County assists children who are involved in a legal matter.	UHA has partnered with CASA of Douglas County for several years on multiple projects and programs. UHA will continue to explore collaborative projects and programs with CASA of Douglas County, and invite CASA of Douglas County personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Neighborworks Umpqua	Neighborworks Umpqua provides housing and economic opportunities.	UHA has partnered with Neighborworks Umpqua for several years on multiple projects and programs. UHA will continue to explore collaborative projects and programs with Neighborworks Umpqua, and invite Neighborworks Umpqua personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Douglas Education Service District (ESD)	Douglas Education Service District has a wide variety of programs, including parenting education, school nurses, and serves as the fiscal home of the area Early Learning Hub.	UHA has partnered with the Douglas ESD for several years on projects including parenting education opportunities and a summer camp for disabled children. They are integral to our work with early learning and early childhood education. UHA will continue to explore collaborative projects and programs with Douglas ESD, and invite Douglas ESD personnel to collaborate on a shared vision of community enhancement.

Community-based organizations	United Community Action Network - UCAN (including Head Start, WIC, Food Pantry, UTRANS)	UCAN has a wide variety of services, including WIC, Douglas County's public transit system UTRANS, Head Start, and more.	UHA has partnered with UCAN for several years on projects including food insecurities and improving access to health services for children in Head Start. They are integral to our work with multiple populations. UHA will continue to explore collaborative projects and programs with UCAN, and invite UCAN personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Mercy Foundation	The Mercy Foundation is a valuable partner, which provides a range of services aimed at meeting the unmet healthcare needs of Douglas County residents.	UHA has partnered with the Mercy Foundation for several years on projects that address food insecurity, oral health and care coordination for diabetic youth. They are integral to our work with multiple populations. UHA will continue to explore collaborative projects and programs with Mercy Foundation, and invite Mercy Foundation personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Family Development Center	Family Development Center offers services aimed at strengthening parents and preserving families to prevent child abuse and neglect.	UHA has partnered with the Family Development Center for several years on projects including parenting education opportunities and expanding access to home visiting services. They are integral to our work with early learning and early childhood education and creating strong and resilient families. UHA will continue to explore collaborative projects and programs with family development center, and invite Family Development Center personnel to collaborate on a shared vision of community enhancement.

Community-based organizations	Umpqua Valley Breastfeeding Coalition	Umpqua Valley Breastfeeding Coalition promotes mothers milk and best feeding practices for infants.	UHA has partnered with the Umpqua Valley Breastfeeding Coalition for several years on projects including breastfeeding education classes. They are integral to our work with early learning and early nutrition. UHA will continue to explore collaborative projects and programs with Umpqua Valley Breastfeeding Coalition, and invite Umpqua Valley Breastfeeding Coalition personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Friendly Kitchen/Meals on Wheels of Douglas County	Friendly Kitchen/Meals on Wheels of Douglas County provides hot, nutritious meals to seniors and people with disabilities.	UHA has partnered with the Friendly Kitchen/Meals on Wheels for several years on projects that address food insecurity. They are integral to UHA's work to ensure access to healthy, nutritious meals for seniors and people with disabilities. UHA will continue to explore collaborative projects and programs with Friendly Kitchen/Meals on Wheels, and invite Friendly Kitchen/Meals on Wheels personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Umpqua Community Veg Education Group (UC VEG)	UC VEG provides healthy eating and lifestyle classes and cooking demonstrations.	UHA has partnered with the UC VEG for several years to provide healthy lifestyle classes and healthy eating opportunities. They are integral to our work with normalizing healthy eating behaviors. UHA will continue to explore collaborative projects and programs with UC VEG, and invite UC VEG personnel to collaborate on a shared vision of community enhancement.

Community-based organizations	Valiant Seed	Valiant Seed is the driving force behind an effort to start a tiny home village in Roseburg.	UHA has partnered with the Valiant Seed for two years on a project to establish a tiny home village in Roseburg. They are integral to UHA's work to address homelessness in UHA's service area. UHA will continue to explore collaborative projects and programs with Valiant Seed, and invite Valiant Seed personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	NAMI Douglas County	NAMI Douglas County educates people on behavioral health issues, as well as operates the Chadwick Clubhouse, a space for people experiencing mental health issues to congregate.	UHA has partnered with the NAMI of Douglas County for two years to establish a Clubhouse for people with mental health issues. They are integral to UHA's work to improve outcomes for individuals with behavioral health diagnoses. UHA will continue to explore collaborative projects and programs with NAMI of Douglas County, and invite NAMI of Douglas County personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Greater Douglas United Way	Greater Douglas United Way provides funding and planning for multiple projects and programs throughout the county, and convenes a group focused on the housing and homeless crisis in Douglas County.	UHA has not partnered with the Greater Douglas United Way on projects or programs, but UHA plans to work with Greater Douglas United Way personnel to collaborate on a shared vision of community enhancement.
Community-based organizations	Canyonville Farmers' Market Umpqua Valley Farmers' Market	All local farmers' markets, including Umpqua Valley Farmers' Market and Canyonville Farmers' Market, provide fresh produce and healthy food options.	UHA has partnered with the several local farmers' markets for several years on projects to increase SNAP benefits at area farmers' markets and to increase youth participation at farmers' markets. They are integral to UHA's efforts to ensure access to healthy and nutritious foods for all in UHA's service area. UHA will continue to explore projects and programs with area farmers' markets, and invite farmers' market personnel to collaborate on a shared vision of community enhancement.

Community-based organizations	Roseburg Mission, Casa de Belen Samaritan Inn, Safe Haven Maternity Home	The Roseburg Mission, Casa de Belen, Samaritan Inn and Safe Haven Maternity Home all offer housing options for individuals experiencing homelessness.	UHA is dedicated to working with local safe housing partners to address homelessness in Douglas County. These partners are integral to that work. UHA will continue to explore projects and programs with Douglas County's safe housing partners, and will invite personnel with these agencies to collaborate on a shared vision of community enhancement.
Community-based organizations	Umpqua Valley disAbilities Network	Umpqua Valley disAbilities Network serves individuals with disabilities and their families through a variety of services.	UHA plans to expand partnership opportunities with Umpqua Valley disAbilities Network by exploring collaborative projects and programs. UHA will invite Umpqua Valley disability Network personnel to collaborate on a shared vision of community enhancement.
Providers, physical health (list in first column below)			
Providers, physical health	All of UHA's contracted agencies are involved in the process and implementation of community engagement: Umpqua Health – Harvard Umpqua Health – Newton Creek Cow Creek Health and UHA Newton Creek UHA Harvard Medical Clinic UCHC CMG East Evergreen Family Medicine Valley Ridge Family Medicine Cow Creek Health and Wellness Family Tree Medical	These agencies provide well-rounded robust medical care to UHA's current members. Our contracted providers must have sensitivity, give members respect, and gain their trust by providing accessible, culturally appropriate high quality health and wellness services. Umpqua Health, as a health plan and medical provider, collaborates with others to advance the wellbeing of everyone. UHA's Provider Network department is committed to improving the health of UHA's members, reducing the cost of health care while building professional relationships with UHA's family of community partners.	One of UHA's top priorities is to engage with all contracted entities by providing monthly education, training, and Quality Metric follow up, and transitional care interventions for best practices. UHA's Provider Network department has implemented a plan to contract with Douglas County providers to ensure that UHA is providing network availability, network access, and network adequacy standards. UHA's Provider Network Department goals include respecting and empowering UHA members in partnership with our provider community to achieve better health outcomes by addressing their needs.

RFA Community Engagement Plan

Providers, behavioral health (list in first column below)			
Providers, behavioral health	Serenity Lane Adapt Compass Valley View South Lane Sooth River CEP Tele Psych	Serenity Lane works to transform lives through the treatment of substance use disorders.	UHA is proud to work with Serenity Lane and our other Behavioral Health Community Partners to offer these much-needed services to UHA members. UHA plans to maintain this relationship by providing regular education, training and quality metric follow up.
Providers, oral health (list in first column below)			
Providers, oral health	Advantage Dental	Advantage Dental is a strong partner in providing oral health services to UHA's members.	UHA is proud to have Advantage Dental serving UHA's members. UHA will maintain this strong partnership through collaborative work with Advantage Dental, including opening a seat on the UHA Board of Directors for an individual with a dental care organization.
Providers, oral health	Advantage Dental	Advantage Dental works to ensure all individuals have access to oral health care.	UHA will strengthen this relationship by providing Advantage Dental with regular education, training, and quality metric follow up.
Providers, long term services and supports (list in first column below)			
Providers, long term services and supports	Avalon/Rose Haven	Rose Haven Nursing Center has been serving Roseburg and surrounding communities for over 50 years. Rose Haven offers a continuum of care to meet an individual's changing medical and healthcare needs	The services provided by Rose Haven include skilled rehabilitation and nursing care on a short or long-term basis due to an orthopedic condition, a prolonged illness or chronic disease. When our members receive rehabilitation services at this center, they receive comprehensive care that focuses on our members The patient and family involvement in the rehabilitation process helps to speed up recovery and promotes successful outcomes. UHA strives to rebuild hope, confidence and self-respect for our members we serve in the community.

RFA Community Engagement Plan

Providers, traditional health workers (list in first column below)			
Providers, traditional health workers	Adapt	Adapt offers substance abuse prevention and intervention services to our Douglas County members and school districts. Adapt's Prevention and Education Program works with UHA locally to prevent substance abuse, promote healthy childhood development and build healthy communities.	Through UHA's collaboration with Adapt's opioid prevention, treatment and recovery options, including fully-integrated Medication-Assisted Treatment at South River Comm Health Center, they provide specialized Opioid Treatment Program, Tele-Medicine to improve access to care for UHA's rural residents and Medically-Monitored Sub-Acute Detoxification and Residential Care. Our full commitment to our members allows patients to transition seamlessly between levels of care appropriate to their individual needs.
Providers, traditional health workers	Umpqua Community College	Umpqua Community College is currently exploring the possibility of starting a community health worker training program at their Workforce Training Center.	Umpqua Health Alliance is working with Umpqua Community College to explore the possibility of starting and developing a training course that meets the OHA requirements for Community Health Workers.
Providers, health care interpreters (list in first column below)			
Providers, health care interpreters	Certified Languages Interpreters	This organization provides over the phone interpreting services and or video remote interpreting services and or document translation services and or assessment services	UHA has an established contract with Certified Language Interpreters. They're currently offering telephone interpreting services, video remote interpreting, written document translation services, and assessment services.
Early learning hubs (list in first column below)			
Early learning hubs	South-Central Early Learning Hub	The South Central Early Learning Hub is a valuable partner in addressing health needs for our members 0-5.	UHA currently has representation on the SCELH Professional Advisory Council, and has partnered with SCELH on multiple projects.

RFA Community Engagement Plan

Local public health authorities (list in first column below)			
Local public health authorities	Douglas Public Health Network	Public health authorities engage the public on topics related to their health and wellbeing. They help create environments that foster optimal health for people in their service areas.	UHA currently has a staff member on DPHN's Board of Directors, and has partnered with DPHN on several initiatives including: a provider training regarding childhood immunization best practices, an initiative that promotes oral health for pregnant women, and more public health programs.
Local mental health authorities (list in the first column below)			
Local mental health authorities	Compass Behavioral Health	Compass Behavioral Health provides a comprehensive system of care that includes an array of evidence-based treatment approaches and services to support healing, personal growth and development and opportunities for positive change.	UHA is lucky to have a strong relationship with Compass Behavioral Health. Compass is part of Adapt's integrated system of care, and the Adapt CEO is on the UHA Board of Directors. Adapt's Senior Director of Operations is on UHA's Community Advisory Council, and serves as the CAC liaison to the UHA Board. UHA and Compass have collaborated on many projects and programs together, most recently UHA has provided funding to Adapt to co-locate primary care into Adapt's behavioral health facility.
Other local government (list in the first column below)			
Other local government	Douglas County Board of Commissioners	The board of county commissioners are valuable partners in aligning UHA goals with community efforts and endeavors.	UHA currently has a Douglas County Commissioner serving on the UHA Board.
Other local government	Department of Human Services	Department of Human Services has a multitude of divisions that serve many of our most at-risk populations, including child welfare and seniors and people with disabilities departments.	UHA currently has regular meetings with multiple departments at Douglas County DHS, and will continue this relationship to find the best ways to serve the needs of UHA's members.

RFA Community Engagement Plan

Tribes, if present in the service area (list in first column below)			
Tribes	Cow Creek Band of the Umpqua Tribe of Indians	The Cow Creek Band of the Umpqua Tribe of Indians is a valued and venerated partner for Umpqua Health Alliance, and all of Douglas County. UHA is proud to work closely with Cow Creek on many issues that seek to improve the health and wellbeing of Douglas County residents.	The Cow Creek Band of the Umpqua Tribe of Indians is a strong partner for UHA through many aspects of operation. UHA has a seat on the CAC designated for a person who is a member of or affiliated with the tribe. UHA has partnered with the tribe on multiple funding projects where we have both put funding towards the same projects to improve the health of the community.
Regional Health Equity Coalitions, if present in the service area (list in first column below)			
Not Applicable	None in Douglas County		
Add additional stakeholder types here (list in first column below)			
Additional Stakeholder	Douglas County Independent Physicians Association (DCIPA)	DCIPA is a physician led and owned organization that aims to serve the needs of Douglas County providers and their patients.	DCIPA partnered with Mercy Medical Center to launch Umpqua Health Alliance in 2013, and has been a strong partner in ensuring the needs of UHA members are met. UHA will continue this strong partnership with DCIPA by including DCIPA on all major decisions by holding a seat for a DCIPA representative on the UHA Board.
Additional Stakeholder	Mercy Medical Center	Mercy Medical Center has been providing care in Douglas County for over 110 years. The 174-bed medical facility is serves patients throughout Douglas County.	Mercy Medical Center partnered with DCIPA to launch Umpqua Health Alliance in 2013, and has been a strong partner in ensuring the needs of UHA members are met. UHA will continue this strong partnership with Mercy Medical Center by including Mercy Medical Center on all major decisions by holding a seat for Mercy Medical Center representatives on the UHA Board.

Table 2: Major activities and deliverables for which the CCO will engage the community	
All applicants must complete this full table.	
Part 2a. List and describe the five to eight major projects, programs and decisions for which the CCO will engage the community.	**Part 2b.** Identify the level of community engagement for each project, program and decision. Answers* must be 1) inform/communicate, 2) consult, 3) involve, 4) collaborate, or 5) shared decision-making. Applicant may include more than one level of engagement for each project, program or decision to account for differences among stakeholder groups.
1. Identify and select projects and programs to receive funding through UHA's CHP funding stream	Inform, collaborate, shared decision-making
2. Explore the possibility of establishing Community Health Worker trainings	Inform, collaborate
3. Work with community partners to explore establishing an allied and mental health college in UHA's service area	Inform, consult, involve, collaborate, shared decision-making
4. Work with community partners to identify potential trainings for providers, community partners and interested community members	Involve, collaborate, shared decision-making
5. Work with community partners to implement Advance Directive into EMR settings, using La Cross, Wisconsin as a best practice model	Inform, collaborate, involve
6. Engage community partners to address oral health issues	Involve, collaborate
7. Create Behavioral Health Task Force, tasked with developing a Behavioral Health Plan	Involve, collaborate, shared decision-making

*

1. **Inform**: Provide the community with information to assist in their understanding of the issue, opportunities, and solutions. Tools include fact sheets, published reports, media releases, education programs, social media, email, radio, information posted on websites, and informational meetings.
2. **Consult**: Obtain community feedback on analysis, alternatives, and/or decisions. Tools include issue briefs, discussion papers, focus groups, surveys, public meetings, and listening sessions.
3. **Involve**: Work directly with the community throughout the process to ensure that community concerns and aspirations are understood and considered. Applicant provides feedback to the community describing how the community input influenced the decision. Tools include meetings with key stakeholders, workshops, subject matter expert and stakeholder roundtables, conferences, and task forces.
4. **Collaborate**: Partner with the community in each aspect of the process, including decision points, the development of alternatives and the identification of a solution. Tools include advisory committees, consensus building, and participatory decision making.
5. **Shared decision-making**: To place the decision-making in the hands of the community (delegate) or support the actions of community initiated, driven and/or led processes (community driven/led). Tools include delegated decisions to members of the communities impacted through steering committees, policy councils, strategy groups, Community supported processes, advisory bodies, and roles and funding for community organizations.

Table 3: Collaboration with other agencies in the service area that have responsibility for developing community health assessments and community health improvement plans					
All applicants must complete this full table. Applicants may add rows as needed.					
Part 1. Applicants with an existing CCO CHA and CHP will submit their most recent CHA and CHP with the community engagement plan.					
Part 2. List of all local public health authorities, non-profit hospitals, other CCOs that share a portion of the service area, and any federally recognized tribe in the service area that is developing or has a CHA/CHP. Add additional rows as needed.	**Part 3.** The extent to which each organization was involved in the development of the Applicant's current CHA and CHP. Answers* must be a) competition and cooperation, b) coordination, c) collaboration, or d) not applicable (NA).**	**Part 4.** For any organization that is a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will list the shared priorities and strategies.**	**Part 5.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the current state of the relationship between the applicant and the organization(s), including gaps.	**Part 6.** For any organization that is not a collaborator for a shared CHA and shared CHP priorities and strategies, the applicant will describe the steps the applicant will take to address gaps prior to developing the next CHA and CHP, and the dates by which the applicant will complete key tasks.***	**Part 7.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed CHAs and CHPs developed by these other organizations. List the health priorities from existing plans.
Local public health authorities (list in this column below)					
Douglas Public Health Network (DPHN)	Not Applicable (Douglas Public Health Network was not involved in development of UHA's current CHA or CHP. The entity that, at the creation of UHA's current CHP, was known as Douglas County Public Health was a collaborator in the creation of UHA's current CHP.)		DPHN was not in existence at the time of the creation of UHA's current CHP. UHA collaborated with the public health entity at the time, Douglas County Public Health. For the most recent CHA, UHA did not collaborate with DPHN.	DPHN is part of a group of organizations in Douglas County that has collaborated on a joint Community Health Needs Assessment and Community Health Improvement Plan. UHA will coordinate with DPHN regarding interest in collaboration on an updated CHA and CHP when this group next begins work on a CHA/CHP. UHA will explore this by July 2021.	

Non-profit hospitals (list in this column below)					
Mercy Medical Center	Coordination		Mercy Medical Center is a strong partner of UHA, and is 50% owner of UHA. UHA and Mercy Medical Center are on different timelines for CHA and CHPs but we communicate regularly about our goals, and contribute ideas to one another's' CHP process.	Mercy Medical Center is part of a group of organizations in Douglas County that has collaborated on a joint Community Health Needs Assessment and Community Health Improvement Plan. UHA will coordinate with Mercy Medical Center regarding interest in collaboration on an updated CHA and CHP when this group next begins work on a CHA/CHP. UHA will explore this possibility by July 2021.	
Current coordinated care organizations, as of 2019 (list in this column below)					
Not Applicable					

Federally recognized tribes that have or are developing a CHA/CHP (list in this column below)					
Cow Creek Band of Umpqua Tribe of Indians	Coordination		UHA has a designated seat on the Community Advisory Council (CAC) for a person affiliated with a tribe. For UHA's current CHA and CHP, this connection has allowed UHA to work with the local tribe, the Cow Creek Band of the Umpqua Tribe of Indians to communicate UHA's work and create a process for information sharing. For example, while UHA was creating the most recent CHA, UHA's CAC member who filled the Tribe seat worked at the Cow Creek Health and Wellness Center and was able to organize one of the focus group for targeted populations at tribal government offices. While there is a strong relationship between UHA and the Cow Creek Band of Umpqua Tribe of Indians, there was no official organizational agreement between the two entities to collaborate on a shared CHA or CHP.	UHA will explore the possibility of working with the Cow Creek Band of the Umpqua Tribe of Indians on a shared CHA and CHP. UHA will explore this possibility by July 2021.	

RFA COMMUNITY ENGAGEMENT PLAN

*

a) Competition and Cooperation: Loose connections and low trust; tacit information sharing; ad hoc communication flows; independent goals; adapting to each other or accommodating others' actions and goals; power remains with each organization; resources remain with each organization; commitment and accountability only to own organization; relational time frame short; low risk and reward.
b) Coordination: Medium connections and work-based trust; structured communication flows and formalized project-based information sharing; joint policies, programs and aligned resources; semi-interdependent goals; power remains with parent organizations; commitment and accountability to parent organization and project; relational time frame medium and based on prior projects; medium risk and reward.
c) Collaboration: Dense interdependent connections and high trust; frequent communication; tactical information sharing; systems change; pooled and collective resources; negotiated shared goals; power is shared between organizations; commitment and accountability to network first, community and parent organization; relation time frame long (3 years or more); high risk and reward.
d) Not applicable

**If the applicant does not have a current CHA and CHP, the applicant will enter not applicable (NA).

***Engagement activities must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.

Table 4: Engagement with social determinants of health and health equity (SDOH-HE) partners for CHA and CHPs **Applicants may add rows as needed.**					
All applicants must complete Part 1.	**Applicants <u>with an existing CHA and CHP</u> must complete Parts 2, 3 and 4. Applicants <u>that intend to change their service area</u> must also complete Parts 2, 3, and 4.**			**Applicants <u>without an existing CHA and CHP or that intend to change their service area</u> must complete Parts 2a and 4a.**	
Part 1. List of organizations that address the social determinants of health and health equity in the applicant's service area. Add additional rows as needed.	**Part 2.** Applicants **with an existing CHA and CHP** will describe existing partnerships with each identified organization, including whether the organization contributed to the applicant's current CHA and CHP.	**Part 3.** Applicants **with an existing CHA and CHP** will describe gaps in existing relationships with identified organizations.	**Part 4.** Applicants **with an existing CHA and CHP** will describe the steps the applicant will take to address the identified gaps prior to developing the next CHA and CHP and the dates by which the applicant will complete key tasks for engagement.**	**Part 2a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area. For each organization listed in Part 1, the applicant will document the organization's level of involvement in developing any other CHAs or CHPs by entering one of these responses: a) The organization was explicitly involved in developing one or more CHAs or CHPs; b) The organization was not explicitly involved in developing a CHA or CHP; c) unknown.	**Part 4a.** Applicants **without an existing CHA and CHP or that intend to change their service area** will demonstrate that they have reviewed community partnerships in place for other LPHA/non-profit hospital/tribal/CCO CHAs and CHPs in the service area by describing the steps the applicant will take to form relationships and secure participation by each organization prior to developing the first or next CHA and CHP, and the dates by which the applicant will complete key tasks for engagement.**

All tribes that are present in the service area (list in this column below). If no tribe is present in the service area, note there are none.					
Cow Creek Band of Umpqua Tribe of Indians	UHA has a strong connection with the Cow Creek Band of Umpqua Tribe of Indians. There is a seat reserved for a tribal member/person affiliated with the tribe on the CAC. During the work done on UHA's most recent CHA, the person who filled this position helped tremendously in arranging focus groups, including one held at tribal offices. Though the tribe did not contribute financially, they have been instrumental partners in helping UHA complete and achieve the vision of the CHA and CHP.	UHA has not invited the Cow Creek Band of Umpqua Tribe of Indians to collaborate on a CHA or CHP beyond the tribal member/person affiliated with the tribe on the CAC.	UHA will invite the tribe to more fully engage in the CHA and CHP processes, including expressly inviting tribal attendance at any and all community meetings regarding the CHA and CHP.		
All regional health equity coalitions (RHECs) that are present in the service area (list in this column below). If no RHEC is present in the service area, note there are none.					

There are no RHECs in the service areas.					
Local government, including counties					
Douglas County Commissioners	A Douglas County Commissioner has been a member of the UHA Board for several years. The UHA Board oversees the work on the CHA and the CHP. Though the Commissioners did not contribute financially, this commissioner did provide oversight.	UHA does have a County Commissioner on the UHA Board, but UHA does not currently have a County Commissioner or a member of county government staff on the CAC. This is a gap, as the CAC is the leading force behind the work relating to the CHA and the CHP.	UHA will invite County Commissioners to participate in CHA and CHP work through community meetings and focus groups. UHA will also invite County Commissioners and members of county government staff to fill the Local Government seat on UHA's CAC.		
Canyonville, Drain, Elkton, Glendale, Myrtle Creek, Oakland, Reedsport, Riddle, Roseburg, Sutherlin, Winston, and Yoncalla City Councils	UHA does not currently have a strong relationship with local city councils, and they did not participate in CHA or CHP work.	UHA has not traditionally partnered with local city councils.	UHA will invite local city council members to attend CHA and CHP strategy and planning sessions.		
Organizations that address the four key domains of social determinants of health* (list in this column below).					
Battered Persons' Advocacy	BPA has been strongly involved with our CHA and CHP work, as the Executive Director has served on the CAC since inception and served as Chairperson and a member of the UHA Board.	UHA has relied on the relationship with the Executive Director as a CAC member to relay information to all of BPA, and has not done specific outreach to this organization.	UHA will invite all affiliated with BPA to CHA and CHP strategy and planning sessions.		

CASA of Douglas County	CASA members were involved in UHA's CHA, but not the CHP.	UHA has not engaged with CASA of Douglas County for several years.	UHA will invite CASA leadership to CHA and CHP strategy and planning sessions.		
Neighborworks Umpqua	Neighborworks Umpqua were not involved with the creation of UHA's CHA or CHIP.	Though UHA works with Neighborworks Umpqua on several projects and programs, they have not been involved in the creation of UHA's CHA or CHP.	UHA will invite Neighborworks Umpqua leadership to CHA and CHP strategy and planning sessions.		
Douglas ESD	Douglas ESD was involved with UHA's CHA, but not the CHP.	UHA works with Douglas ESD on several projects and programs, and the Superintendent of Douglas ESD serves on the CAC. But UHA has relied on this CAC member to relay all information to all Douglas ESD staff.	UHA will invite all affiliated with Douglas ESD to all CHA and CHP strategy and planning sessions.		
UCAN (including Head Start, WIC, Food Pantry, UTRANS)	UHA partnered with UCAN on the most recent CHA, and various forms of UCAN were involved in UHA's CHP.	UCAN is an extremely large organization with many different focus areas, but not all departments have been involved in all planning sessions.	UHA will invite all affiliated with UCAN to all CHA and CHP planning sessions.		
Mercy Foundation	Mercy Foundation was not involved in UHA's CHA or CHP.	Mercy Foundation is the charitable organization associated with Mercy Medical Center (MMC). They partner to help complete the hospital's CHA. As MMC and UHA are on different timelines, the organizations have not partnered on CHA or CHP work.	UHA will invite Mercy Foundation to all CHA and CHP planning sessions.		

Family Development Center	Family Development Center was not involved in UHA's CHA or CHP.	Though UHA has partnered with Family Development Center on multiple projects and programs, FDC was not involved in the CHA or CHP process.	UHA will invite Family Development Center to all CHA and CHP planning sessions.		
Umpqua Valley Breastfeeding Coalition	Umpqua Valley Breastfeeding Coalition was heavily involved in UHA's CHA, even helping to organize some of the focus groups and disseminated community surveys, but was not involved in the creation of UHA's CHP.	Though UHA has a strong relationship with UVBC, working together on the CHA and partnering on projects and programs, UVBC was not involved in the creation of UHA's CHP.	UHA will invite Umpqua Valley Breastfeeding Coalition to all CHA and CHP planning sessions.		
Friendly Kitchen/Meals on Wheels of Douglas County	Friendly Kitchen/Meals on Wheels of Douglas County was not involved in UHA's CHA or CHP.	Though UHA has partnered with Friendly Kitchen/Meals on Wheels of Douglas County on several projects and programs, Friendly Kitchen/Meals on Wheels of Douglas County was not involved in the creation of UHA's CHA or CHP.	UHA will invite Friendly Kitchen/Meals on Wheels of Douglas County to all CHA and CHP planning sessions.		
UC VEG	UC VEG was involved in the creation of UHA's CHA, but not UHA's CHP.	UHA partners with UC VEG on several projects and programs, and UC VEG was an instrumental partner in completing UHA's CHA but was not involved in creating UHA's CHP.	UHA will invite UC VEG to all CHA and CHP planning sessions.		

Valiant Seed	Valiant Seed was not involved in the creation of UHA's CHA or CHP.	UHA partners with Valiant Seed on several projects and programs, but Valiant Seed was not involved in creating UHA's CHA or CHP.	UHA will invite Valiant Seed to all CHA and CHP planning sessions.		
NAMI Douglas County	NAMI Douglas County members were involved in the creation of UHA's CHA in several capacities, but not in UHA's CHP.	UHA partners with NAMI Douglas County on several projects and programs, and NAMI Members were involved in several aspects of creating and shaping UHA's CHA, but were not involved in UHA's CHP.	UHA will invite Valiant Seed to all CHA and CHP planning sessions.		
Greater Douglas United Way	Greater Douglas United Way was not involved in the creation of UHA's CHA or CHP.	UHA did not partner with Greater Douglas United Way on either UHA's CHA or CHP.	UHA will invite Greater Douglas United Way to all CHA and CHP planning sessions.		
Local Farmers' Markets	Individuals associated with area farmers' markets were not involved in the creation of UHA's CHA or CHP.	UHA did not partner with individuals associated with area farmers' markets on either UHA's CHA or CHP	UHA will invite individuals associated with area farmers' markets to all CHA and CHP planning sessions.		
Roseburg Rescue Mission	The Roseburg Rescue Mission was not involved in the creation of UHA's CHA or CHP.	UHA did not partner with Roseburg Rescue Mission on either UHA's CHA or CHP	UHA will invite Roseburg Rescue Mission to all CHA and CHP planning sessions.		
Casa de Belen	Casa de Belen was involved in the creation of UHA's CHP, but was not engaged on UHA's CHA.	UHA did not partner with Casa de Belen on either UHA's CHA or CHP.	UHA will invite Casa de Belen to all CHA and CHP planning sessions.		
Samaritan Inn	Samaritan Inn was not involved in the creation of UHA's CHA or CHP.	UHA did not partner with Samaritan Inn on either UHA's CHA or CHP	UHA will invite Samaritan Inn to all CHA and CHP planning sessions.		
Safe Haven Maternity Home	Safe Haven Maternity Home was not involved in the creation of UHA's CHA or CHP.	UHA did not partner with Safe Haven Maternity Home on either UHA's CHA or CHP	UHA will invite Safe Haven Maternity Home to all CHA and CHP planning sessions.		

Umpqua Valley disAbilities Network	Umpqua Valley disAbilities Network was not involved in the creation of UHA's CHA or CHP.	UHA did not partner with Umpqua Valley disAbilities Network on either UHA's CHA or CHP	UHA will invite Umpqua Valley disAbilities Network to all CHA and CHP planning sessions.		

Traditional Health Workers (THWs) affiliated with organizations listed in OAR 410-141-3145 (list in this column).					
Not applicable: the agencies listed do not have THW					
Culturally specific organizations and organizations that work with underserved or at- risk populations (list in this column below).					
Phoenix Charter School	Phoenix Charter School was not involved in the creation of UHA's CHA or CHP	Though UHA has partnered with Phoenix Charter School on several projects and programs, UHA did not partner with Phoenix Charter School on either UHA's CHA or CHP	UHA will invite Phoenix Charter School to all CHA and CHP planning sessions.		
Other organizations (list in this column below).					
*The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health.					
Engagement activities **must begin by March 31, 2020 and applicant will report on progress through the June 2020 CCO CHP progress report.					

Table 5: Assessment of existing social determinants of health priorities and process to select Year 1 social determinants of health priorities		
All applicants must complete this full table to describe how the applicant will identify social determinants of health ("SDOH-HE") priorities to meet the CCO SDOH-HE spending requirements. Housing must be included as one of the SDOH-HE spending priorities.		
Part 1. List of existing SDOH-HE CHP priorities* in applicant's proposed service area from its own CHP or other existing CCO, local hospital, local public health authority and/or tribal CHPs, if applicable. Add additional rows as needed.	**Part 1a.** Source for priority (i.e. which CHP it came from).	**Part 1b.** Whether priority describes a health outcome goal (i.e. addressing food insecurity to address obesity as a health issue) **or** priority populations (i.e. addressing early childhood education for children as a priority population) **or** other.
Access	2014 CHP	Health outcome goal: increase access to healthcare services
Addictions	2014 CHP	Health outcome goal: reduce the number of individuals addicted to tobacco, alcohol and other drugs
Mental Health	2014 CHP	Health outcome goal: increase integration of services for severe and persistently mentally ill
Parents & Children	2014 CHP	Health outcome goal: improve outcomes for children by investing early and addressing core risk factors for health
Healthy Lifestyles	2014 CHP	Health outcome goal: increase access to physical activity and healthy food choices
Housing	Though housing is not one of the priorities included in UHA's current CHP, it is identified as one of UHA's internal SDOH-HE spending priorities.	Priority population: providing services and supports for people experiencing homelessness.
Part 2. Description of process through which the applicant will identify and vet SDOH-HE priorities** in line with CHP priorities for submission to OHA by March 15, 2020. This must include, timelines, milestones, methods for vetting selected priorities with community partners (such as those described in Table B, Part 1) and CAC, and planned actions to clarify and define CCO housing priority in line with statewide priority. - Process may also include planned actions to identify additional community-based SDOH-HE priorities from CHP priorities. - If housing has not been identified as a priority in existing CHPs, note that housing must still be selected as an SDOH-HE priority. Consider adding the housing priority in alignment with either a health outcome goal or priority population identified in Part 1b.		

RFA Community Engagement Plan

Umpqua Health Alliance relies on its Community Advisory Council to help identify and vet CHP and SDOH-HE priorities. Our CAC, through a collaborative, community-based approach is able to work with partners and stakeholders to identify the priorities that matter most to our community. The CAC will: - Hold a community meeting regarding initial vetting of SDOH-HE priorities by September 30, 2019 - Gather community input by December 31, 2019 - In conjunction with the CAC and UHA Board, further clarify and define SDOH-HE priority by February 20, 2020 - Submit SDOH-HE priorities to OHA by March 15, 2020
*Applicants must include description of housing priority if already identified in CHPs. (e.g. housing overall, housing for targeted populations).
**The four key domains of social determinants of health are economic stability, education, neighborhood and built environment, and social and community health. Refer to the Social Determinants of Health and Health Equity Glossary reference document.

Umpqua Health Alliance—Community Engagement Plan

Umpqua Health Alliance (UHA) has a strong history of community partnership on which it is building the CCO 2.0 Community Engagement Plan.

General Component

1. Identify stakeholders to be included in the engagement process, which will include:

Table 1 (see Required Community Engagement Plan Tables) identifies the stakeholders that will be included in UHA's engagement process. UHA will be engaging the following types of stakeholders: OHP consumers, community-based organizations that address disparities and the social determinants of health (SDOH), providers, early learning hubs, local government and public health authorities, and tribes.

2. Identify five to eight major projects, programs, or decisions with which to engage the community

UHA has selected seven major projects and programs for which we will engage the community; these are described in **Table 2** (see attached Required Community Engagement Plan Tables).

3. Describe the process for members, health care providers, other service delivery partners, and other stakeholders to provide input that will inform CCO decision making.

UHA uses the Community Health Improvement Plan (CHP) as the basis for collaboration with CCO decision makers. Members, health care providers, other service delivery partners, and other stakeholders all have a strong input into the CHP. UHA's work relies on the CHP, both at the time of its creation and extending for several years. The CHP, which has key focus areas identified in the plan, is the guiding document for a funding stream that supports community projects and programs. The CHP is created through a process that requires input from community partners and members. The Community Advisory Council (CAC), a group that represents a wide array of interests and expertise, oversees the creation of the CHP. The diverse nature of interest and focus area of CAC members enables UHA to engage a unique and vast swath of the community in the planning process.

The Community Health Assessment (CHA) helps drive the priority areas in the CHP, and is a crucial step in aligning UHA's work with community needs. As such, it is imperative to include as many voices in the data gathering process, both through primary and secondary data sources. The CAC has been instrumental to gathering input, being in a unique position to reach community members UHA may not be able to engage. In the most recent CHA process, UHA held a number of focus group for what the CAC deemed priority areas. These focus groups were advertised by CAC members with a particular interest or knowledge base regarding each target population. For example, UHA held a focus group for Latino/Spanish-speaking members of the community. A member of UHA's CAC speaks Spanish, and was able to work with the local Latino/Spanish-speaking population to garner interest in the focus group (which resulted in attendance by 17 Latino/Spanish-speaking people).

At UHA, the CHP is used as a guiding document for funding decisions in what UHA refers to as Community Health Improvement Plan funding. In regards to this funding, the CAC has complete autonomy as to how the funds are spent. Each year, the CAC has a minimum of $250,000 to allocate to community projects and programs that touch on at least one of the five priorities identified in UHA's most recent CHP: access, addictions, mental health, parents & children and healthy lifestyles. This funding allows UHA to engage community partners, while also allowing for the CAC to inform CCO decision making.

Another way UHA ensures open and continuous dialog with UHA's partners and the community is through a transparent governance system. The entirety of UHA Board meetings are completely open to the public, allowing all stakeholders to inform CCO decision making at the Board level. UHA Board meetings also allow time for public comment, and welcome input from stakeholders and the community.

4. Describe how the Applicant will ensure the member voice is elevated.

When specifically thinking of elevating the member voice, UHA is proud to ensure members have the opportunity to inform CCO decision making in several aspects. UHA CAC meetings are open to the public, and community members are welcome to speak during the meeting. The CAC directs which CAC members sit on the UHA Board, which can include OHP consumers. This structure adds an additional feedback loop for the CAC and UHA Board while allowing for a member voice within UHA Governance.

5. Describe (via narrative) potential barriers to community engagement and how the Applicant will address these barriers. The applicant will include: a. Known or anticipated barriers for the community the Applicant intends to serve (e.g. transportation and costs, accessibility, childcare, language access, literacy and numeracy levels and dominance of oral culture, rural isolation, gaps in information);
b. The methods the Applicant will use to address barriers. This must include description of strategies to avoid exclusionary practices and allocation of necessary resources, including funds.

A. Anticipated Barriers: One of the largest known barriers for the proposed service region is transportation costs. Douglas County has several large communities, and multiple smaller communities. Transportation for individuals in outlying areas can be a barrier, contributing to rural isolation for individuals outside of larger towns.

Childcare is also a barrier for many parents to attend community events, and has been a barrier discussed by potential CAC members.

B. Strategies: Providing the following items helps CAC members to attend CAC meetings, therefore encouraging community engagement that will inform CCO decision-making:

- UHA provides free transportation services to UHA members who are members or guests of the CAC, to all CAC meetings or other UHA-sponsored community meetings through UHA's Flexible Services – Transportation Agreement with Bay Cities. Utilizing this service allows individuals with special needs to secure the transportation they need.

- UHA provides a $50/meeting stipend for CAC members that covers their time/travel costs.
- UHA provides a $20/meeting for CAC members that assists with childcare costs.
- UHA provides free meals for all CAC members at all CAC meetings. These meals take individual diets into consideration.

6. Describe (via narrative) the plan to ensure continual quality improvement of the high-level plan throughout the life of the contract, including how quality improvements will be shared back with engaged stakeholders and the larger community.

UHA will guarantee continual quality of the Community Engagement Plan by establishing quality metrics to ensure continual quality improvement. These metrics will be included in the Transformation and Quality Strategy (TQS) semi-annual reports. UHA will establish measurement baselines in 2020 in the following areas:

- Enhance member voice
- Engage community partners
- Address potential barriers to community engagement

UHA will monitor this plan on a regular basis, and report through the TQS reporting mechanism on a semi-annual basis. The CAC will have oversight of the Community Engagement Plan measures, and will be able to continue to drive UHA's community engagement strategies.

Community Advisory Committee Component

1.B. An Applicant with one or more existing CACs will describe its current CAC structure and role(s) and, if applicable, its plans for adapting its CAC structure based on a new or adjusted CCO service area. The applicant must also include:
□□A description of how it defines its population, and
□□Any planned changes to CAC recruitment and engagement strategies to align CAC membership with that population and with CHP priorities.

UHA's current CAC structure is a 16-person CAC, with one Chairperson and one Vice-Chair. The Chair and Vice-Chair positions are nominated by the CAC, and approved by the UHA Board. The CAC has five at-large seats, as well as specific positions (seniors and people with disabilities, mental illness and addictions, health/medical, dental, education, local government, children, tribal, housing, and the faith community). Members serve two-year terms, and can serve up to three consecutive terms. The UHA Board can extend terms. The CAC meets monthly (with a break in August), and holds CAC meetings in public to increase community engagement possibilities.

UHA defines member population using the Physical Health Service Delivery Report by Gender and Race-Ethnicity. As the vast majority (roughly 95.7%) of UHA's members are Caucasian or identify as other/unknown, UHA also considers other attributes when allowing for diversity within CAC membership. Douglas County's biggest city is Roseburg, OR, located in the center of the county. Most of the county's resources are located within Roseburg and the surrounding larger communities. While Douglas County's population is not necessarily racially or ethnically

diverse, the sheer size of the county lends itself to geographic diversity. The CAC takes into consideration geographic information when recruiting for a new member, as the needs of residents in northern Douglas County vary from those located in Roseburg, and those living further east.

1.C. All Applicants will describe how they will meaningfully engage OHP consumer representatives on the CCO board, and how they will meaningfully engage tribes and/or tribal advisory committees (if applicable).

OHP consumer representative on the CCO Board is through appointment of two CAC members on UHA's Board. The CAC is constructed with community partners and OHP consumers. The CAC directs which CAC members sit on the UHA Board, which can include OHP consumers. Additionally, the CAC Chair also provides a CAC report to the UHA Board at every UHA Board meeting, ensuring ongoing communication between CAC and UHA Board members. UHA currently has a seat on the CAC that is designated for an individual who is engaged with our local tribe, the Cow Creek Band of the Umpqua Tribe of Indians.

1.D. All Applicants will describe strategies for collaborating with CACs from other CCOs that have overlapping services areas. Include strategies to ensure best use of local capacity and resources to avoid overtaxing the community (for example, if the same county, community-based organizations or OHP consumers being asked to participate in more than one CAC or more than one CHA/CHP process).

Douglas County is a relatively small county, which means the people who are willing to participate in a process such as the ones utilized to create a CHA and a CHP are often asked to do so multiple times, by multiple organizations. UHA strives to ensure that those who are willing to do this work are not burdened by repeated requests for participation. UHA will invite all CCOs in our shared service area to collaborate on all work surrounding the CHA/CHP process. This includes potentially creating a shared CHA or CHP, in collaboration with additional community partners. UHA will also explore the possibility of holding joint CAC meetings with any CCO that shares UHA's service area, when topics relevant to both CACs are addressed. UHA is best suited to coordinate collaborative meetings with any other CCOs or community partners, as UHA has an established history of leadership in healthcare in Douglas County. UHA has the established community footprint, existing partnerships and historical knowledge to establish UHA as the most well-suited organization to coordinate collaboration between community partners and any other CCOs that share UHA's service area.

Introduction

Approximately 37 percent of the U.S. population is comprised of ethnic minorities—many of whom are immigrants and don't speak fluent English. The relatively recent cultural competence movement encourages us to look at things from the perspectives of our minority patients, whose experiences and languages have put them at a substantial cultural distance from American healthcare.

2%

Course Overview

OVERVIEW

This course has 28 lesson pages and seven review questions.
Estimated time to complete is 30 minutes.

DESCRIPTION

Imagine receiving medical care in a place where your native language isn't spoken. It must be frightening in many ways. As the U.S. has always been a melting pot of ethnicities, treating minority patients is hardly the exception.

This course explores in more detail how and why to incorporate cultural awareness into healthcare.

Welcome to Culturally Competent Care, An Overview.

Imagine receiving medical care in a place where your native language isn't spoken. It must be frightening in many ways.

As the U.S. has always been a melting pot of ethnicities, treating minority patients is hardly the exception.

This course explores in more detail how and why to incorporate cultural awareness into healthcare.

5%

Learning Objectives

After completing this course, participants can:

- Define culturally competent care.
- Describe common barriers to cultural competency.
- Discuss the elements that go into an effective model of cultural competence.
- Explain how other cultures may have very different philosophies for healthcare.
- Describe the role of communication and language in providing culturally competent care.

After completing this course, you will be able to:

- Define culturally competent care.
- Describe common barriers to cultural competency.
- Discuss the elements that go into an effective model of cultural competence.
- Explain how other cultures may have very different philosophies for healthcare.
- Describe the role of communication and language in providing culturally competent care.

Now, let's get started.

BF11010 - Culturally Competent Care: An Overview V2

Certificate

Save & Exit

Introduction to Cultural Diversity

- In 2012, 314 million people in U.S.
- 37% of Americans are “ethnic minorities.”
- Most cultures keep some or all of their practices from their native country and may not speak English.

As of 2012, the United States included approximately 314 million people. Some of the latest figures show that about 37 percent of Americans are “ethnic minorities.”

Although the U.S. has often been referred to as a “melting pot,” diverse cultures don’t all “melt” or assimilate together into one unit—most keep some or all of their practices from their native country and may only speak that language.

10%

Introduction to Cultural Diversity (cont.)

- Cultural diversity is a challenge in healthcare.
- Majority of healthcare employees are English speaking and white.
- Study found that Limited English Proficient (LEP) hospital patients are more likely to experience adverse events that result in harm.

This wide diversity of languages, cultures, customs and beliefs results in a vast challenge for the healthcare industry. While some hospitals, clinics and other healthcare facilities have added more diverse staff members, the majority are still white and English speaking. Further, even if you speak your patient's language, you may not fully understand their culture or what they believe about healthcare.

Why is this such a concern? A 2007 Commonwealth Fund study found that, due to language barriers, Limited English Proficient (LEP) hospital patients are much more likely to experience adverse events that result in harm.

Review Question

LEP patients are:

- Ethnic minorities.
- Not fluent in English.
- Limited English Proficient.
- All of the above.

Answer

Please read and answer the review question on this lesson page.

BF11010 - Culturally Competent Care: An Overview V2

Certificate

Save & Exit

History of Culturally Competent Care

Patient-centered care:

- Medical term since 1960s.
- Suggests medical professionals look at each patient as unique and treat him or her accordingly.

Culturally competent care:

- An extension of this belief.
- Dr. Madeleine Leininger defined it as "the use of sensitive, creative and meaningful care practices to fit with the general values, beliefs and lifeways of clients for beneficial and satisfying healthcare, or to help them with difficult life situations, disabilities or even death."
- Term began to be used in 1990s.

Patient-centered care, which suggests medical professionals look at each patient as unique and treat him or her accordingly, has been part of medical terminology since the 1960s.

Culturally competent care is an extension of this belief, and has grown in importance as our diverse population has expanded.

Dr. Madeleine Leininger, a pioneer in this field, defined it as "the use of sensitive, creative and meaningful care practices to fit with the general values, beliefs and lifeways of clients for beneficial and satisfying healthcare, or to help them with difficult life situations, disabilities or even death."

The term "cultural competence" did not begin to appear consistently in healthcare literature until the early 1990s, and since 1998, myriad programs addressing cultural competence in healthcare have been developed.

17%

History of Culturally Competent Care (cont.)

The majority culture of U.S. clinicians:

- Biomedical Model of Care.
- White.
- Middle-class.

Cultural competence movement promotes perspectives of patients whose experiences and language are different from American healthcare.

The Civil Rights Act of 1964, Title VII:

- Includes executive order signed in 2000 requiring hospitals and providers to take reasonable steps to ensure LEP individuals have access to vital programs and services.

The majority of U.S. clinicians are white, middle-class and believers of the biomedical model of care.

The cultural competence movement encourages looking at the perspectives of patients, mainly immigrants, whose experiences and language have put them at a substantial cultural distance from American healthcare.

The Civil Rights Act of 1964, Title VII, now includes an executive order signed in 2000 that requires hospitals and providers receiving certain federal funds, such as Medicaid and Medicare reimbursements, to take reasonable steps to ensure that LEP individuals are able to have meaningful access to vital programs and services.

History of Culturally Competent Care (cont.)

- 2010 Patient Protection and Affordable Care Act does not directly address cultural competence.
- Hospitals and various other providers required to include the needs of LEP consumers when designing programs.

The 2010 Patient Protection and Affordable Care Act does not directly address cultural competence; however, hospitals and some other providers are required to include the needs of LEP consumers when designing programs. All private nonprofit hospitals, for instance, are required to conduct a community health needs assessment every three years to assess the needs of ethnic minority patients and establish a plan to address those documented needs, which can include increased access to interpretation services.

Review Question

Healthcare facilities must provide language assistance to LEP persons without cost according to:

- The American Medical Association.
- Title VII of the 1964 Civil Rights Act.
- The Affordable Care Act.

Answer

Please read and answer the review question on this lesson page.

Impact of Diversity on Quality of Care

- A Korean man presents to the ER.
- He is unconscious, and his chest is covered with red welts.
- The staff assumes the patient's lack of consciousness is related to the welts, and spends crucial time exploring incorrect diagnoses linking the welts and unconsciousness.
- The family speaks no English and no interpreter is available.
- By the time the staff discovers the patient's ailment, it's too late to save him.
- Had they known more about Asian medical practices, they would have ignored the welts, which had been caused by a traditional Asian practice known as "coining" (vigorously rubbing the body with a coin believed to draw the illness out of the body).

Here is an example offered by Dr. Geri-Ann Galanti, a faculty member of the Doctoring Curriculum, UCLA School of Medicine, in an article in *The Diversity Factor.*

A Korean man was brought into the Emergency Room, unconscious, his chest covered with red welts. The staff assumed that the patient's lack of consciousness was related to the red welts and spent many crucial minutes exploring incorrect diagnoses that could link the welts and unconsciousness.

The family spoke no English and no interpreter was available. By the time the staff discovered what the patient was suffering from, it was too late to save him. Had they known more about Asian medical practices, they would have known to ignore the welts, which had been caused by a traditional Asian practice known as "coining," involving vigorously rubbing the body with a coin. This form of healing is believed to draw the illness out of the body, a result that is confirmed by the presence of raised welts.

Impact of Diversity on Quality of Care (cont.)

Possible solutions to ensure medical professionals can give culturally competent care:

- Further education.
- Making sure the staff reflects the culture of the community in which it operates.
- Having translation services available or having access to language assistance services by phone or computer.

What would have made a difference in the case of the Korean patient? Healthcare organizations are working to come up with effective solutions to make sure medical professionals can give culturally competent care. These solutions include further education, making sure the staff reflects the culture of the community in which it operates, having translation services available or having access to language assistance services by phone or computer, and more.

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The Need for Culturally Competent Care

- The U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH), which developed the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS), published in December of 2000.
- Healthcare providers should be familiar with these standards to help make their practices more culturally and linguistically accessible.

The need to "ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner" was recognized by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH), which responded by developing the *National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)*, published in December of 2000.

While these standards are directed at healthcare organizations, individual healthcare providers should be familiar with them in order to help make their practices more culturally and linguistically accessible.

31%

Culturally Competent Care Definition

Culturally competent care standards include:

- Ensuring patients receive effective, understandable and respectful care compatible with their cultural health beliefs and practices, and in their preferred language.
- Medical care staff should hire and promote minorities.
- Staff should receive regular training on culturally and linguistically appropriate service delivery.

Culturally competent care standards include ensuring patients receive effective, understandable and respectful care compatible with the cultural health beliefs and practices they follow, and in their preferred language.

Medical care staff should hire and promote minorities, and all staff should receive regular training on culturally and linguistically appropriate service delivery.

In the example of the Korean man, if the staff had had more training on other cultures' healthcare methods and had better access to language assistance services, the patient may have been saved.

Language Access Services Definition

- Bilingual staff and interpreter services must be provided at no cost to the patient.
- Non-English speaking patients must be given verbal and written notices in their own language informing them of the right to request language assistance.
- Any language assistance service must be assured as competent.
- Written patient materials available and signage posted in the languages most often encountered.
- Healthcare organizations must develop and implement strategic plan to ensure accountability and oversight in these services.
- Organizations must conduct initial and ongoing self-assessments of these activities.
- These can be included in their internal audits.
- Patients' race, ethnicity, and spoken and written language must be collected in health records.

Language access services standards address the need for language assistance service, including bilingual staff and interpreter services at no cost to the patient.

Non-English speaking patients must be provided with verbal and written notices in their own language informing them of their right to request language assistance.

Any language assistance service must be assured as competent. In addition, healthcare organizations must have patient materials available and signage posted in the languages most often encountered.

Organizational support standards ask that healthcare organizations develop and implement a strategic plan to put in place mechanisms for accountability and oversight in these services. They should conduct initial and ongoing self-assessments of these activities and are encouraged to add these to their internal audits.

It must be ensured that data on a patient's race, ethnicity, and spoken and written language are collected in health records and integrated into the information management systems with regular updates.

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Collaborate with Community to Support Competent Care

Healthcare organizations should:

- Keep track of the demographic and cultural profile in their communities.
- Work with their communities to facilitate involvement in culturally competent care.
- Ensure that conflict and grievance resolution processes are sensitive to the various cultures.
- Make public information available to the community about the progress with their efforts in meeting these standards.

Organizations should keep track of the demographic and cultural profile in their community. They also should collaborate with their communities to facilitate involvement in culturally competent care.

The organizations should ensure that conflict and grievance resolution processes are sensitive to the various cultures. Finally, organizations are urged to make public information available to the community about the progress with their efforts in meeting these standards.

If the hospital serving the Korean man had been aware that the community's demographics and cultures included a large number of Koreans, more Korean staff members or a Korean interpreter may have been available to assist in understanding the situation. This simple action would have helped them to avoid the detrimental misunderstanding.

38%

Review Question

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) include:

- A. Culturally competent care standards.
- B. Language access service standards.
- C. Organizational support standards.
- D. Healthcare performance standards.
- E. A, B and C.

Answer

Please read and answer the review question on this lesson page.

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Barriers to Culturally Competent Care

- Ethnic minorities are growing, but healthcare management continues to be largely white and believes in the biomedical model of care.
- Terms like “self-reliance” and “women’s rights” don’t necessarily translate into other cultures.

While it is obvious that culturally competent care is more necessary than ever, it’s also apparent that many barriers exist that block that care.

Although the ethnic minorities are growing in population here, healthcare management continues to be largely white and believes in the biomedical model of care. Terms like “self-reliance” and “women’s rights” don’t necessarily translate into other cultures.

Ethnocentrism and Stereotyping

Barriers to culturally competent care:

- Ethnocentrism – Assuming one's own ethnicity is superior to others'.
- Stereotyping – Generalizing entire cultures or races.
- Racism – The belief that inherent differences among the various human races determine cultural or individual achievement. Usually involves the idea that one's own race is superior and has the right to rule others.

People tend to be ethnocentric and assume their own ethnicity is superior to others'. A large majority of people don't even realize they have this attitude, but if they've grown up in a homogeneous environment with little ethnic or racial diversity, they may subconsciously feel this way.

Another thing that's absorbed by humans is the practice of generalizing or stereotyping various ethnic groups. Some have consciously held attitudes based on overtly racist notions. Ethnocentrism, stereotyping and racism are all huge barriers to culturally competent care.

Case Example

- A 62-year-old female Mexican undergoes bypass graft on her leg.
- Wakes in the recovery room and begins screaming in pain.
- The nurse immediately administers morphine, but to no avail.
- The patient's vital signs and pulse are stable, her dressing has minimal drainage. She appears in good condition.
- The nurse becomes annoys and assumes the patient is a "typical whining Mexican, exaggerating her pain."
- After an hour of cries, the surgical team finds her wound has a large amount of blood pressing on her nerves, causing pain. She is sent back to surgery.
- Stereotyping the patient nearly caused a major complication in the patient's care.

When a 62-year-old female Mexican patient who had a bypass graft on her leg awoke in the recovery room, she began screaming in pain. Her nurse immediately administered the dosage of morphine the doctor had prescribed, but to no avail. He then checked her vital signs and pulse and found that all were stable. Her dressing had minimal drainage. To all appearances, the patient was in good condition.

The nurse soon became annoyed over the patient's outbursts, and stereotyped her as a "whining Mexican female who, as usual, was exaggerating her pain," and took no further action.

After an hour of cries, however, the nurse called the physician. The surgical team opened the woman's wound dressing to find a large amount of blood, which was pressing on the nerves and tissues in the area and causing her excruciating pain. She was immediately sent back to surgery.

Stereotyping Mexican females as "whiners who exaggerate their pain" almost caused a major complication in this patient's care.

Review Question

Generalizing about a culturally different patient is called:

- Ethnocentrism.
- Racial bias.
- Stereotyping.
- All of the above.

Answer

Please read and answer the review question on this lesson page.

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Western Medicine vs. Non-western Approaches to Health

- Biomedical Model of Care: American/western model of care in which disease theory and treatment practices are based on the manipulation of biochemical and physical processes that occur in nature and the human body.
- Many cultures take radically different approaches to health and the processes that maintain and damage health, including:
  - Natural/holistic treatment.
  - Keeping laws of nature in balance.
  - Supernatural beliefs in which good or evil forces are affecting health.
- Understanding how other cultures define health and illness, how healers cure and care for them, and how they maintain wellness is a big step toward being culturally competent.

In America, our Western biomedical model bases disease theory and treatment practices on the manipulation of biochemical and physical processes that occur in nature and the human body.

Many patients, however, come from cultures with radically different approaches to health and the processes that maintain and damage health. These other approaches include natural or holistic treatment, involving keeping laws of nature in balance, and even supernatural beliefs in which good or evil forces are affecting health.

These nonwestern approaches to health should be understood by caregivers as they can come in direct conflict with treatment being prescribed.

Understanding how other cultures define health and illness, how healers cure and care for them, and how they maintain wellness is a big step toward being culturally competent.

52%

Language and Communication

- More than 25 million people in the U.S. are not fluent in English.
- Lack of Americans' fluency in different languages presents major barrier in culturally competent care.
- Difficult to ensure the patient understands diagnoses and treatment instructions without fully understanding each other.

Considering that more than 25 million people in the United States are not fluent in English, the lack of Americans' fluency in different languages is definitely a major barrier in culturally competent care. Healthcare providers cannot make accurate diagnoses or be sure the patient understands treatment instructions if there is little understanding of what one is saying to the other.

The Healthcare Environment

- Can be difficult to find time to develop culturally competent care skills.
- Awareness of cultural differences will make it possible to provide better care more efficiently.

The current frantic pace of the healthcare environment presents another barrier to culturally competent care, as many professionals find it difficult to find the time to develop and practice this new skill. However, in the long run, awareness of cultural differences will make it possible to provide better care more efficiently.

Review Question

What is a major barrier to culturally competent care?

- A. The fast pace of the healthcare environment.
- B. Lack of fluency in other languages.
- C. Learning America's biomedical model.
- D. Stereotyping.
- E. All of the above.
- F. All but C.

Answer

Please read and answer the review question on this lesson page.

60%

Approaches to Competency

- Multiple approaches to developing cultural competency.
- Josepha Campinha-Bacote's model:
  - Healthcare workers should become more aware of their own culture and its influence on healthcare, and then be open to learning about other cultures and models of healthcare through five basic steps.

There are many approaches to developing cultural competency, and many models that can be employed.

One popular model is by Josepha Campinha-Bacote, who says healthcare workers should become more aware of their own culture and its influence on healthcare, and then be open to learning about other cultures and models of healthcare through five basic steps.

We'll go over these five steps, next.

62%

Cultural Desire

Component One: Cultural Desire

- The motivation of the care professional to want to engage in the process of becoming culturally competent.
- Always treat patients with respect and care.

The first component, cultural desire, is defined as "the motivation of the care professional to want to engage in the process of becoming culturally competent." The goal is to always treat patients with respect and care—even those who directly challenge our sense of morals and appropriate conduct.

Cultural Awareness

Component Two: Cultural Awareness

- The self-examination and in-depth exploration of one's own cultural background.
- Understanding your own background better equips you to understand that of others.

The next component is cultural awareness, "the self-examination and in-depth exploration of one's own cultural background."
By becoming fully aware of the components and beliefs of your own background (which includes your socioeconomic group, age group, ethnic group, religion, etc.), you are able to better recognize and understand contrasts between your own culture and those you encounter.

Cultural Knowledge

Component Three: Cultural Knowledge

- The process of seeking and obtaining a sound educational base about culturally diverse groups.
- The goal is to understand the worldview—especially regarding health and illness—of others.

Cultural knowledge is "the process of seeking and obtaining a sound educational base about culturally diverse groups."

A primary goal in seeking this cultural knowledge is to understand the worldview—or explanatory model—of various cultures as described earlier, particularly as they relate to concepts of health and illness.

69%

Cultural Skill

Component Four: Cultural Skill

- The ability to collect relevant cultural data regarding the client's presenting problems as well as accurately perform a culturally-based physical assessment.
- This skill hones the ability to perform a physical assessment that is culturally appropriate.

Cultural skill is the "ability to collect relevant cultural data regarding the client's presenting problems as well as accurately perform a culturally-based physical assessment."

This skill hones the ability to perform a physical assessment that is culturally appropriate, based on information learned from performing a cultural assessment.

Cultural Encounters

Component Five: Cultural Encounters

- The process that encourages the healthcare professional to directly engage in face-to-face interactions with patients from culturally diverse backgrounds in order to become familiar with different cultures.
- Other models of culturally competent care exist; most reflect the ideas of Campinha-Bacote.

Campinha-Bacote's final component is the cultural encounter, which she defines as, "the process that encourages the healthcare professional to directly engage in face-to-face interactions with patients from culturally diverse backgrounds" in order to become familiar with different cultures.

Other models of culturally competent care exist, and most reflect the ideas of Campinha-Bacote's model.

Review Question

To develop cultural competency according to Campinha-Bacote's model, healthcare professionals should:

- Be motivated to learn about other cultures.
- Familiarize themselves with other cultures through face-to-face encounters.
- Learn how to accurately perform a culturally-based physical assessment.
- Understand their own cultural beliefs.
- Obtain, through education, a good base of cultural knowledge.
- All of the above.

Answer

Please read and answer the review question on this lesson page.

Language and Communication

- Linguistically appropriate care is of utmost importance.
- This applies even to those immigrants fluent in English, since occasionally they will translate their words in the filter of their own culture, which could lead to misunderstandings.

The U.S. government, through Title VII and the medical community, has declared that linguistically appropriate care is of utmost importance.

Keep in mind that this can apply not only to non-English-speaking patients, but at times, even to patients who claim a good knowledge of English.
In some cases, immigrants can speak English almost fluently, but still translate the words through the filter of their own culture, which could lead to misunderstandings.

Strategies for Language Assistance

Click the image to be able to download a list of strategies for your go-to resource when working with non-English speaking patients.

These strategies can be used whether or not an interpreter is present.

On this lesson page, you can find some strategies for working with non-English patients of different cultures.

These strategies can be used whether or not an interpreter is present. You may find that an LEP patient has enough language proficiency for the care required, or alternatively, the need for care is too urgent to wait for the services of an interpreter.

Review Question

When speaking with an LEP patient, you should:

- A. Speak slowly.
- B. Speak loudly.
- C. Rephrase and summarize.
- D. Write out everything.
- E. Only A and C.

Answer

Please read and answer the review question on this lesson page.

Nonprofessional Interpreters

- Avoid nonprofessional interpreters, such as the patient's children, other family members and friends.
- Nonprofessional interpreters may not possess the vocabulary to describe symptoms or care procedures, or may withhold important information for cultural reasons.
- If patient refuses professional interpreters, follow your organization's policy for documentation of refusal.

The use of nonprofessional interpreters should be avoided for several reasons. If you rely on the patient's children, other family members or friends to interpret, they may not possess the vocabulary to describe symptoms or care procedures.

Also, they may withhold important information for cultural reasons. The private nature of many health conditions can cause disruption to family and friend dynamics.

In using non-professional interpreters, even if they work in a healthcare facility, you take a risk in trusting their vocabulary to describe symptoms or care procedures. However, some patients may refuse professional interpreters, and in these cases you should follow your organization's policy to document and handle their decision.

Using Professional Interpreters

- Use an interpreter similar in age and gender to the patient.
  - Particularly when discussing sexual issues.
- Brief the interpreter on the situation and describe the key information you need to have conveyed.
- Talk to the patient as you would any patient you encounter; direct your attention to him/her.
- Form a triangle with yourself, the patient and the translator, so that each person can observe the gestures and expressions of the others.

When using interpreters, there are several things that can be done to make the process more efficient and effective. If possible, use an interpreter similar in age and gender to the patient. This may be particularly important when discussing sexual issues where opposite genders or age disparities may be culturally inappropriate.

Before speaking with the patient, brief the interpreter on the situation and describe the key information you need to have conveyed. Even when using an interpreter, continue to talk to the patient as usual, directing your attention to the patient.
It may be useful to form a triangle with yourself, the patient and the translator, if possible, so that each person can observe the gestures and expressions of the others.

Other Strategies for Working with Interpreters

- Be concise. Avoid complex sentences.
- Keep it short. Only speak for one or two minutes then let the interpreter work.
- Be patient. The interpreter must convey information, not just words, in a culturally appropriate way. Many languages are not as direct as English; it could take twice as long to convey the same information in another language.
- Ask the interpreter the best way to present sensitive information, such as bad news or information of a sexual nature, to the patient and family.

Here are some other strategies for working with interpreters:

- Be concise. Avoid complex sentences.
- Keep it short. Only speak for one or two minutes before letting the interpreter work.
- Be patient. Remember, the interpreter must convey information, not just words, in a culturally appropriate way. Many languages are not as direct as English and it may take twice as long to convey the same information in another language.
- Ask the interpreter the best way to present sensitive information, such as bad news or information of a sexual nature, to the patient and family.

Culturally Competent Care: An Overview

SUMMARY

The growing population of ethnic minorities in the U.S. compels the government and healthcare practitioners to provide more "culturally competent" healthcare.

This involves:

- Education on different cultures and their philosophies on healthcare.
- Working with patients from different cultures.
- Avoiding ethnocentrism, stereotyping and racial bias.
- Surveying to identify the demographics and cultures in your community.
- Offering language assistance to non-English-speaking patients.

These measures provide better healthcare for all inhabitants of America.

The growing population of ethnic minorities in the U.S. compels the government and healthcare practitioners to provide more culturally competent healthcare.

This involves educating healthcare professionals on different cultures and their philosophies on healthcare, and working with patients from different cultures. It also calls for avoiding ethnocentrism, stereotyping and racial biases. By following these guidelines, as well as being aware of demographics and cultures in your community, and offering language assistance to non-English-speaking patients, we can provide better healthcare for all inhabitants here, and enjoy a healthier population overall.

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Post-Test Instructions:

You are now ready to complete your course post-test. If you took notes, make sure they are handy.

* Once you take the test it will count as an attempt. Be sure to click 'Grade Test' or your test score will be 0%.

You must pass the test with a score of 80% or higher.

You have completed 0 attempt(s) of Unlimited post-test attempts allowed by your Proctor.

Take Test Now ›

It's now time to take your post-test. You can only proceed if you?ve viewed ninety-percent of the course pages. If you've completed this requirement, click on the "Take Test Now" button.

95%

CORPORATE POLICY & PROCEDURE

	Policy Name: Nondiscrimination of Members
Department: Member Services	Policy Number: MS2
Version: 1	Creation Date: 5/31/2017
Revised Date:	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Sue Goldberg, VP Network and Business Development Date: 6/15/17

POLICY STATEMENT

All Umpqua Health Alliance (UHA) internal and external personnel will comply with federal and State laws pertaining to non-discrimination requirements with regards to its members. All members will be treated fairly regardless of age, ethnicity, race, disability, gender, marital status, religion, etc. (42 CFR §438.100 (b)(2)(3);(d)).

PURPOSE

To ensure that UHA employees and providers treat each member fairly and without judgement or prejudice.

RESPONSIBILITY

Member Services

DEFINITIONS

Internal Personnel: All Umpqua Health employees, providers, and volunteers

External Personnel: Individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities and their workforce.

PROCEDURES

How Members are Notified of Rights

1. UHA's members are entitled to be treated fairly under the state and federal civil rights laws. UHA informs its members of this right by providing this information online and in the UHA Member Handbook which is also mailed to each member when they first become eligible on the health plan.

	Policy Name: Nondiscrimination of Members
Department: Member Services	Policy Number: MS2
Version: 1	Creation Date: 5/31/2017
Revised Date:	Review Date:

2. Members who wish to receive an additional handbook may do so by calling UHA Member Services Department and request another handbook to be mailed to them or they may come into the office and pick it up in person.

How Members Notify UHA of a Grievance

1. Members who wish to report a concern or get more information may contact UHA's Member Services Department, who can provide more information or assist the member in filing a grievance.
2. An individual also has the right to file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights (OCR). Contact that office one of these ways:

Oregon Health Authority (OHA) Office of Equity and Inclusion
Diversity, Inclusion and Civil Rights Manager
421 S.W. Oak St., Suite 750, Portland OR 97204
Fax 971-673-1330 or email OHA.PublicCivilRights@state.or.us
Toll-free phone number: 1-844-882-7889 (voice) or 711 (TTY)

Oregon Bureau Of Labor and Industries (BOLI)
800 N.E. Oregon St., Suite 1045, Portland, OR 97232
www.oregon.gov/boli/CRD/Pages/C_Crcompl.aspx
971-673-0764 (voice) or 711 (TTY)

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Rights
Department: Member Services	Policy Number: MS3
Version: 1	Creation Date: 5/31/2017
Revised Date:	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Sue Goldberg, VP Network and Business Development Date: 06/20/2017

POLICY STATEMENT

Umpqua Health Alliance (UHA) is dedicated to providing the best possible care and experience for its members. Therefore, UHA, along with its subcontractors, will comply with all federal and State laws regarding member rights as described in the UHA Member Handbook as well as the Oregon Administrative Rules (OAR) 410-141-3320 and Coordinated Care Organization (CCO) Contract Exhibit B, Part 3.

PURPOSE

To ensure that UHA members, employees and providers are aware of the Health Plan members' rights under Medicaid law.

RESPONSIBILITY

Member Services

DEFINITIONS

Care team: the group of providers, community members, and/or volunteers assigned to work with the member.

External personnel: Individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities, and their workforce.

Internal personnel: All Umpqua Health employees, providers, volunteers.

Member: a Medicaid beneficiary who is currently enrolled in Umpqua Health Alliance or who may potentially enroll.

	Policy Name: Member Rights
Department: Member Services	Policy Number: MS3
Version: 1	Creation Date: 5/31/2017
Revised Date:	Review Date:

PROCEDURES

1. Members are informed of their rights through the Member Handbook, which is provided to members upon enrollment and when requested.
2. In the event an individual feels that one of their rights have been violated, the member may contact UHA's Member Services Department, in which a grievance will be filed.
    a. UHA's Clinical Engagement Department periodically review grievances pertaining to Member Rights.
3. In accordance with 42 CFR §438.100 (a)(2), internal and external personnel are required to comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure they observe and protect those rights. Failure to do so will result in corrective actions, up to and including termination of employment or contract.
4. UHA members are entitled to the following rights as outlined in OAR 410-141-3320 and UHA's CCO Contract Exhibit B, Part 3:
    a. To be treated with dignity and respect with due consideration for his or her privacy;
    b. To be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;
    c. To choose a Primary Care Provider (PCP) or service site, and to change those choices as permitted by UHA's administrative policies;
        i. For a member in a service area serviced by only one Prepaid Health Plan (PHP), any limitation UHA imposes on his or her freedom to change between PCPs or to obtain services from non-participating providers if the service or type of provider is not available with the UHA's provider network may be no more restrictive than the limitation on disenrollment under CCO contract Exhibit B, Part 3, Section 6.b.
    d. To refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;
    e. To have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;
    f. To be actively involved in the development of their treatment plan;
    g. To be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments, including alternative treatments;
    h. To consent to treatment or refuse services (i.e. medical, surgical, substance use disorders, and/or mental health treatment) and be told the consequences of that decision, except for court ordered services;
    i. To execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 -- Patient Self-Determination Act;

j. To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
k. To have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;
l. Have in place a mechanism to help members and potential members understand the requirements and benefits of UHA's plan and develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280 and 410-141-3300;
m. To receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;
n. To make certified or Qualified Health Care Interpreter Services available free of charge to each potential member and member. This applies to all non-English languages, not just those that Oregon Health Authority (OHA) identifies as prevalent. UHA shall notify its members and potential members that oral interpretation is also available free of charge for any language and that written information is available in prevalent non-English languages in service area(s) as specified in 42 CFR 438.10(c)(3) . UHA shall notify its members how to access oral interpretation and written translation services;
o. To receive oversight, care coordination and transition and planning management from UHA to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;
p. To receive necessary and reasonable services to diagnose the presenting condition;
q. To receive integrated person centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;
r. To have a consistent and stable relationship with a care team that is responsible for comprehensive care management;
s. To receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member’s care team to provide cultural and linguistic assistance appropriate to the member’s need to access appropriate services and participate in processes affecting the member’s care and services;
t. To obtain covered preventive services;

u. To have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;
v. To receive a referral to specialty providers for medically appropriate covered coordinated care services, in the manner provided in the CCO's referral policy;
w. To have a clinical record maintained which documents conditions, services received, and referrals made;
x. To have access to one's own clinical record, unless restricted by ORS 179.505 or other applicable law and to request that the records be amended or corrected as specified in 45 CFR Part 164;
y. To transfer of a copy of the clinical record to another provider;
z. To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
aa. To receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
bb. To be able to make a complaint or appeal with UHA and receive a response;
cc. To request a contested case hearing;
dd. To receive a notice of an appointment cancellation in a timely manner;
ee. Ensure members are aware that a second opinion is available from a qualified health care professional within the provider network, or that UHA will arrange for members to obtain a qualified health care professional from outside the provider network, at no cost to the members;
ff. Ensure members are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that a member has a right to report a complaint of discrimination by contacting UHA, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR);
gg. Provide notice to members of UHA's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A;
hh. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270;
ii. Allow each member to choose his or her health professional from available participating providers and facilities to the extent possible and appropriate. For a member in a service area serviced by only one Prepaid Health Plan (PHP), any limitation UHA imposes on his or her freedom to change between PCPs or to obtain services from non-participating providers if the service or type of provider is not available with the UHA's provider network may be no more restrictive than the limitation on disenrollment under CCO contract Exhibit B, Part 3, Section 6.b;

jj. Require, and cause its participating providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand;

kk. Furnish to each of its members the information specified in 42 CFR 438.10(f)(2)-(3), and 42 CFR 438.10(g), if applicable, as specified in the CFR within 30 days after the UHA received notice of the member's enrollment from OHA or for members who are Fully Dual Eligible, within the time period required by Medicare. UHA shall notify all members of their right to request and obtain the information described in this section at least once a year;

ll. To ensure members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion;

mm. Ensure, and cause its participating providers to ensure, that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the UHA, its staff, subcontractors, participating providers or OHA, treat the member. UHA shall not discriminate in any way against members when those members exercise their rights under the OHP;

nn. Ensure that any cost sharing authorized under the CCO contract for members is in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.

oo. Notify members of their responsibility for paying a co-payment for some services, as specified in OAR 410-120-1230; and

pp. UHA may use electronic methods of communications with members, at their request, to provide member information if:

i. The recipient has requested or approved electronic transmittal;
ii. The identical information is available in written form upon request;
iii. The information does not constitute a direct member notice related to an adverse Action or any portion of the grievance, appeals, contested case hearings or any other member rights or member protection process;
iv. Language and alternative format accommodations are available; and
v. All HIPAA requirements are satisfied with respect to personal health information.

CORPORATE POLICY & PROCEDURE

	Policy Name: Written Notices to Members
Department: Member Services	Policy Number: MS4
Version: 1	Creation Date: 6/5/2017
Revised Date:	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Sue Goldberg, VP Network and Business Development Date: 6/15/17

POLICY STATEMENT

To ensure the best quality of services to members, Umpqua Health Alliance (UHA) shall develop and provide written informational materials and educational programs as described in Oregon Administrative Rule (OAR) 410-141-3280 and OAR 410-141-3300. UHA shall also notify all Members of their right to request and obtain the information described in this section at least annually. These materials and programs shall be in a manner and format that may be easily understood and tailored to the backgrounds and special needs of members and potential members.

PURPOSE

To ensure that UHA's Member Services Department provides the required written materials within the contracted timeframes.

DEFINITIONS

None

RESPONSIBILITY

Member Services

PROCEDURES

1. Member Handbook and Member ID card
    a. UHA shall furnish to each of its members with a UHA Member Handbook that contains all required information as outlined in the Oregon Health Authority's (OHA) Coordinated Care Organization (CCO) Contract with UHA, within 14 days of the member's effective date of coverage with UHA.

	Policy Name: Written Notices to Members
Department: Member Services	Policy Number: MS4
Version: 1	Creation Date: 6/5/2017
Revised Date:	Review Date:

i. All new and re-enrolling UHA members shall be mailed a Member ID card and Member Handbook within 14 days of eligibility information confirmed by the Oregon Health Authority's (OHA) initial 834 listing with UHA.
    1. If requested by member, UHA will deliver the Member Handbook electronically as consistent with Exhibit B, Part 3, Section 2(s)(t) of the OHA CCO Contract.

ii. UHA shall review the Member Handbook annually and revise it as needed to stay current with all requirements.
    1. UHA shall notify all existing members of each revision and its location on UHA's website
        a. Upon request, to UHA will mail members a printed copy of the handbook.

2. Notices to Members and Timeframes
    a. UHA shall provide written notice to affected members of any material change pertaining to program, policies and procedures that are reasonably likely to impact the affected member's ability to access care or services from UHA's participating providers.
        i. Such notices shall be provided at least 30 days prior to the intended effective date of those changes, or as soon as possible if the participating provider(s) has not given UHA sufficient notification to meet the 30 day notice requirement.
        ii. The OHA Materials Coordinator will review and approve such materials within two business days.
        iii. Member requests for written materials are completed and mailed out same day or by Friday of the current week.
    b. Requests for alternate formats will be further tracked in the Requests for Alternate Format Materials Log (see UHA policy MS5- Requests for Interpreter or Alternative Format).
    c. Mail Log sheets will be used to track the mailing or postmark dates to ensure compliance.

CORPORATE POLICY & PROCEDURE

	Policy Name: Requests for Interpreter or Alternative Format Policy
Department: Member Services	Policy Number: MS5
Version: 2	Creation Date: 6/5/2017
Revised Date: 4/16/19	Review Date:
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Harvard ☐ Umpqua Health - Newton Creek ☐ UHA Community Activities ☐ Professional Coding and Billing Services	☐ Umpqua Health Management ☐ Physician eHealth Services ☐ Umpqua Health Network ☐ ACE Network
Signature: Approved By: Michael von Arx, Chief Operating Officer	Date: 4/17/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) and its subcontractors shall ensure members and potential members understand that Certified or Qualified Healthcare Interpreter Services and alternative formats of written UHA materials are available to them and free of charge. Thus appropriately tailoring communications to those with special needs who, for example, are visually limited or have limited reading proficiency.

PURPOSE

The purpose of this policy is to ensure that all members and potential members have access to available communications, outreach and services in alternative formats as well as languages that meet member and potential member needs as required by federal and state law as well as by Oregon Health Authority's (OHA) Coordinated Care Organization (CCO) contract.

RESPONSIBILITY

Member Services

DEFINITIONS

Alternative Formats: means of communication provided free of charge to the Member or Potential Member, in English and non-English languages, such as large print, Braille, audiotape, oral presentation, and/or electronic format in accordance with Title II of the American with Disabilities Act and Title VI of the Civil Rights Act.

Subcontractor: Any participating provider or any other individual, entity, facility, or organization that has entered into a subcontract with UHA or with any subcontractor for any portion of the work under the CCO contract.

UMPQUA HEALTH

CORPORATE POLICY & PROCEDURE

Policy Name: Requests for Interpreter or Alternative Format Policy	
Department: Member Services	Policy Number: MS5
Version: 2	Creation Date: 6/5/2017
Revised Date: 4/16/19	Review Date:

PROCEDURES

1. Members are informed at enrollment, or when seeking to enroll, that they may seek assistance obtaining an interpreter (including a telephonic oral interpreter) or alternative formats of UHA's written materials by doing the following actions:
    a. Make a request by phone, members and potential members may call UHA Member Services at 541-229-4842 / TTY 541-440-6304.
    b. Make a request in person either through UHA Member Services or the provider.
    c. Make requests through any other reasonable methods, such as but not limited using the patient portal to communicate needs..
2. Member Services staff will then contact UHA's interpreter service as described in the Procedure for Interpreter Alternative Format.
3. Member Services staff will confirm request for the alternate format or language and the item requested.
4. Member Services staff will track all requests using the Requests for Alternate Format Materials Log (see sample below).

Sample Requests for Alternate Format Materials Log

Date of Request	Member Service Staff Who Received Request	Member ID Number	Item(s) Requested	Format Requested	Language Requested	Date Item Sent	Method Used to Provide Materials	Email Address Material(s) Sent to…

Attachment 10 — Social Determinants of Health & Health Equity

A. Community Engagement

A.1 Evaluation Questions

A.1.a. Did Applicant obtain Community involvement in the development of the Application?

Yes, the Community Advisory Council (CAC) was consulted on the Community Engagement Plan. The CAC viewed the Community Engagement Plan, as well as some of the corresponding tables and provided input on the process. The CAC represents a diverse array of community representatives, ensuring a strong community voice on the Community Engagement Plan.

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.

UHA's community engagement plan is attached as part of the required documentation.

A.2. Requested Documents

We have included the following requested documents: **RFA Community Engagement Plan** with all required elements and **RFA Community Engagement Plan Required Tables.**

B. Social Determinants of Health and Health Equity (SDOH-HE) Spending, Priorities, and Partnership

This section describes how your current and future plans align with the state's goals on SDOH-HE spending:

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. SDOH-HE Bonus Fund Strategy by OHA 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.

B.1 Informational Questions

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.

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.

Yes, Umpqua Health Alliance holds memorandums of understanding (MOUs) with multiple

organizations that address SDOH, including housing partners. Each of the MOUs require the applicant to complete a specific scope of work, plus submit two interim reports and a final report to UHA. SDOH-HE partners apply for the funding through a defined CAC process, during which the CAC and UHA staff determine the scope of work. Current agreements include:

- Increasing SNAP benefits up to $10 per customer visit at a local farmers' market
- Funding to support a program that provides oral health to pregnant women
- Funding to provide 22 raised garden beds for a housing complex that houses seniors, people with disabilities and families living below the poverty line
- Funding to help establish primary care services within a behavioral health facility
- Funding to help establish a clinic in Drain, OR
- Funding to help establish access and case management of school-based trauma-informed intervention, social emotional education, skill building and therapeutic services to children who attend Phoenix Charter School and their families
- Funding that has helped to prepare a lot for a tiny home village in Roseburg, OR
- Funding supports Total Health Improvement Project classes that teach whole foods/plant-based eating and natural movement lifestyle classes free of charge
- Funding to help provide meals to seniors and people with disabilities through our local meals on wheels chapter
- Funding that will be used to purchase equipment that allows for on-site hearing and vision screenings at UCAN and Head Start

These examples are just a few of the MOUs that UHA has entered into in 2019. UHA has additional MOUs from previous years with entities that address social determinants of health.

UHA is working with Valiant Seed in an effort to address homelessness in Douglas County. UHA provided funding to prepare a lot in Roseburg to serve as a tiny home village. This tiny home project will initially house four individual homes, with the capacity for future expansion. This tiny home village follows the housing first model, with a preference given to women who have experienced trauma. In addition, UHA utilizes HRS funds to provide temporary housing (motel) for individuals under case management for interventions that improve health outcomes. This fills gaps until more permanent housing options are available with our community partners.

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. 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.

UHA does not currently have milestones or metrics in place related to SDOH-HE. Much of UHA's spending to address SDOH-HE comes through community benefit investments. UHA has utilized its Community Advisory Council (CAC) to administer and allocate funds in accordance with UHA's Community Health Improvement Plan (CHP). The CHP application requires that projects have *specific, measurable outcomes*, and defined outcome criteria. The outcome criteria may be different for every project, but should include a specific way to measure the level of performance or achievement from the activity or services the organization provided. Interim reports are required for project-related investments, including pre- and post-test metrics of

success. Final reports from each project are analyzed through CHP progress reports each year. UHA carefully targets its programs to ensure that costs incurred in HRS are really addressing SDOH-HE priorities in the community. Moving forward, all programs and projects that receive funding through UHA's community benefit initiative funding stream must align with at least one of the five key focus areas identified in UHA's most recent CHP.

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.

UHA's CAC does play a role in tracking, reviewing, and determining how SDOH-HE spending occurs, however a more formal policy needs to be created to fully capture the role the CAC plays in this process. The UHA CAC is crucial to UHA's work with community benefit investments addressing SDOH-HE. The CAC oversees the Community Health Assessment and CHP, and also oversees the Community Health Improvement Plan funding process. UHA's CAC is tasked with administering and allocating funds in accordance with UHA's CHP, which serves as UHA's approach in funding the community benefit initiatives for SDOH-HE as part of our global HRS strategy. This allows UHA's CAC to identify the community needs. CAC members are also responsible for reviewing final and interim reports to track and review community benefit initiative funding. Portions of this work are captured in the attached CE02 - Health Related Services policy, however further elements are needed to fully define the CAC's role.

B.1.d. Please describe how Applicant intends to award funding for SDOH-HE projects, including avoiding potential conflicts of interest, creating a transparent and equitable process, and demonstrating outcomes:

- **How Applicant will guard against potential conflicts of interest;**
- **How Applicant will ensure a transparent and equitable process;**
- **How Applicant will demonstrate the outcome of funded projects to Members, SDOH-HE partners, and other key stakeholders in the Community.**

UHA currently has a process for awarding funding for SDOH-HE projects that relies on UHA's CAC members to drive the funding decisions. UHA's CAC members help UHA staff disseminate the funding application, and UHA CAC members review all applications. The applications are discussed in a subcommittee meeting. All CAC members are welcome to join the subcommittee that reviews all applications and makes funding recommendations. All CAC members must complete a conflict of interest disclosure form. During the funding discussions, all CAC members affiliated with the organization seeking funding that is being discussed are asked to leave the room, to guard against potential conflict of interest. All CAC members affiliated with the organization seeking funding that is being discussed are also not allowed to vote on the funding for that particular project or program. While the subcommittee meeting is a closed meeting, the CAC then votes on the subcommittee's funding recommendation at a meeting in public, ensuring a transparent and equitable process. UHA requests one final and two interim reports from all partners receiving funding for SDOH-HE initiatives. All projects have *specific, measurable outcomes* and a defined outcome criteria that is captured in these reports. UHA then prepares a public report regarding the outcome of these funded projects. The report is reviewed by CAC members both via email and in person at a CAC meeting as well as UHA Board members, and is also presented to the public at a CAC meeting and is available on UHA's website.

B.1.e. For the statewide housing priority only: please provide proposed metrics for assessing the impact of investments in this area.

UHA proposes that a housing investment metric would assess impacts using a gross rent savings index for all individuals impacted by investments in housing, such as the following equation:

Property Price/Gross Annual Savings in Rent = Gross Rent Savings Index

As an example, UHA has previously worked with an agency known as Valiant Seed to establish a tiny home village in Roseburg, the county seat of Douglas County. Individuals who will live in this village will not be asked to pay rent. In Douglas County, the average rent is $629 per month, for an annual cost of $7,548. UHA has provided $63,997 for this project, which features four individual dwellings. Each dwelling represents the $7,548 in savings, for an average total amount of rent saved at $30,192. This equation would be: $63,997.50/$30,192 = 2.1

The metric could establish the Gross Rent Savings Index numbers. Though this proposed metric is simply a rent saving, the additional income would represent increased opportunity to use healthy options. This saving in housing represents additional income for UHA members. This is money these individuals can spend on items that would impact their overall health, and could also reduce stress for individuals facing financial hardships.

B.2. Evaluation Questions

B.2.a. Please describe the criteria Applicant will apply when selecting SDOH-HE partners.

The CAC selects SDOH-HE partners using the following criteria. Organizations must:

1. Be designed to improve health quality.
2. Increase the likelihood of desired health outcomes in a manner that is capable of being objectively measured and produce verifiable results and achievements.
3. Be directed toward either individuals or segments of members, or provide health improvements to the population beyond those enrolled without additional costs for the non-members.
4. Be based on any of the following:
    a. Evidence-based medicine.
    b. Widely accepted best clinical practice.
    c. Criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

The partner must also have a project or program that is related to UHA's Community Health Improvement Plan key focus areas. These key focus areas are currently: access; addictions; mental health; parents and children; and healthy lifestyles.

B.2.b. Please describe how Applicant will broadly communicate the following information to the public and through its network of partners: its SDOH-HE spending priorities, the availability of funding for projects, how interested parties can apply for consideration, and the project selection process.

UHA uses several ways to communicate its spending priorities, availability of funding for projects, how interested parties can apply for consideration, and information regarding the project selection process for SDOH-HE funding. First and foremost, UHA relies on CAC

members to help disseminate information regarding its SDOH-HE spending priorities, the availability of funding, how interested parties can apply for consideration, and the project selection process. CAC members represent and have good connections with a wide variety of local community organizations and populations. UHA also releases information to local media and posts information to UHA's website and social media accounts. UHA staff and CAC members have also appeared on local radio and television shows, as well as disseminated information at community partner meetings. The information is also shared at CAC meetings, which are held in public.

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.

UHA requires SDOH-HE partners submit a final report, as well as two interim reports, that detail expenses and outcomes for any projects and programs that received funding from UHA. The CAC also establishes guidelines for the interim and final reports, requesting specific information regarding outcomes, outputs, and general project/program information.

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.

See the attached Community Engagement Plan Required Tables, Table 5.

C. Health-Related Services (HRS)

C.1 Informational Questions

C.1.a. Please describe how HRS Community benefit investment decisions will be made. Include 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.

Health-related services (HRS) are non-covered services under Oregon's Medicaid State Plan intended to improve care delivery and overall member and community health and well-being. HRS are primarily designed to meet at least one of the following criteria consistent with 45 CFR 158.150:

- **Improve health outcomes compared to a baseline and reduce health disparities among specified populations;**
- **Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;**
- **Improve patient safety, reduce medical errors, and lower infection and mortality rates;**
- **Implement, promote, and increase wellness and health activities;**
- **Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set forth in 45 CFR 158.151 that promote clinic community linkage and referral processes or support other activities as defined in 45 CFR 158.150.**

UHA identifies and provides health-related services (HRS) addressing social determinates of health to improve health outcomes and alleviate health disparities.

Eligibility & Application Process: For community benefit investments, UHA has used its CAC to administer and allocate funds. UHA's procedures for implementing the CHP allows the CAC to identify the community needs and fund the community benefit investment portion of the HRS.

The CHP Program application identifies who is eligible to apply (including schools, non-profit

agencies, community partners and any entity seeking funding for a project or program that aligns with UHA's CHP), how to apply for funding, and the process on how the funds are awarded. CAC members are incredibly involved in the entire process by reviewing the submitted applications. CAC members revise and approve the initial application, aid in promoting the funding availability, review all applications and make funding recommendations to the UHA Board for funding. In addition, the CHP application requires that projects have *specific, measurable outcomes*, and defined outcome criteria. The outcome criteria may be different for every project, but should include a specific way to measure the level of performance or achievement that occurred because of the activity or services the organization provided. In 2019, UHA is increasing the funds (to $400,000) allocated to the CHP Program.

HRS Spending and CHP Priorities: The CHP has used HRS to fund numerous community wide programs addressing social determinants of health (SDOH) to improve health outcomes and alleviate health disparities. HRS are applied to areas demonstrating the greatest needs of the community. The CHP is currently focused on access to care, addictions, mental health, parents and children, and healthy lifestyles. The following programs exemplify how these areas of focus translate into programs funded as a community benefit investment through UHA's CHP:

- **Healthy Lifestyles:** Some current examples are Alternative Health Classes that teach yoga, meditation and mindfulness; Total Health Improvement Program for healthy lifestyle education; the Kitchen Garden Project that provides raised garden beds and gardening education to families identified as being furthest from opportunity; and the Mobile Food Market mobile food pantry for areas identified as food deserts.
- **Access to Care:** Some current examples are co-locating primary care into a behavioral health setting, providing funding for an area Federally Qualified Health Center to open a new clinic in a rural part of UHA's service area, and providing equipment to the area Head Start for on-site hearing and vision screenings.
- **Addictions:** Some current examples are the Opioid Treatment Program which provides outpatient services, the New Day Program for pregnant women struggling with substance abuse, or tobacco cessation counseling programs.
- **Mental Health:** Some current examples are a training for staff at UHA's LMHA in Applied Suicide Intervention Skills Training (ASIST) which will result in four ASIST trainings for community members; the Chadwick Clubhouse that serves as a space for people with mental illness to gather and learn about community resources; and a project to establish school-based trauma-informed intervention, social-emotional education, skill building and therapeutic services to children attending an area charter school.
- **Parents and Children:** Some current examples are parent education opportunities, a juvenile diabetes outreach program that helps children manage diabetes and other chronic conditions, a project that provides oral health education and items (including a three month supply of Xylitol) to pregnant women, and the Food Hero at the Farmers' Markets which encourages youth to attend farmers' markets and eat more fruits and vegetables.

Some programs address multiple categories of community need. For example, the following CHP Programs assisted with food, other social resources, or housing support:

- Increasing SNAP benefits at area farmers' markets
- Friendly Kitchen/Meals on Wheels of Roseburg

- Tiny Home Village
- Adverse Childhood Experiences Science and Trauma Informed Care Practices
- Health and Safety Education and Training for Childcare Professionals and Early Learning Educators
- A comprehensive calendar of healthy activities through summer 2019 through a project known as KickStart Douglas County

Flexible Services: At an individual level, UHA engages members to address a variety of needs that improve health outcomes. Providers are encouraged to submit requests for individual members for qualifying Flexible Services which are reviewed by case management. Flexible Services have also historically been used to improve access to health care through transportation benefits, or items specific to members' needs to improve their health quality, such the following:

- Home and living environment items, or improvements not otherwise covered by 1915 Home and Community Based Services authorities
- Non-Durable Medical Equipment (DME) items to improve mobility, access, hygiene, or other improvements to address a particular health condition such as an air conditioner, athletic shoes, or other special clothing
- Transportation not covered under State Plan benefits, including transportation for non-medical purposes;
- Housing supports related to social determinants of health, including temporary housing or shelter, utilities, or critical repairs;
- Food vouchers to fill a gap before other assistance is available to members;
- Providing cell phones to members discharged from the hospital and Emergency room or in a defined program (New Day) to ensure communication for follow-up care, thus avoiding readmission or deterioration of status. (We strive to replace these interim phones with more permanent one through federal programs.)
- Equipping special needs children with assistive devices on recommendation of schools and therapists (e.g. weighted blankets for autism);
- Gym memberships for lifestyle improvements in members with obesity, diabetes, or musculoskeletal conditions when demonstrated to benefit outcomes.

Community Benefit – Efficiency and Quality: UHA understands that supporting methods to improve efficiency, providing Quality Improvement assistance and CCO payments will help improve the efficiency and quality of services delivered. By supporting UHA's provider panel through targeted HRS spending, UHA is able to ensure efficient and quality service delivery:

- HRS funds support a community electronic health record (EHR) to improve care coordination across many providers and to promptly and efficiently access medical records. UHA is also able to leverage this tool to review medical records during activities to identify improper payments.
- HRS funds are used to develop and maintain information (Inteligenz) that allows providers to access up-to-date information to better manage their attributed members.
- HRS is used to reduce unnecessary hospital readmissions while decreasing costs,

avoiding the financial stressors within the hospital/ health plan partnership and to meet the cost management goals of the plan while increasing the quality of care provided to our UHA and ATRIO members through its Transitional Care team. The Transitional Care Model (TCM) emphasizes identification of patients' health goals; design and implementation of a streamlined plan of care; and continuity of care across settings and between providers throughout episodes of acute illness (e.g., hospital to home). Under this model, care is both delivered and coordinated by the registered nurse in collaboration with patients, their family caregivers, physicians, and other health team members. The TCM supplements care provided to patients in the hospital and substitutes for care provided by professional nurses in patients' homes. TCM benefits include:

  - Reduces Risks by improving the quality of documentation, maintaining security and integrity of data, checks for drug interactions, helps to analyze payer relationships, and helps keep documentation and coding in compliance with laws.
  - Improves Quality by improving documentation, presenting and managing protocols, tracking and summarizing indicators, alerting providers, and helping to track recalls.

- Five organizations have undergone policy changes related to trauma-informed care and integration of ACEs practices through three pilot projects. At the Battered Persons' Advocacy, Cow Creek Health & Wellness Center, and Phoenix Charter School, 295 people were trained by the Creating Community Resilience (CCR) team. Though UHA's funding for this project is complete, the work will continue. The three pilot sites will complete organizational assessments, identify a total of 30 staff members to participate in a 5-day training, and complete an on-site consultation with the Sanctuary Institute.
- Through the Healthy Households Home Visiting Project, funds are used to extend the length of home visits by Family Development Center staff. This extended time allowed a health component to be added to the home visits and allowed training on health-related topics through parent education curriculum.
- UHA is creating the following positions to help increase efficiency and improved quality in service delivery: three behavioral health/substance use disorder coordinators, a severe and persistent mental issue coordinator, a behavioral health director, and one traditional health worker.

D. Community Advisory Council membership and role

D.1. Informational Questions

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.

UHA will use the Physical Health Service Delivery by Gender and Race-Ethnicity report to define the demographic composition of Medicaid members in UHA's service area. This report contains a data snapshot and reflects only those enrolled or eligible on the 15th of every month.

D.2. Evaluation Questions

D.2.a. Applicant will submit a plan via the RFA Community Engagement Plan for engaging CAC representatives

See the attached **Required Community Engagement Plan Tables** for details on CAC Representatives.

E. Health Equity Assessment and Health Equity Plan

E.1. Informational Questions

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.

UHA currently coordinates with our county mental health agency, Adapt, and our provider network will be incorporated in their health training implementations. Adapt will work with UHA to provide training, skills, and other tools to providers in our community to enhance patient care and restore hope and healing. Specific to addressing health equity, Cliff Coleman, MD, MPH from OHSU, speaks to UHA's communities about culturally and linguistically appropriate services (CLAS) to improve care and appropriately handle cultural biases during individual treatment. Dr. Coleman provides a two-part training, beginning with a two-hour didactic session (to raising awareness and knowledge of CLAS) and then followed by a two-hour skill-building workshop (to promote behavior change).

In 2018, UHA collaborated with the DCO and Ford Family Foundation to financially support a community training by Dr. Ken Ginsburg, MD, MS, Ed, with the topic of ACEs and creating resiliency. In addition to the Implicit Bias and Poverty trainings, UHA is committed to developing trainings around SDOH and barriers to care. While UHA does not currently mandate that our network of contractors specifically complete health equity training, UHA is developing training modules for our provider network and subcontractors in this area. UHA will incorporate training materials, tracking charts, and workshops soon to enhance these relationships.

UHA contracts with a DCO to provide dental care for its members. To ensure cultural competency, the DCO requires all primary care dentists and staff to complete the Bridges Out of Poverty Training; a framework for understanding poverty, for service providers whose daily work connects them with the lives of people in poverty. They also have a Cultural Competency Training focused on being aware of one's own culture and factors that may influence the culture of others. It is presented by a certified trainer from the Cross-Cultural Health Care Program.

E.1.b. Please describe Applicant's capacity to collect and analyze REAL+D data.

UHA has three data streams for REAL+D:

(1) UHA-administered HRA survey: the survey tool is used to collect the data, which is analyzed and shared with several sub-departments within Clinical Engagement.

(2) UHA receives data from OHA Dashboard monthly; this data is loaded into UHA's Business Intelligence Platform and used to manage complex patient populations, specifically SPMI.

(3) OHA's sends data using the 834 file format to PH Tech; UHA case management and provider network have access to this data set.

E.2. Evaluation Questions (Health Equity Assessment)

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.

UHA is engaged with many Patient-Centered Primary Care Homes (PCPCH) in Douglas County. The clinics qualifying as a PCPCH have a focus on standards of care to be accessible,

accountable, comprehensive, continuous, coordinated, and patient and family centered. A PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice and translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.

UHA utilizes Community Integration Manager (CIM), a web-based platform, to house all member eligibility, demographics, and language information, prior authorization requests, and claims processing. This system collects member race and ethnicity information provided by OHA and is available to all UHA staff and providers. CIM documents and statistically tracks any communication assistance or unique member needs, plus provision of those services, such as:

- A preferred language for discussing health care
- Sensory communication needs
- Limited English proficiency (EP)
- The need to be addressed by any name or gender preferred
- Have auxiliary aide available at the Member Services department
- Any other need that affects care

UHA coordinates care services for all members; arranging for services to be provided by non-participating referral providers when necessary. UHA uses a multipronged approach to engaging members in culturally and linguistically appropriate ways:

- Use qualitative methods to identify members with SDOHE and if possible engage the member in the preferred communication method
- Proactively identify providers who are sensitive to the concerns of LGBT members or who can accommodate a specific communication, cultural, or other unique need.
- Provide certified or qualified interpreter services in person at UHA administrative offices, especially those of member services and complaint and grievance representatives
- Include Traditional Health Workers (THWs) as part of the member's primary care team to help with health plan navigation as needed
- Distribute multilingual member material announcing the availability of communication and language assistance services (as described below).

For all member materials, UHA also strives to use plain language and continues to educate staff and monitor delegates. All member materials are approved by OHA, including OHA required templates that are adapted for CCO use; OHA reviews for accuracy and readability requirements. In 2019, UHA appeal and grievance staff attended a health literacy conference which provided interactive workshops and resources. The event focused on a variety of factors that impact health literacy and offered insight on poverty, youth in foster care, using the voice of the community, and raising awareness for health literacy issues in the community and within organizations.

UHA's DCO is currently participating in the Oregon Accountable Health Communities (AHC) project. Through this project, select staff model dental practices that will screen OHP members for health-related social needs and facilitate referrals based on screening responses. If successful, we plan to roll this program out statewide. Additionally, the DCO is nearing connection to Unite Us, a software program that facilitates referrals related to SDOH.

The DCO is always looking to improve care coordination processes, and the DCO is implementing an intelligent decision-making tree based off the direction of its new Health Equity and Special Populations Manager and the Vice President of Clinical Services. This decision tree

will be developed in 2019 for implementation by 3rd quarter of 2019. The goal of this is to increase efficiencies and ensure that all members access care in an easy and timely manner.

UHA is committed to providing high-quality interpreter services for our non-English speaking and sight- or hearing-impaired members. To ensure all members have access to an interpreter at any time, UHA works with several organizations specializing in interpretation services including: Certified Language International, Passport to Languages, and Language Line Solutions. Many contracted dental provider offices also have a staff member or a provider in the office who is bilingual. Regardless, all providers can access the interpreter services listed above. The DCO is also able to provide video interpreting in its staff model dental practices by utilizing bilingual customer service staff.

UHA and the DCO provides translation of new member welcome packets into prevalent languages and audio disk, large print, and braille upon request or if staff identify the need through other data, records, or interactions. Materials requested by a member can be translated into their non-prevalent language. Educational brochures can be translated as well.

UHA accounts for demographic reports and appeals and grievance data. This information allows UHA to identify needs for culturally competent care, education, and accommodations. Data is reviewed across all service types established by the appeal and grievance state requirements, which provide specific categories related to discrimination and cultural issues. Any complaints involving discrimination are investigated and responded to, consistent with both state requirements and Section 1557 of the Patient Protection and Affordable Care Act.

While any complaints suggesting a lack of culturally or linguistically appropriate services are taken very seriously, UHA also understands the need for a proactive approach to support members, providers, and the overall community. Staff have received cultural competency training and have been educated on the available resources.

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.

To provide equal employment and advancement opportunities to all individuals, employment decisions at UHA are based on merit, qualifications, and abilities. UHA does not discriminate in employment opportunities or practices on the basis of race, color, religion, gender (sex) national origin, age, veteran status, sexual orientation, gender identity, disability, genetic information or any other characteristic protected by applicable law.

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.

UHA is committed to providing high-quality interpreter services for our non-English speaking and sight- or hearing-impaired members. To ensure all members have access to an interpreter at any time, UHA works with several OHA-certified organizations specializing in interpretation services including: Certified Language International (CTL), Passport to Languages, and Language Line Solutions. UHA contracts with CTL for the provision for interpretive services by

telephone and remote video. CLI meets the new Joint Commission Standards; are fully compliant with HIPAA, HITECH, and DNV Healthcare standards; are certified for PCI compliance; and are Safe Harbor certified. CTL is available to translate for medical, behavioral health, or dental care visits, and home health visits. The interpreting service customers are connected to interpreters 24/7 and 365 days a year. Many contracted dental provider offices also have a staff member or a provider in the office who is bilingual in addition to the translation services.

UHA Member Services, Care Managers or Providers can all arrange for a translator when a member needs assistance. Providers and members are informed of the availability of these services through the Provider and Member Handbooks and the Member Services department. UHA members can also bring someone with them to their appointments.

UHA uses CIM to house member information such as race and language. UHA tracks when a different format or language is requested. All needs for communication assistance or any unique member specific needs' as well as the provision of those services, will be documented in CIM and tracked statistically. Reports and analysis of appeals and grievance data also allows UHA to identify areas of need or quality issues with the provision of linguistically appropriate services.

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.

UHA has an Intensive Care Manager (ICM) that is available Monday through Friday, 8:00 am to 5:00 pm, to assist Members who have complex medical needs or special needs. This Intensive Care Coordination program is designed to help coordinate health care services for persons who are 65 or older, blind, disabled, or children with special needs. Members who need assistance with medical supplies, equipment, scheduling appointments, or other health care needs can contact UHA's ICM. This program also helps members get the dental care they need. Providers, caseworkers, care providers, or family members can also let us know if someone is in need of assistance. They can contact UHA's Member Services. This information is provided to all new member within 14 days of enrollment and whenever requested via the Member Handbook.

UHA also has a contracted interpreter Service to assist in Communication and Language assistance. All members have a right to know about Umpqua Health Alliance's programs and services. UHA provides the following at no cost to members: Sign language interpreters, Spoken language interpreters for other languages; Written materials in other languages; Braille; Large print; and Audio and other formats. If members need an interpreter at their appointments, they can let their provider's office know that they need an interpreter and for which language. TTY is available for all members. Some of the resources available include the provision of free interpretive services by telephone and remote video for any requested language (including sign language), the use of a THW who acts as part of the primary care team and assists with health care navigation, multilingual/alternative format member materials to address wellness and prevention resources for member education. We monitor the provision of these services using our standard Quality Improvement processes as described in Attachment 7, Section 7.8.

E.3. Requested Documents

Policies and procedures describing language access services, practices, evaluation, and monitoring for appropriateness and quality: Please see the attached MS5 – Requests for

Interpreter or Alternate Format Policy, CLI Interpreter Services SOP, MS4 – Written Notices to Members, CE-01 Grievances, CE-20 Appeals, CE-21-Adverse Benefit Determinations

Policies and procedures related to the provision of culturally and linguistically appropriate services: Please see the attached Culturally Competent Care Course, MS-2 Non-discrimination of Members, MS3 – Member Rights

F. Traditional Health Workers (THW) Utilization and Integration

F.1 Informational Questions

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.
THWs collaborate with UHA staff and healthcare providers to deliver culturally competent and non-clinical care to diverse populations and support the triple aim of better health, better care, and lower costs. UHA currently utilizes THWs through peer-delivered services by contracted Behavioral Health providers. Peer Support Specialists (PSS) are assigned to the following programs: Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA) and IPS Supported Employment. In addition, one person is assigned to Clinical Case Management and one is assigned to our Forensics programs.

PSS approach an individual from shared lived experience. They promote illness management and recovery skills by helping individuals recognize the symptoms of mental illness or substance abuse that they experience. They can teach individuals to use unique strategies that they choose and rehearse to minimize the effects of those symptoms. In addition, PSS assist in teaching and being a positive role model in the areas of problem-solving, goal-setting, and stress management while the individual is working on community integration. They help individuals navigate the areas of independent living, employment, finances, connecting with healthcare professionals in primary and oral care, and completing criminal justice system requirements. UHA measures THW performance through adherence to Fidelity requirements, supervision to monitor scheduling, documentation, and billing. UHA also has contracts that provide two Community Relations Managers (CRM) in SUD outpatient care. They primarily work to connect people to community resources and to remove barriers to service delivery (e.g. transportation). One of them also is liaison to Mercy Medical Center and connects with medical inpatients about SUD services. Performance is measured by assessing schedules and productivity (billing encounters).

UHA currently utilizes the following THW resources:
- 2.5 FTE Peer Support Specialists actively employed, one .5 FTE open position at Compass
- 2 FTE Community Relations Managers in Adapt SUD outpatient

In addition to the current services, UHA is in the process of expanding the availability these services by employing an in-house THW. Throughout 2020, UHA will support recruitment and retention of additional THWs in the community through direct full-time employment and/or contracting. The community health worker will assist with housing/homelessness, addiction, and obesity (such as diabetes education). UHA's in-house community health worker will be part of the case management team and will receive referrals from case management coordinators or the transitional care team for members that agree and would benefit from services. The community health worker will assist the member with achieving the member's goal from the patient centered care plan created by the case management coordinator. UHA has been working with its Innovator Agent along with local Community College to help bring a program to a local

community college to train peer support, along with other THWs. The hope is to expand the number of trained peer support and THWs within Douglass County.

UHA will provide information about THWs in the member handbook, at events, and through the case management team. Participating providers receive information to share with members when appropriate. THWs will continue their training and development by using resources from OHA's Office of Equity and Inclusion and the Oregon Community Health Workers Association to compliment the THW commission's best practices. UHA will continually look for ways to enrich the quality of THW work and support integration with programs that would benefit all members.

F.1.b. If Applicant currently utilizes THWs, please describe the payment methodology used to reimburse for THW services, including any alternative payment structures.

UHA provides a Care Coordination fee to Adapt, our local mental health agency, designed to offset some THW financial barriers. Adapt provides direct billable PSS that are reimbursed through OHP. Primary Care clinics can bill CCOs for Family and Youth Support services provided to OHP members aged 0 to 18 enrolled in a CCO. Medicare and other commercial insurances do not reimburse for PSS. Individuals who are dually enrolled in Compass Outpatient and Choice Model programs may be authorized to receive PSS reimbursed from Choice Model funds. Additionally, some individuals without insurance can self-pay based on a sliding fee scale.

Behavioral health organizations can bill UHA as documentation for an advance payment made under the capitated rate (e.g., wraparound for children) or bundled rate (e.g., ACT for adults). For services to children, providers bill for support services even when those services are part of the child's service/referral plan or wraparound program, such as family support provided to the parent. For services to adults, THW services can be billed for adult Addictions or adult Mental Health services when the adult's needs include peer support, case management or skills training for their own health and wellness, such as individual peer support or case management.

F.2. Evaluation Questions

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.**

We have attached the THW Integration and Utilization Plan as a separate document.

F.3. Requested Documents

We have included the following requested document: **THW Integration and Utilization Plan.**

G. Community Health Assessment and Community Health Improvement Plan

G.1. Evaluation Questions

G.1.a. Applicant will submit a proposal via the RFA Community Engagement Plan.

Please see the attached **Community Engagement Plan** for UHA's strategies for engaging its CAC, Community Health Assessment process, and CHP priorities and strategies, including HRS.

Umpqua Health Alliance—Traditional Health Workers (THW) Integration and Utilization Plan

Introduction

UHA currently utilizes traditional health workers (THWs) through peer-delivered services by the contracted mental health providers. In addition to the current services, UHA is in the process of expanding the availability these services by employing an in-house THW. Throughout 2020, UHA will support recruitment and retention of additional THWs in the community through direct full-time employment and/or contracting. By working with the local community, THW programs, THW Commission, and organizations such as the Oregon Community Health Workers Association (OCHWA), UHA expects to incorporate a diverse workforce to meet the needs of the community.

THWs in the community are currently reimbursed on a fee-for-service (FFS) basis. Consideration will be given in the future for alternative payment structures, such as case rates, per-member-per-month rates, or capitation agreements. Alternative payment methods may be limited due to the CCO contract's THW reporting requirements.

There is an opportunity in Douglas County for increased availability of THWs to further improve the health of its members, and the overall community. In addition to improving member and provider education, treatment compliance, access to social services, and access to care, the incorporation of THWs supports the individual. Each member is in a unique circumstance which comes with unique barriers. The experience and training of a THW can help facilitate individualized care that takes into consideration the individual's needs and the impact of social determinants of health (SDOH).

Evaluation of the needs of the community will be done through utilization, member and provider recommendations, and community health assessments (CHA). THWs will be considered by each type: Community Health Worker (CHW), Personal Health Navigator (PHN), Peer Wellness Specialist (PWS), Peer Support Specialist (PSS), and Doula. The THWs currently utilized are primarily related to PSS. However, UHA will consider recruitment of all THW types based on the needs of the community.

THW Care Delivery Integration Plan

Applicant's proposed plan for integrating THWs into the delivery of services;

UHA has a strategy for incorporating THWs into our care coordination program at the health plan level. The THW will focus on SDOH the raise the risks of adverse health outcomes, such as homelessness/ housing, substance use disorders (SUD), and obesity (diabetes education). THWs will be integrated into UHA's case management department and will offer follow-up to assigned members via a home visit, meeting in the transitional care clinic, or other appropriate setting. The THW provides encouragement, coaching and social support, health education, and outreach.

The THW will receive referrals from case management coordinators or the transitional care team for members that agree and would benefit from services. The THW will assist the member with

achieving the member's goal from the patient centered care plan created by the case management coordinator.

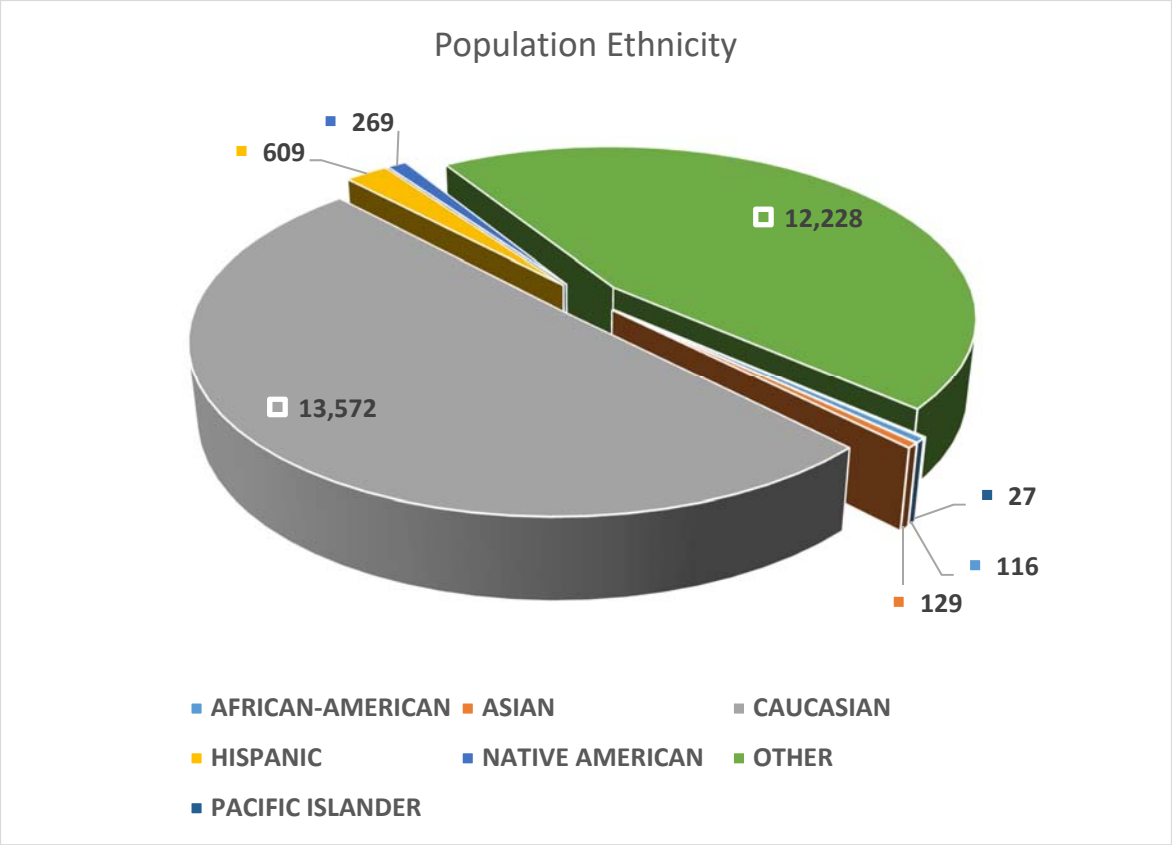
THWs will assess social determinants of health and address barriers. They assist the member in peer-delivered support by collaborating with providers and using community resources to provide the member with needed services. They will work with the ICM to improve outcomes, and address barriers to the integration of care by collaborating with behavioral, physical, and oral health providers. They ensure patients receive the right care at the right time and in the right place. UHA will continually look for ways to enrich the quality of THW work and support integration with programs and interactions that would benefit members from all backgrounds.

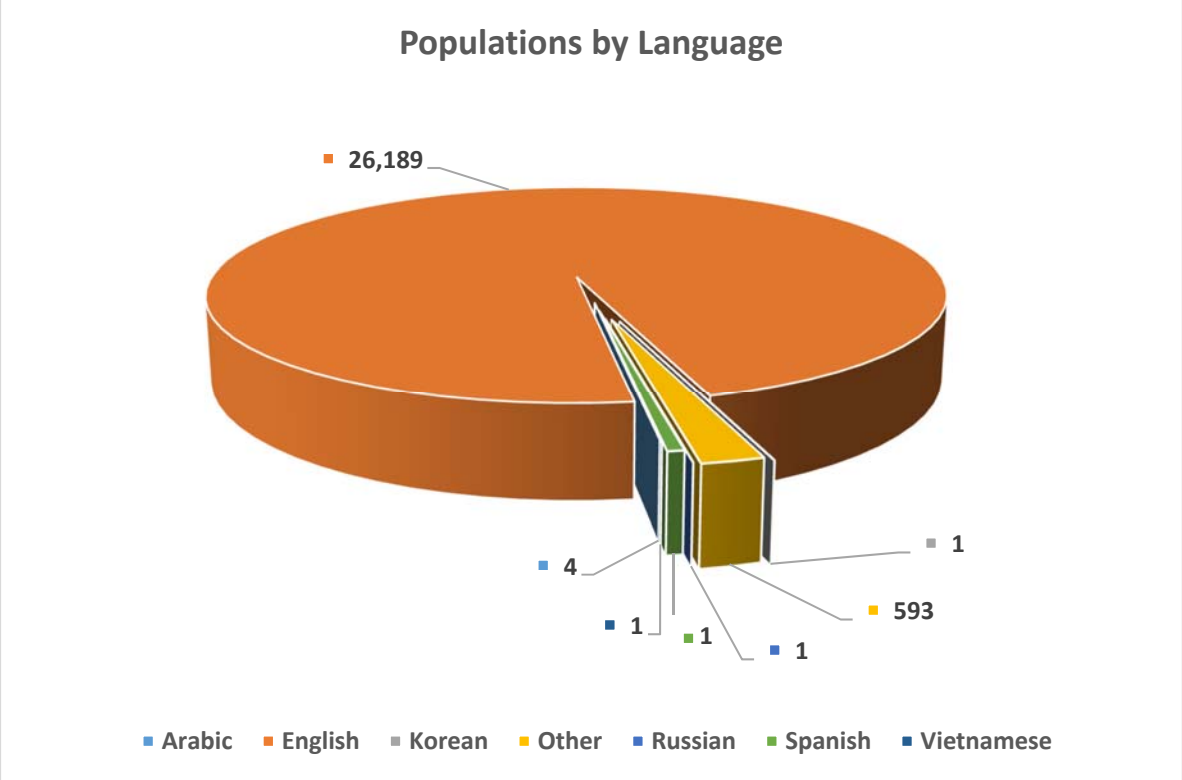
UHA has created a comprehensive multi-phase integration plan to operationalize the expansion of THW services:

THW Integration & Adoption	**Year 1**				**Year 2**				**Years 3-4**				**Year 5**			
Milestones & Activities	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Assessment of utilization and availability	X															
Determine potential need for recruitment and/or contracting	X															
Assess barriers to THW expansion and identify/apply changes to address barriers		X														
Provider & Member Engagement & Adoption			X		X				X				X			
Monitoring of program																
		Targeted completion date														
		Ongoing effort														

Phase I: Assessment of needs, utilization, and availability

UHA is continuing to evaluate the current availability of THWs. Currently, there are 220 active THW certifications in Douglas County according to the Oregon Health Authority (OHA). Over 250 UHA members received THW services in 2018, an increase from prior years. In order to evaluate the needs of members, UHA takes in to consideration membership demographic data such as the following:


Population Ethnicity
269
609
12,228
13,572
27
116
129
AFRICAN-AMERICAN
ASIAN
CAUCASIAN
HISPANIC
NATIVE AMERICAN
OTHER
PACIFIC ISLANDER


Populations by Language
26,189
4
1
593
1
1
1
Arabic
English
Korean
Other
Russian
Spanish
Vietnamese

This data in combination with the needs identified through health risk assessments and the community health assessment will determine the types of THWs needed, including any ethnic/linguistic needs. The number of positions needed for hiring or contracting with will depend on historical utilization compared to utilization trends following assessment and further implementation phases. The type of settings (clinic, non-clinic, community-based) will also be considered in utilization.

Phase II: Determine potential need for recruitment and/or contracting

UHA will pursue contracts with certified THWs in addition to hiring a full-time employee (FTE) as necessary. The FTE will work with the Case Management team to also fulfill the role of THW Liaison. The Liaison will also support recruitment and contracting efforts with other THWs. UHA is collaborating with Umpqua Community College (UCC) Workforce Training towards the establishment of THW training. A successful program will facilitate training to recruit and build the THW workforce in the community. Ongoing work is being done to determine the scope and implementation of this program.

Phase III: Assess barriers to THW expansion and identify/apply changes to address barriers

The integration plan and resources will be reassessed to identify possible barriers. An action plan to address barriers will be completed if necessary. Further assessment of the type of THW or changes in a recruitment plan will be considered.

Phase IV: Provider and member engagement/adoption

Written communication for members will be created and sent via mail and also included in the member handbook. The provider network will be notified through a standardized newsletter, and also through in-person interactions/events. The case management team will work with the THW to identify and engage members identified through existing cases, new referrals, provider/member requests, and other assessments. UHA will also explore collaboration with Patient-Centered Primary Care Home providers in order to integrate or better promote the services that THWs can offer.

Phase V: Monitoring of program and ongoing management

UHA will evaluate the success of the program using data derived from multiple sources, including claims, encounter data, and appeals and grievance data. Additional internal performance metrics may be applied for FTEs. UHA will staff a THW Liaison, who will support the ongoing education and training of THWs, especially with regard to health equity, cultural competency, and social determinants of health. Training and education will be provided both internally and externally. THWs will continue their training and development by using resources from OHA's Office of Equity and Inclusion and the Oregon Community Health Workers Association to compliment the THW commission's best practices. The Liaison will continue to monitor access and utilization for ongoing evaluation of success and penetration. The Liaison will facilitate THW involvement with or review of the CHA, Community Advisory Council, and Community Health Improvement Plan.

The work of THWs will be recorded and reported for the 5 THW types. UHA will collect data to measure the integration and utilization of THWs using the reporting template provided by OHA, consistent with the CCO contract for the following:

1. An assessment of member satisfaction with THW services;
2. Ratio of THWs to the total number of members;
3. Number of THWs employed by Worker Type (FTE/Contracted);
4. Number of requests from members for THW services (by THW types);
5. Number of engagements of THWs as part of the Member's Care Team (by THW types);
6. Demographics of THWs and CCO membership: including Race, Ethnicity, Language, Disability; and
7. The number of clinic and community-based THWs.

Encounter claims are submitted for any THW interactions that are eligible to be submitted and processed as encounter claims. UHA will document the number of interactions between THWs and members in each setting:

1. Clinic Setting;
2. Non-Clinic Setting; or
3. Community-Based Setting.

UHA will measure baseline utilization and performance over time. Data sources may include but not be limited to:

1. Claim/encounter data;
2. Appeals and grievances;
3. Emergency department utilization;
4. Community health program participation; and/or
5. Diabetes HbA1c.

THWs and all UHA staff are encouraged to continue building their skills and experience. To encourage recruitment and retention, UHA will consider the recruitment of staff that will pursue their THW certification within a designated timeframe through an OHA-approved program. Certified THWs may also be eligible to receive funding for ongoing education, training, and conference participation related to their role and career goals. The experience from the THW role may also create opportunities for advancement in other areas within UHA or the community. UHA maintains an organizational culture that supports the growth and development of its staff, providers, and community partners.

Attachment 11 - Behavioral Health Questionnaire

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.

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?

Umpqua Health Alliance (UHA) already manages the mental health and physical health benefit in house so members experience integrated behavioral and physical health services and consolidated benefit management. Portions of the substance use disorder (SUD) benefits are managed by a Adapt, however UHA intends to bring that work in house in 2020. This change will allow for a seamless and integrated experience for UHA members with regards to the behavioral health and physical health services.

As to oral health, UHA will be working closely with its dental care organization (DCO) to make the experience smooth from the member perspective. UHA's DCO has strong systems of communication with all members, including welcome letters for new enrollees and ongoing multi-channel communications that inform members of dental benefits, provider assignment, and what to do in case of a dental emergency. They also follow the MORE Care model (Medical - Oral Expanded Care) for inter-professional connection to foster closed loop referrals and provider-level emphasis on the need for integration to ensure members receive whole person treatment. UHA will collaborate with its DCO to create joint informational materials, systems for warm handoffs of phone calls, and ways to share care coordination. We are confident our DCO will be an effective partner in ways to improve the member experience.

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?

UHA has made concerted attempts over the last few years in actively managing the Behavioral Health benefit internally, producing contracts that align with value based payment (VBP) requirements, while maintaining the sustainable growth rate year over year. For mental health services, UHA currently is managing the benefit internally and does not have any pre-defined cap on spending. For SUD services, UHA will be working with its contract facilities to ensure that beginning in 2020, the benefit is managed internally and that there is no pre-defined cap on spending. Additionally, UHA is in the process of building out its Behavioral Health Utilization Management and Care Coordination teams who will serve as the conduit for integrating and coordination care across the delivery system.

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?

UHA recognizes that the demand and prevalence of Behavioral Health continues to increase not just in its service area, but across Oregon. Therefore, UHA recognizes that the amount of funding to support Behavioral Health services will likely increase over the coming years. UHA has steadily increased its funding of Behavioral Health services year over year, and will work with OHA to ensure the appropriate level of funding is identified not just through the local level but through a policy level within regards to rate setting. UHA will remain dedicated to funding Behavioral Health services in line with the prevalence in the community and in line with the Mental Health Parity and Addiction Equity Act of 2008 ("Mental Health Parity") Furthermore, UHA intends to compensate Behavioral Health services at or above Medicaid rates, consistent with its other provider types. Lastly, UHA has substantially reduced barriers to how its members access care by removing prior authorization requirements for Behavioral Health services that are more strict than physical health services, consistent with Mental Health Parity.

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?

UHA monitors the need for Behavioral Health Services through numerous domains, and does so in an effort to address the ongoing prevalence. UHA expects that the needs and prevalence will increase year over year. The number of members seeking care has increased exponentially.

With regards to monitoring cost and utilization, UHA monitors the adequacy of its Network through an annual Network Adequacy Study, which reviews the availability for physical, dental, and behavioral health services. Additionally, UHA holds a monthly Utilization Management committee meeting that evaluates over- and under-utilization of services and holds a monthly Network Performance committee meeting that evaluates UHA's ability to provide services within its network. Both of these committees identify any potential gaps in services and act to either expand our network or expand out-of-network coverage. These committees also provide reports to the Quality Advisory committee and the Finance Advisory committee, who evaluate the potential gaps or trends to determine if UHA needs higher actions, such as developing new quality metrics for clinics and providers or creating alternative payment methods to improve provider availability. These Advisory committees ultimately roll up to UHA's Board of Directors in an effort to provide accurate and timely information to the Board regarding the prevalence and needs for Behavioral Health services in an effort to keep the Board apprised and educated on the proper funding of Behavioral Health services.

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?

UHA is light years ahead in ensuring Behavioral Health services are being delivered in primary care service delivery locations. Over 78% of UHA members receive primary care in settings that have integrated Behavioral Health Services. UHA does not restrict where Behavioral Health services are being delivered and will continue to encourage Behavioral Health and primary care integration. UHA is currently developing a model for additional investment opportunities to

primary care providers that will lessen the financial impact of delivering Behavioral Health in a primary care setting.

UHA also recognizes the role of "reverse integration", in which primary care is being delivered in a Behavioral Health location of care. UHA recently awarded Adapt $100,000 to build out their ability to provide physical health services in their Behavioral Health care environment. The feedback Adapt received from its clientele was that nearly 40% of their patients did not seek primary care, and 66% of them would seek primary care if it was more accessible and integrated. Many of these individuals have a strong relationship with Adapt's care team, and adding primary care into the team would make it a seamless integration. The funding UHA provided to Adapt will offset some of the personnel and capital expenses Adapt will have while operating the program.

UHA does offer and reimburse for the complete Behavioral Health Benefit package. UHA routinely receives feedback from its network of providers on the costs and barriers for delivering the entire benefit package. In some situations, UHA has made changes to its reimbursement in an effort to fully support the entire Behavioral Health Benefit package. [redacted]

A.6. How will Applicant ensure the full Behavioral Health benefit is available to all Members in Applicant's Service Area?

Behavioral Health services are available throughout Douglas County. The makeup of UHA's Behavioral Health delivery system includes:

- CMHP
- Residential/inpatient
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Individual practices
- Group practices
- School-based delivery

At least annually, UHA conducts a multi-faceted Network Adequacy Study that identifies network gap across multiple domains. UHA uses this information to ensure its membership has access to Behavioral Health throughout its services area. This report, along with access and availability monitoring is reviewed monthly at UHA's Network Performance committee, in which recommendations and actions are taken to satisfy any network gap.

UHA contracts with the local CMHP, Compass, who provides many of the specialized Behavioral Health services within the geographical area of Douglas County. These specialized services include ACT, Early Assessment and Support Alliance, Individual Placement and Support (IPS) Supported Employment, Forensics Programs (Mental Health Court, Jail Diversion, ORS 167.370 Aid and Assist support, Psychiatric Security Review Board), Crisis Support,

Healthy Transitions, Choice Model, Clinical Case Management (to include Peer Support and Skills Training), Therapeutic Learning Classroom (TLC) and Wraparound services.

Additionally, school-based Behavioral Health services are also embedded within 28 different school locations (to include a School Based Health Center) through memorandum of understandings (MOU) with both Douglas County Education Service District and Roseburg Public Schools. UHA uses the Choice Model (Intensive Care Coordinators) to coordinate support to and from higher levels of care (Oregon State Hospital, Secure Residential Treatment Facilities (SRTF), Residential Treatment Facilities (RTF)/Residential Treatment Homes (RTH), Adult Foster Homes (AFH) and Personal Care Assistant 20) transitions related to Behavioral Health within Douglas County and across the State of Oregon.

In an effort to offer choice, UHA also contracts with FQHCs, RHCs, Behavioral Health groups, and individual clinics to round out the Behavioral Health network. This allows for a robust network that can be deployed throughout Douglas Country to ensure that the complete spectrum of need is satisfied locally and at the right level of support for its members.

A.7. How will Applicant ensure timely access to all Behavioral Health services for all Members?

UHA's Network Performance committee reviews monthly providers' compliance with access standards. UHA expects its providers to meet or exceed the requirements laid out in Oregon Administrative Rules as well as the CCO Contract. At least quarterly, UHA solicits feedback from its Behavioral Health providers on their ability to deliver care in a timely manner. This is done through a survey in which Behavioral Health providers identify appointment availability. If a provider is found to be out of compliance, UHA places the provider on a corrective action plan and asks them to remediate the finding. This information is brought to the Network Performance committee, who will review this information as well as other data points (e.g. out-of-network referrals, grievances, etc.) to assess whether the lack of timely access is unique to an individual provider, or is a systemic issue. If systemic, the Network Performance committee will then identify strategies to expand the network, in order to reduce gaps and ensure timely access.

UHA monitors and incentivizes access to CMHP services [redacted]

UHA is fully accountable for our members to ensure that its network is meeting the following time and distance access standards. As part of the provider's onboarding process, UHA provides key policies that outline the access and availability requirements for the organization. Specifically, UHA has policies and procedures that ensure scheduling for member appointments are appropriate to the reasons for, and urgency of, the visit. The member shall be seen, treated, or referred for Behavioral Health services within the following timeframes:

- In the Douglas County Rural area, the time is 60 miles or 60 minutes or the community standard, whichever is greater.
- Behavioral Health Providers must meet the availability standard that non-urgent behavioral health appointments occur within 2 weeks from the date of request (OAR 410-141-3220(8)(g)).

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?

Because UHA is located in a rural community, it recognizes that at times members need referral out of the service area due to lack of access. Historically, UHA has not experienced this issue with its Behavioral Health panel, as that portion of the network is quite adequate. However, in the event there were access issues, UHA would authorize the out-of-area request, and coordinate payments so the member is not responsible. UHA has routinely accommodated such requests in the past, such as authorizing services for children at OHSU's Child Development and Rehabilitation Center located in Eugene and for UHA members who are in foster care in other counties.

UHA typically finds out the need for an out-of-area referral either through the member or their provider. When the need is identified, UHA will first try to find a suitable provider in network and in area. However, if one is not identified, UHA will then provide an authorization for the members to receive the out-of-area services, and assist with any additional coordination that is needed (e.g. transportation, medications, etc.).

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?

UHA's physical and Behavioral Health providers use evidenced-based screening tools, such as the clinical depression and SBIRT screenings for members over 12 years of age. The ability to complete these screenings is measured and monitored in compliance with the CCO accountability metrics set by OHA. UHA's Quality Department provides guidance and technical assistance to providers to ensure they understand and are trained on administering the SBIRT. Additionally, the Quality Department provides dashboards to providers that identifies the percentage of their qualifying patients who are receiving the screening. Lastly, providers are given access to a provider portal in which they can identify in real time, the members needing screenings.

UHA's DCO has a goal to screen and risk assess all members and triage to care as appropriate. To facilitate these efforts in the community setting, the DCO utilizes a screening tool developed from the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey and the International Caries Detection and Assessment System (ICDAS). The screening tool is embedded into ADIN, their proprietary HIE, and uses an algorithm that auto-populates a risk-score based off the answers provided such as change in tooth structure, breakdown in enamel, or previous decay. In February of 2017, the DCO rolled-out the Risk Assessment tool in the practice setting. An on-line training is available for staff and contracted dental providers. The DCO's case management team regularly collaborates with UHA's case management team through phone, email, fax or the interdisciplinary team (IDT) meetings; and UHA holds the DCO accountable for performance on screening through obligations in the provider agreements.

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?

UHA's contracts with the local CMHP, Compass, to provide these services as they have a long history of coordination and success with Mobile Crisis Services. The CMHP has a 24/7 crisis line that is available to all community members. This line has remained the same for close to 20 years and is well-advertised. Law enforcement agencies, community partners, members and members' families communicate with the CMHP about individuals who have need for mobile crisis services. Protocall Crisis services receives all crisis calls after regular business hours. Protocall, law enforcement, and the local hospital (Mercy Medical Center) have access to a separate after-hours crisis number when there is a need for a mobile crisis intervention throughout Douglas County. In addition, in conjunction with the City of Roseburg, the CMHP is a sub-awardee of a 3-year grant to provide specialized co-deployment of two (2) Qualified Mental Health Professionals (QMHPs) to respond to mental health calls received by dispatch 12 hours day/7 days week from the hours of 12:00 pm to 12:00 am within the Roseburg City limits and surrounding areas. A strong relationship between local law enforcement agencies and the CMHP ensures that police reports pertaining to individuals with suspected mental health problems are referred for health care follow-up. The CMHP mental health professionals additionally have been engaged with local law enforcement for the last 3 years to conduct routine ride-alongs focusing on calls with individuals with suspected mental health concerns.

To support Crisis services (Crisis Walk-ins, Crisis Calls, Mobile Crisis, Co-Deployment Crisis and Pre-Commitment Investigations) in Douglas County, the CMHP employs 6 Full-Time staff (5 QMHPs and 1 QMHA) with 4 FTE dedicated to routine Crisis work (Crisis Calls, Mobile Crisis and Pre-Commitment Investigations), and 2 FTE to Co-deployment Mobile Crisis.

A.11. Describe how Applicant will utilize Peers in the Behavioral Health system.

Currently Peer Support Services (PSS) are used through local Behavioral Health providers. Programs of PSS are incorporated into Assertive Community Treatment (ACT), Early Assessment and Support Alliance (EASA), and IPS supported employment. Currently, there is a shortage of PSS within Douglas County, primarily due to the lack of training resources. UHA has been working with its Innovator Agent along with the local Community College to create a program to train peer support, along with other THWs. The hope behind this collaboration would be to expand the number of trained Peer Supports and THWs within Douglas County. Additionally, UHA is also looking at offering additional subsidies to local Behavioral Health providers to expand the usage of PSS.

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?

UHA will continue to promote and ensure awareness among providers and decision makers of the importance of health equity, with the goal of ensuring equitable access to preventive and curative health care services. UHA has regular learning opportunities for providers to increase the knowledge base to better understand the nature and causes of health care inequities and appropriate interventions to eliminate them. An example of this was in 2018, in which UHA was a key sponsor of the Resilience Summit in which providers were given the opportunity to receive information and education on adverse childhood experiences (ACEs) and trauma-informed care. We continually strive to create a culturally competent health care system capable to delivering the highest quality of care available to every member regardless of race, ethnicity, social class,

culture, ability to pay, or language proficiency. UHA will ensure health system accountability in equitable care quality by tracking, monitoring, and reporting equity quality measures.

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.

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.

Historically, the documented barriers associated with Warm Handoffs often includes issues associated with reimbursement as well as availability.

Regarding reimbursement, UHA currently reimburses appropriately billed services including warm handoffs and has not seen any significant barriers to billing. Warm handoffs are often occurring on the same day within a primary care setting that has integrated behavioral health services. For example, the occurrence of CPT code 96127 'Brief Emotional/Behavioral assessment' has been recognized since early 2015. For years ending 2017 and 2018, UHA encountered 470 instances of this code from primary care settings with integrated behavioral health providers.

As to availability, all UHA contracted FQHCs and RHCs have integrated behavioral health services and provide same day warm handoffs. Because of this approach, now 14% of UHA's Behavioral Health services are now delivered in an integrated setting, where warm handoffs, can easily occur.

For evidence-based treatments, UHA has been an avid supporter of working with the local CMHP in providing the necessary funding to support these programs. UHA provides the CMHP a monthly care coordination fee to offset some of the financial burden of offering these evidence-based treatment and fidelity programs. Most recently, UHA has also worked with the CMHP to ensure that the reimbursement specifically for PCIT is at a level that supports the viability of the program.

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?

UHA will review in-home care utilization by analyzing claims data along with prior authorization requests. Additionally, UHA has a strong and collaborative relationship with the local CMHP, which provides the majority of in-home services for Behavioral Health. Part of UHA's dialogue with the CMHP is to identify the needs in the community and whether additional services need to be expanded. UHA is dedicated to working with the CMHP, along with other Behavioral Health providers, in providing the best level of access for its members, in the most convenient environment. Furthermore, as part of its Community Behavioral Health Task Force, UHA will work with the Behavioral Health community to help identify the specific

needs and barriers to demands for in-home care, and work collectively with the Behavioral Health community to incorporate this information into future plans. Part of that may include adding additional Care Coordinators, identify access points, workforce needs, or other options.

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.

UHA has comprehensive systems in place to reduce the risk of hospital readmissions and to support members in care transitions. A key piece of this planning infrastructure is careful case management: Case Management Coordinators are notified of all admission, inpatient acute hospital, inpatient psychiatric, residential, skilled nursing facility, and psychiatric residential treatment services (PRTS) either by PA request or hospital census report. Cases are assigned to the case manager by needed specialty services. Once a case manager is assigned to a member, a care plan is developed with the member, their family and the members' care team. The care plan looks across the entire spectrum of care longitudinally to ensure a successful transition. This process is concurrent at each level of care to ensure discharge planning is being done through the episode. The case manager follows the patient through each level of care, receiving updates periodically from the facility for review of continued stay. Authorizations for continued stays are extended based on medical necessity and discharge planning needs. Care Plan and discharge planning documents are provided to the member and their care team to ensure future care team members understand the goals and interventions for the member. Once the patient discharges from an episode of care, UHA's case manager continues to follow and engage the member and their family to ensure a smooth and orderly transition, and to address the remaining care plans.

UHA has electronic tools in place (InterQual) that helps the case managers review each case to determine the appropriate level of care. A transition of care tool is built into the EHR system, and it guides the decision on the discharge planning needs for the member. The case management coordinator assists the facility coordinators, the member, and the member's designated health care partner with each transition. Support for the transition encompasses transportation, home health services, follow-up appointments both behavioral health or physical health providers, durable medical equipment, or long-term placement

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.

UHA does not treat Fully Dual Eligible members differently with regards to care coordination. These members are given the same level of care and access to UHA's Case Management program. The Dual Eligible members are managed consistently across UHA's membership. They have the same opportunity to receive a health risk survey, care plan, interventions, and coordination of care. UHA is affiliated with ATRIO health plan to support the Dually Eligible members. Through a Master Services Agreement with ATRIO, UHA actually performs the utilization and care coordination on behalf of ATRIO members in Douglas Country. This ensures a true integration between Medicaid and Medicare health plans, in which members will have a care plan that addresses all of those concerns, including having one care team.

Additionally, UHA provides ATRIO its network in Douglas County, ensuring an overlap of behavioral health provider. This ensures that the member will not have a gap in care, access barriers, or billing issues due to a provider not being contracted with both plans. This further empathizes that the plans have seamless integration, in which UHA members are able to utilize a behavioral health provider without service disruption.

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.

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.

Over the last six years, UHA has built a foundation for behavioral health services that are unique to Douglas County. The amount of change to the delivery system over the last six years has been quite drastic, and UHA played an integral role in stabilizing and expanding access to the members of Douglas County. This experience alone, puts UHA in a key position to understand the needs of its community to identify the best plan possible to propel Behavioral Health services in Douglas County. To fully develop such plan, it is important to understand the history of Behavioral Health services in Douglas County:

Historical Experience

Douglas County has one of the most complex behavioral health delivery systems in the state. In 2014, UHA took an active role in stabilizing behavioral health services. Shortly after CCOs were initially formed, Douglas County's Commissioners gave the Local Mental Health Authority (LMHA) responsibility back to the Oregon Health Authority and gave notice of its intent to close the county operated CMHP. At that time, state officials contacted UHA and requested our services to find or develop a new delivery system for all residents of Douglas County. The county officials gave 90 days' notice of its intent to discontinue mental health services in March 2014. As a result, UHA stepped in and launched a nonprofit (through governance, administrative, and financial assistance) called Community Health Alliance. Community Health Alliance was recognized as the CMHP by the state on July 1, 2014. Most of the county's mental health professionals were terminated from the county and hired into the newly formed entity along with the transfer of the county's behavioral health assets. UHA then engaged in a contractual arrangement with Community Health Alliance to successfully offer mental health services to the entire population of Douglas County effective July 1, 2014. In the fourth quarter of 2014, UHA was compelled to add additional independent mental health providers to its panel as Community Health Alliance struggled to provide adequate services under the newly formed entity.

In less than a year, Douglas County would be shattered by the tragic shooting at its local community college, Umpqua Community College, where ten individuals lost their lives. Suddenly, Douglas County was thrust into a mental health emergency and through the collaboration of federal, state, and local officials, UHA participated by providing the newly formed mental health delivery system in response to the shooting. Eleven days after the shooting OHA's director reached out to UHA to offer the first ever behavioral health deployment of its

SERV-OR volunteer network. UHA worked hand in hand with the state agencies and leadership at Adapt to open the Umpqua Wellness Clinic where anyone in the community could receive mental health services at no cost. In preparation for the opening of the Umpqua Wellness Clinic, the local VA hospital psychiatrists provided intense PTSD training for the local mental health delivery network. This was only the second time these services were provided beyond the walls of the VA, the first was in response to the shootings at Sandy Hook Elementary School. During this same time, to increase access to mental health care, UHA responded by increasing its reimbursement rates to 150% of DMAP behavioral health fee schedule. Fortunately, UHA had already built a mental health delivery system beyond the standard county delivery network to meet the community's needs during this tragedy. During the months after the shooting, UHA solicited and updated a weekly dashboard that polled its behavioral health providers to determine access availability then pushed the report back out to the entire network on a weekly basis. OHA's SERV-OR officials had never seen a tool such as this and felt it was invaluable.

In the fall of 2016, Community Health Alliance was acquired by Adapt, Inc. who moved the Community Health Alliance book of business under its subsidiary, Compass Behavioral Health. Since the acquisition, UHA has made significant investments in both time and financial resources to ensure a smooth transition for the county's only CMHP. This has resulted in a stable behavioral health network, along with expansion of access through Adapt/Compass as well as the independent mental health providers. For clarification Adapt's Board of Directors is the Douglas County LMHA and Adapt dba as Compass Behavioral Health is recognized as both the CMHP for Douglas County.

In terms of the delivery of behavioral health care, roughly 60% of Behavioral Health services are provided by the CMHP, 26% by independent providers, and the remaining 14% in integrated FQHC/RHCs.

With regards to SUD-related services, UHA has also played an important role in expanding access. UHA's SUD providers offer the entire spectrum of care that is delivered locally in Douglas County. This ensures members can receive care in their community, by their community. Historically speaking, there was once a gap where members were forced to either go to Medford or Eugene on a daily basis to receive Opioid Treatment Program (OTP). In 2017, UHA worked with Adapt to help launch an OTP that is delivered to the local community. UHA's role was a capital infusion to offset the initial costs to offer the service. This has been a tremendous success in stabilizing and providing a much needed service locally. Lastly, in 2019 UHA also expanded access to include Serenity Lane into its SUD network to offer choice to our members. Members now have different options to receive SUD service, dependent on their needs and preferences.

Future Expectation

As to future expectations and needs, UHA has seen a tremendous demand for Behavioral Health services. There are lots of reasons as to why this demand has exponentially increased, and it tends to be multifaceted. Access, availability, provider education and the de-stigmatization of Behavioral Health have all played an important role in reducing the barriers for Behavioral Health. With that being said, UHA expects that it needs to continue to identify and provide resources to address future needs and expectations. Currently, UHA envisions the following domain of Behavioral Health needing attention in 2020 and beyond:

- Expanded Access

- Severe and Persistent Mental Illness (SPMI) Population Engagement
- SPMI population engagement in primary care
- Opioid Dependence Utilization
- Inpatient Residential Program
- THW Workforce Development

Development of Behavioral Health Plan

To address the future expectations, in collaboration with the LMHA, UHA will develop a Community Behavioral Health Task Force that will be tasked with developing a Behavioral Health Plan. The Task Force will be a subset of the Community Advisory Council (CAC), and will include a spectrum of stakeholders in Behavioral Health domains. Because the support from the community is imperative for addressing Behavioral Health needs, it is crucial that community stakeholders are engaged in the process of identifying the needs and planning to remove barriers and offer a full spectrum of coordinated Behavioral Health services. The Task Force will be responsible for implementing this approach as laid out below in Table 11.1.

Table 11.1. Behavioral Health Planning Milestones

Behavioral Health Planning		Year 1				Year 2				Years 3-5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone: 1/1/2020	Form Community BH Task Force	X											
Milestone: 9/30/2020	BH Needs Assessment		X										
Milestone: 6/30/2021	BH Improvement Plan						X						
2021 & Ongoing	Evaluate BH Needs Assessment Process												

The Milestones and associated activities for Behavioral Health Planning are described below:

- **Community Behavioral Health Task Force**: UHA will form a Community Behavioral Health Task Force. The Task Force will be made up of a mixture of the CCO, LMHA representative, CMHP, local hospitals, key Behavioral Health providers, and public health representatives. The Task Force will report their efforts to UHA's CAC, who ultimately oversees UHA's CHA and Community Health Improvement Plan (CHP), and reports to UHA's Board of Directions.
- **Behavioral Health Needs Assessment:** The Task Force will conduct a Behavioral Health needs assessment, to quantify and document the community needs for the Behavioral Health services within the county. This assessment will be presented to the CAC and be incorporated into UHA's Community Health Assessment.
- **Behavioral Health Improvement Plan**: Once the Needs Assessment is completed, the Task Force will work on developing a specific improvement plan to address the concerns noted in the needs assessment. This information will be presented to UHA's CAC and be

added to UHA's CHP.

- **Evaluate Behavioral Health Needs Process:** UHA and the CAC will take a look back at the entire process to evaluate the process by which community behavioral health needs were assessed and planned for. This is to ensure that all needs that were identified were successfully managed by the improvement plan. Together with the Community Behavioral Health Task Force, they will determine the best way to incorporate behavioral health needs assessments into the ongoing planning work moving forward and to address any remaining needs that still exist.

C.2. Describe how Applicant plans to collaborate and coordinate with the Local Mental Health Authority in the development of the CHP.

UHA has a strong relationship with many partners, including the LMHA in UHA's service area. At UHA, the CHP is used as a guiding document for much of UHA's work in social determinants of health, economic drivers of health and health equity initiatives. As such, it is imperative to engage with a multitude of partners to ensure the CHP reflects the values and needs of the entire community.

UHA has several strong ties to our area LMHA. First and foremost, the director of our LMHA is on the UHA's Board of Directors. The UHA Board of Directors oversees the CAC, including all work done by the CAC (which includes Community Health Assessments (CHA), CHPs and other community benefit efforts). UHA also has a spot on the CAC designated for a person with special interest or knowledge in mental health and addiction, which has traditionally been filled by a person affiliated with the LMHA in UHA's service area. Currently, this role is filled by Adapt's Senior Director of Operations. This person is also the CAC Chairperson, and thus serves on the UHA Board of Directors. As the CAC is responsible for overseeing the CHA and adopting a CHP to serve as a strategic population health and health care system service plan, this relationship directly ties our LMHA to the creation and development of a CHA.

UHA's CAC helps identify and vet CHP and social determinants of health and health equity priorities. UHA's CAC achieves this in a variety of ways, including collaborating and coordinating with UHA's community partners. This community approach to health and well-being heavily relies on community partnerships, including UHA's work with our LMHA. Currently, UHA's CAC is working on the completion of a CHP based on the CHA finished in 2018. Both the work of the CHA and the CHP have involved and included our LMHA. First and foremost, the process is led by UHA's CAC and overseen by UHA's Board of Directors, both of which have robust participation from LMHA personnel. Also, the CHA process included quantitative and qualitative data through the use of focus groups and an online and paper survey. Not only did UHA's LMHA representative help disseminate the survey to its staff and clients, but staff working for the LMHA also helped organize one of the focus groups (specifically, the focus group for individuals with knowledge of or interest in behavioral health). LMHA organization personnel are also invited to all community partner meetings regarding the CHP. Through this collaborative, community-based approach, UHA's CAC will continue to work with the area LMHA and other partners and stakeholder to identify the priorities that matter most to UHA's community. UHA's CAC is working on the following timeline:

- The CAC will complete work on a CHP by June 30, 2019. This work includes collaborating with community partners and stakeholders, including the area LMHA. This work will be carried out by the CAC, with oversight by the UHA Board of Directors,

both of which enjoy robust participation with personnel from the area LMHA organization.

- The CAC will hold a community meeting regarding initial vetting of social determinants of health and health equity priorities by September 30, 2019.
- The CAC will gather community input by December 31, 2019.
- The CAC and the UHA Board will further clarify and define social determinants of health and health equity priorities by February 20, 2020.
- UHA will submit social determinants of health and health equity priorities to OHA by March 15, 2020.

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.

As described above in C.1, UHA has had a longstanding collaborative partnership with Adapt whose Board of Directors is now the LMHA in Douglas County. Working together we are focused on the implementing several local plans to provide access to members that include crisis, urgent, and routine services. In recent months, UHA and the LMHA have created a crisis respite task force that includes local law enforcement, judicial partners, county commissioners, community hospital representatives, and other community stakeholders to bring a crisis respite or behavioral health unit to Douglas County. Additionally, the LMHA representative will be invited to participate in the Community Behavioral Health Task Force and will play an important role in identifying the needs and creating a plan to address the Behavioral Health items in Douglas County.

With regards to the coordination with the LMHA in development of the Behavioral Health plan, UHA intends to do this through the Community Behavioral Health Task Force, as indicated in C1. Specifically, UHA will follow the timeline outlined below:

Table 11.2. Behavioral Health Planning Milestones

Behavioral Health Planning		Year 1				Year 2				Years 3-5			
Milestones & Activities		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestone: 1/1/2020	Form Community BH Task Force	X											
Milestone: 9/30/2020	BH Needs Assessment		X										
Milestone: 6/30/2021	BH Improvement Plan						X						
2021 & Ongoing	Evaluate BH Needs Assessment Process												

The Milestones and associated activities for Behavioral Health Planning are described below:

- **Community Behavioral Health Task Force**: UHA will form a Community Behavioral Health Task Force. The Task Force will be made up of a mixture of the CCO, LMHA representative, CMHP, local hospitals, key Behavioral Health providers, and public

health representatives. .

- **Behavioral Health Needs Assessment:** The Task Force in partnership with the LMHA will conduct a Behavioral Health needs assessment, to quantify and document the community needs for the Behavioral Health services within the county.
- **Behavioral Health Improvement Plan**: Once the Needs Assessment is completed, the Task Force and the LMHA will work on developing a specific improvement plan to address the concerns noted in the needs assessment.
- **Evaluate Behavioral Health Needs Process:** UHA, its CAC, and the LMHA will take a look back at the entire process to evaluate the process by which community behavioral health needs were assessed and planned for. This is to ensure that all needs that were identified were successfully managed by the improvement plan. Together with the Community Behavioral Health Task Force, they will determine the best way to incorporate behavioral health needs assessments into the ongoing planning work moving forward and to address any remaining needs that still exist.

C.4. Does Applicant expect any challenges or barriers to executing the written plan or MOU extension with the Local Mental Health Authority?

As described above in C.1, UHA and the CMHP have been in a contractual relationship since 2014. Adapt has only recently (fall of 2018) been designated the LMHA and is now working closely with UHA to meet its community mental health needs assessment and planning responsibilities. The LMHA (Adapt) is agreeable to extending its current agreements with UHA to cover the collaborative work of the CCO and the LMHA.

UHA maintains a strong community collaboration with the Adapt (LMHA/CMHP), and therefore there are no foreseen barriers to the continued contractual partnership.

D. Provision of Covered Services

Applicant must monitor its Provider Network to ensure mental health parity for their Members.

D.1. Please provide a report on the Behavioral Health needs in Applicant's Service Area.

UHA has a significantly high population of members with Behavioral Health needs that include detox, residential SUD treatment, intensive outpatient therapy, outpatient, medication assisted treatment (MAT), counseling, inpatient mental health, and subacute mental health services. The climate for Behavioral Health services has changed drastically over the years, and UHA has been quite nimble in responding to the demands and needs of the community. This began in 2014, the year in which UHA had to launch a nonprofit serving as the CMHP (Community Health Alliance, as described above) to stabilize access after the county mental health department decided to close its doors. Then in late 2014, UHA took the reins in expanding access to independent Behavioral Health providers in response to pent-up-demand and the UCC shooting. In 2017, UHA infused capital into Adapt in order to offer a local OTP in Roseburg; previously Douglas County residents were forced to travel to Eugene or Medford each day to receive OTP services. UHA continues to provide financial investment into Compass, through care coordination dollars, to ensure it can maintain a stable and healthy CMHP in Douglas County.

The experience from our past tells us that UHA has to be flexible in understanding the needs of

our members and providers, specifically related to Behavioral Health services. UHA's local presence and strong community ties, has been instrumental in managing and supporting the Behavioral Health needs in Douglas County. As to future needs, UHA expects the following:

- Expanded Access
- SPMI Population Engagement
- SPMI Population Engagement in Primary Care
- Opioid Dependence Utilization
- Inpatient Residential Program
- THW Workforce Development

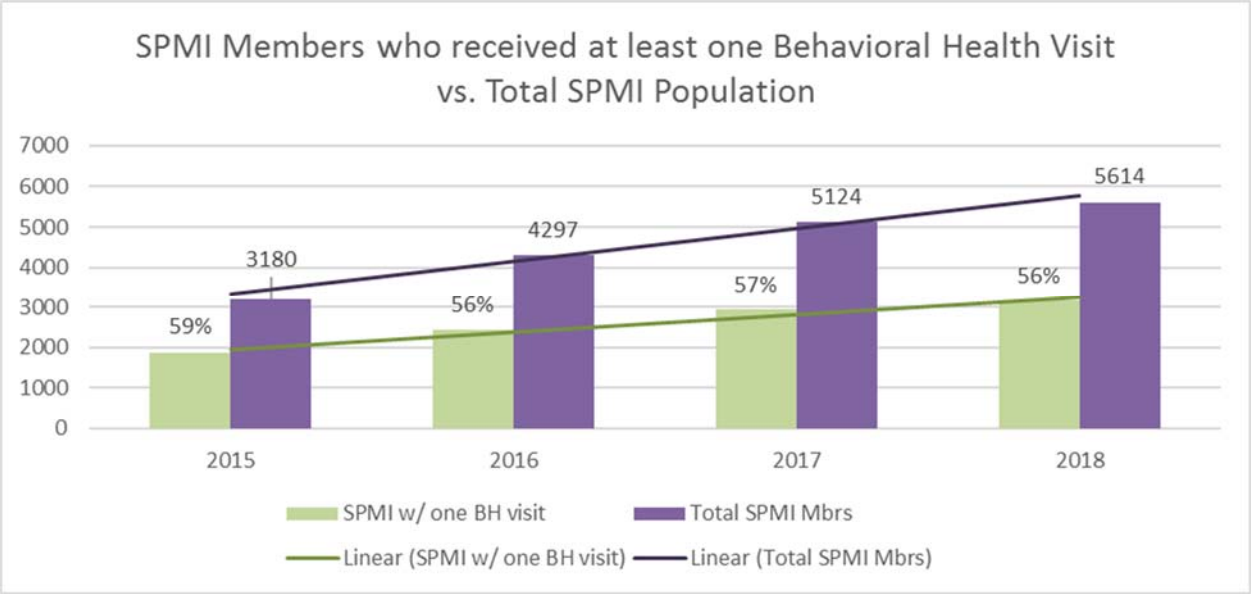
Expanded Access

UHA expects Behavioral Health needs to continue to increase in the coming years. As Behavioral Health services have become more readily available as well as less stigmatized, UHA has seen a significant increase in the number of distinct members that seek out services. As indicated in the chart below, the demand for Behavioral Health services has increased substantially, and UHA believes the trend will continue into the future by at least 5% growth each year. This tell us that UHA members are seeking out more Behavioral Health services than ever before, specifically in the outpatient setting. UHA does believe it has an adequate Behavioral Health outpatient network to serve the demand, however if trends continue at its current rates, the number of resources in Douglas County to support the demand will be scarcer. As discussed previously, UHA has had an active role in expanding and supporting Behavioral Health access since 2013, through numerous investments and local engagement. UHA will continue to work with its local provider community and key stakeholders to develop an adequate network to support the demand. UHA will also need to work closely with its provider community to also begin the discussion of how outcomes play an important role in understanding access and availability. Not only does UHA want to provide access, it also wants to ensure that care delivery is done effectively, with high quality of standards, and with improved health outcomes for its members.

SPMI Population

The complexity of care has drastically changed each year, and that trend is expected to continue. The number of UHA members that meet SPMI classification has increased each year, however the utilization of services for that cohort has not followed the same trend line. This demonstrates the need for strong, active, care coordination and strategies to increase active outreach and engagement. A recent look back at the end of 2018, showed that while nearly 70% of UHA's SPMI had received services in the last four months, only 62% of the SPMI population has some form of Behavioral Health service during that time. To help offset some of the coordination needs, UHA has recently implemented VBP arrangement to bend the cost curve. Incentive measures have been added to UHA's contract with Compass to provide more timely and expedited access to this population during episodes of crisis. Additionally, UHA is in the process of executing a contract with Vituity, for them to provide telepsychiatry in the Emergency Department (ED) setting. In comparison to the rest of UHA's member population, the SPMI cohort utilizes the ED about 20% more than their peers. UHA is trying to solve the problem, not just of the initial entry into the ED for care, but rather the repetitive ED utilization and

unaddressed Behavioral Health needs. The contract with Vituity will provide telepsychiatry to be administered in the ED but will have a financial withhold that requires Viutity to make a warm handoff to Compass, the CMHP, to ensure proper follow-up care. This will directly impact UHA's SPMI population that come into the ED for services, as once stabilized, timely outreach and post ED engagement will have a higher success rate.



Opioid Dependence

Prior to 2016, the most commonly treated Behavioral Health diagnosis for UHA was Post-traumatic Stress Disorder. However, since that time, Opioid Dependence has been the most common diagnosis in terms of units of care. This means UHA is experiencing the same dilemma as the rest of Oregon and the nation, in the rapid increase of opioid use. Additionally, in comparing opioid prescription fills per 1,000, UHA has historically had higher averages then the rest of the State. Since 2015 UHA has worked with Adapt to develop a robust continuum of MAT for Opioid Use Disorder. In 2015 a medically monitored detoxification program with eleven beds was opened as part of the Crossroads Residential facility. This service prepares members not seeking ongoing MAT the ability to engage in treatment including residential and outpatient for relapse prevention. These members can be offered extended release naltrexone through Adapts FQHC South Rivers Community Health Center (SRCHC) which provides primary care integrated with residential. Also, in 2015 UHA supported SRCHC in developing a MAT program utilizing buprenorphine integrated with primary care and the evidence based behavioral intervention Motivational Stepped Care. As noted earlier in 2017, UHA provided capital for Adapt to open an OTP facility in Roseburg. This much needed program has helped create an access point to methadone integrated with Motivational Step Care for Douglas County resident, and initial indications are that the program has been a great success. In 2019, UHA added Serenity Lane into its network to expand access for its membership. However, in 2020 and beyond, UHA expects to see the continue rise of opioid dependence, and therefore will develop multi-dimensional strategies to address the ongoing need. Such strategies will include

member and provider engagement, enhanced care coordination, expanded access, and relevant VBP targeted to reduce recidivism. Additionally, UHA will also continue to look at barriers such as removing restrictions for generic buprenorphine/naloxone and long-acting SUD injectable medications.

Behavioral Health Inpatient and Psychiatric Residential Treatment Services (PRTS) Availability

A growing concern statewide is the lack of inpatient Behavioral Health as well as PRTS beds that are available. For some members needing inpatient or PRTS Behavioral Health care, the wait for an available placement can be a lengthy. In 2018, at times there were significant wait period for an inpatient or PRTS bed for UHA members. This is consistent with the experience across the entire State. Mercy Medical Center in the past had an inpatient Behavioral Health unit but was closed years ago due to budgetary constraints. Currently, Mercy Medical Center is contemplating reopening the unit as a means to reduce the lack of availability that is being experienced statewide. Availability will continue to be an issue in 2020 and beyond, as the growing numbers of individuals seeking care is increasing, and the cost to provide such care is becoming more expensive. UHA intends to work with its provider community as well as OHA to ensure access and availability exists for inpatient Behavioral Health services and PRTS. However, proper financial alignment through outcome-based payments will need to be examine to ensure members receive right amount of care, with a reasonable expected outcome.

Traditional Healthcare Workers

The last Behavioral Health need that UHA expects in 2020 and beyond is the development of a traditional healthcare workforce (THW). Utilization of THWs in Douglas County to date has been isolated to Adapt, which supplies Peer Support Specialists for individuals seeking SUD services. UHA plans on hiring a THW in 2019 that will be deployed within its Care Coordination program. With this pilot position, UHA hopes to test the use and success of integrating THW into the health plan. Also, UHA is currently in the process of developing a possible incentive program in which PCPCHs that integrate a THW within their organization can receive some form of stipend for the integration. However, the biggest need is the actual development and training of the workforce. Currently, no program or certification is being delivered within Douglas County to train THWs. UHA has been exploring the opportunity of working with Umpqua Community College in bring a THW certification program for local workforce creation. UHA expects to see the usage of THWs to increase in 2020 and beyond, however the concern is whether there is an adequate workforce to support the demand. Therefore, it is imperative that UHA work with its community partners to find and fund opportunities to develop the workforce.

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.

UHA's analysis of its workforce capacity is that it will need to expand further to meet growing demand of Behavioral Health needs for this population. As discussed earlier, demand for utilization and care coordination is increasing. This is in large part due to the increase of SPMI members, overall utilization, and an increase in SUD-related services. Therefore, UHA is actively growing its workforce specifically for the Behavioral Health population.

UHA historically has delegated oversight of Behavioral Health services to the CMHP. However,

beginning in 2018, UHA began to slowly move the oversight and administration of Behavioral Health services in house. By the end of 2019, UHA expects to be fully overseeing and administering the benefit internally. In addition, UHA is currently in the process of hiring a Behavioral Health Manager, additional Behavioral Health Care Coordinators, as well as a THW, who will ultimately be responsible for the utilization and coordination of Behavioral Health services. The hope behind this integration is to understand member need and establisher higher collaboration and coordination with members and the providers. Lastly, UHA is also dedicated to developing our existing workforce through training and career advancement opportunities. UHA provides tuition reimbursement towards a training program, certificate, or degree that will contribute to an employee's work at UHA.

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?

UHA has worked hard to build a partnership with Oregonians for Rural Health, a coalition of local community leaders, educators, and healthcare providers, and George Fox University, a nationally recognized college based in Newberg, Oregon, to explore building an allied and mental health college in Roseburg. The college is envisioned to provide a reliable pipeline of skilled healthcare professionals in multiple high-demand medical fields and connect individuals to living wage jobs through locally delivered degree programs. An exclusive MOU between these groups will ensure access to critical care for our members and reverse provider shortages for Douglas County. The need for skilled providers and mental health workforce shortages in Southern and rural Oregon pose serious healthcare access issues, despite aggressive and costly recruiting efforts. UHA is proud of this innovative partnership to help train a local workforce and sustain an adequate workforce in the future. Additionally, UHA has been in talks with its Innovator Agent and Umpqua Community College with the hopes of offering a THW certificate program. Currently, only a handful of THWs are operating in Douglas County, and no program exists locally to train and develop a workforce. Lastly, UHA has provided training to its provider community, specifically about understanding how trauma and ACEs can impact the care one seeks. This was done in the spring of 2018 through the Resilience Summit, which provided an opportunity for providers to receive information and education on ACEs and trauma-informed care.

In terms of future plans, UHA intends to work with its Community Behavioral Health Task Force that will be conducting a needs assessment. Part of this assessment will look to identify workforce and training gaps to get a better understanding of what specific needs must be addressed. This information will then be populated into an improvement plan that will look at providing opportunities to address the workforce and training needs.

D.4. What is Applicant's strategy to ensure workforce capacity meets the needs of Applicant's Members and Potential Members?

UHA strategy to ensure our workforce meets the needs of our members is to consistently monitor ratios, gap in services, key department performance indicators, and overall changes in contractual requirements. UHA uses its annual budgetary process to develop a strategy ensuring an adequate workforce that meets the needs of its members. UHA routinely monitors workload and contractual requirements to ensure it is able to comply with regulatory requirements and ongoing demands. As part of its annual budgeting process, UHA leadership reviews changes to

contractual requirements to ensure needed workforce in captured in future budgets. Additionally, leadership looks at key initiatives, which it incorporates into its Strategic Plan. These initiatives are geared to providing optimal care and support to UHA members and network providers.

In 2018, UHA recognized it needed to move the needle in terms of utilizing data to make decisions, for provider contracting, and to better understand our members. As a result, we designed a department that is specifically tasked with providing the analytics to support decision making. The Decision Support Department has now grown to four FTEs that can readily produce an abundance of reports to better care for our members. In 2019, UHA budgeted for a substantial investment in expanding its internal Behavioral Health department, as well as adding THWs into its workforce. Recognizing the growing demand of higher integration of Behavioral Health services, UHA took a dedicated approach in 2019 in ensuring that it has the talent and skillset internally to best serve its members. Because of the rural nature of Douglas County, finding competent talent is also a barrier at times. In 2019, UHA developed strategic initiatives to invest in training and educational opportunities for its current workforce to further develop skills and competencies.

D.5. What strategies does Applicant plan to use to support the workforce pipeline in Applicant's area?

UHA's strategy to support the workforce pipeline is multi-faceted. Internally, the organization is aggressively hiring to meet the evolving needs of its members, the additional work associated with meeting new contractual requirements, and implementing key strategic initiatives. Additionally, UHA has dedicated internal resources and programs to further develop the skills and education of its internal workforce.

Externally, UHA's strategy to develop a strong workforce pipeline includes working with key community, educational, and business ventures to bring talented workers into Douglas County. Some of these activities have been financial support for ventures with Umpqua Community College, offering medical school rotations for pediatric medical students within our own clinics, and funding opportunities to support Allied Health and Behavioral Health educational opportunities currently being developed by George Fox University.

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?

UHA currently has a performance improvement plan for the SPMI members. Using claims data, SPMI members with high ED utilization are identified and tracked in PreManage, a software system that provides real-time ED utilization data. UHA has on staff a case management coordinator, who makes every attempt possible to engage SPMI members and provide resources during episodes of care. For example, for a member utilizing the ED for a warm bed, the case manager was able to connect with the member in the ED to provide a temporary cell phone and lodging. The case manager assisted the member with placement in a foster home and continued to coordinate service with ACT team and primary care provider.

UHA also intends to work closely with its PCP and Behavioral Health providers to ensure members with SPMI are being actively engaged in services. UHA is able to provide data to its

providers to ensure that services are being offered and effectively provided to this cohort. At the end of 2018, UHA did a four month look back, and recognized that nearly 70% of its SPMI population has received some form of services within that four-month period, and that 62% of the SPMI population had received some form of Behavioral Health service during that same period. With that data, UHA was able to pinpoint and examine which members needed assistance with obtaining services. Additionally, over 87% of UHA's SPMI population is assigned to a primary care provider that has integrated Behavioral Health services. This high level of integration ensures that the members and their care team can freely and easily coordinate about care.

UHA will track member engagement in behavioral health services through coordination of services between mental health providers, primary care, and substance use programs. UHA will track incoming referral sources and outgoing referral sources to ensure continuity of care for members. UHA will review utilization of services through the prior authorization process for any out-of-area or out-of-network services and will assist with coordinating care back to the UHA service area.

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?

UHA was one of the first CCOs to contract with a local tribal organization. Through this contractual arrangement, UHA serves its tribal members by having providers within the Cow Creek Health and Wellness Center, which is a Cow Creek Tribal clinic with over 700 assigned members. This PCPCH clinic offers not only physical health and behavioral health, but also diabetes medical nutritional therapy and education, adult and child psychiatry, and child psychiatry via telemedicine. The Cow Creek Health & Wellness Center (CCHC&WC) continues to build strong collaborative relationships with UHA. Through diligence and perseverance, the two parties have been in an established agreement since December of 2016. CCHC&WC is dedicated to the health and welfare of all citizens of Douglas County and strives to deliver culturally competent and trauma-informed care to any member of a recognized American Indian or Alaskan Native Tribes who chooses to receive their care through CCHC& WC Clinics.

All CCO members have their choice of providers but UHA can be assured that if any member of an American Indiana Tribe or Alaskan Native Tribe request culturally and competent care that CCHC&WC will be ready to offer primary care, behavioral health, child and adult psychiatry and health nutrition education including crisis services.

UHA invites our partner organizations to collaborate during our CHA meetings. For the CHA completed in 2018, UHA worked with Umpqua Community Health Center and United Community Action Network to help in establishing plans for servicing our Tribes and Indian Health Care Providers. UHA also had extensive help from CAC members, who include the Cow Creek Band of Umpqua Tribe of Indians along with a wide swath of our community partners. Organizational goals are set to ensure accurate and clear communications are being provided to our families and individual residents so UHA can provide a model of care that keeps patients healthy with integrated comprehensive care with our behavioral health providers. For members who are engaged in UHA's Care Coordination program, UHA would work with the member to identify their cultural needs and support. UHA would include in its care plan with the member,

further engagement and referrals to CCHW&WC to ensure appropriate delivery of culturally related services. Once that is established, UHA would work in conjunction with CCHW&WC to ensure a smooth transfer of care if possible, or at the very least, establish additional support services that CCHW&WC can offer to the member

E. Covered Services Components

E.1. Substance Use Disorder

How will Applicant support efforts to address opioid use disorder and dependency?

UHA helped to establish an Opioid Treatment Program (OTP) provided through contracted services. In 2016, UHA's CAC awarded funding to Adapt, UHA's contracted SUD provider, to help kick start the program, which began serving patients in April, 2017. When Adapt opened the local OTP, members were able to transfer in from being served out of the community in locations such as Grants Pass, Eugene, and Bend. These services are now local in Roseburg and no longer require long daily drives for these patients. In addition, UHA has a program called New Day, where a team provides support and resources to pregnant women who have SUD, and collaborates with their doctor and other community partners. Also, UHA offers the New Beginnings program to focus on children prenatal to age five, working with the children and their families that have significant ACEs or are impacted by opioid use.

In response to growing concerns about increasing opioid use, opioid disorders and dependency, UHA established the Douglas County Pain Management Committee in 2012. The establishment of this committee came out of extensive causal and barrier analysis; UHA reviewed existing literature on the issue of opioid use. In the early stages of addressing opioid misuse in Douglas County, UHA solicited feedback from various stakeholders in the community and brainstormed the potential causes and barriers contributing to the growing opioid epidemic. UHA determined that the problem required a partnership between UHA and the community. The Douglas County Pain Management Committee develops interventions to address causes of opioid use disorder and barriers to treatment identified through a continuous cycle of quality improvement.

UHA is committed to providing services to ensure that our behavioral community partners, like Adapt, continue to implement processes for members that are admitted under SUD care. UHA programs ensure that patients are screened over the phone when they are in the hospital so Adapt or Compass can use their rapid access programs for the residential services that are offered for our members. UHA will continue to enhance the SUD program by implementing the behavioral health task force, hiring additional care coordinators, traditional health workers and continue to expand service options for members. For example, UHA is contracted with not only with local CMHP for substance use treatment but also with Serenity Lane.

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?

As described above, UHA has long standing relationships with facilities that offer integrated services for members presenting with SUD needs. These community partners have designated community health programs and delegated services that provide family counseling and medication management services along with crisis interventions. Our community partners can expect patients to be met with their safest path of treatment including MAT; Detoxification

Services; Psychotropic Medications; Buprenorphine; Mental Health Therapy Programs; Nicotine Replacement Therapy; Psychiatric treatment; and Oxycodone, Heroin and other therapy measures that are a pivotal part of effective substance abuse treatments. Our community partners also offer intensive, inpatient, and outpatient treatment programs for members who also suffer from other addictions.

UHA provides members with translation services, including sign language, at no cost to the member. These services can be used for medical and specialist appointments and for members receiving SUD services at any level of care. Members are informed of this service upon enrollment through the UHA member handbook, which is available in multiple languages. Our member services or providers can also arrange for translators to assist the SUD providers with their patients. UHA has designed an evidence-based Preferred Drug List (PDL) and associated Utilization Management (UM) criteria to ensure the right member gets the right drug at the right time if a SUD provider is prescribing controlled medications. UHA's PDL is posted and accessible on our website.

In addition, UHA, through its CHP, supports an OHSU workshop designed to improve OHP member engagement. The workshop increases provider's awareness of cultural differences and social inequalities. Improved cultural understanding leads to stronger provider-patient relationships through the channels of outpatient, intensive outpatient, residential, detoxification, and MAT services. The training provided will enhance patient care in both clinical and non-clinical settings.

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?

UHA provides culturally responsive and linguistically appropriate alcohol, tobacco and other drug abuse prevention services by providing training to our providers and staff of services on cultural and linguistically awareness. UHA follows the National Culturally and Linguistically Appropriate Services (CLAS) standards issued by the U.S. Department of Health and Human Services for guidance and training of this organization, the providers, the staff, and its subcontractors. UHA holds subcontractors to the same standards of annual training requirements for providers and staff. UHA will ensure that staff and other personnel will receive cross-cultural education and training, and that the skills in providing culturally competent care are assessed through testing, direct observation and monitoring of member satisfaction. UHA has partnered with Adapt Prevention Services previously to provide presentations and workshops for at least 300 people throughout the community. UHA plans to continue to provide community workshops regarding cultural and linguistic awareness, including language assistance service at no cost to the member. Informational material will be reflective of the National CLAS standards, including appropriate literacy level.

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 service

UHA informs members in a culturally and linguistically manner about availability of SUD services, outpatient services, intensive outpatient services, residential detoxification and MAT services through the member's handbook, member website, provider offices, LHMA provider, and media campaigns. UHA has hosted community events that are intended to support the whole

community in sensitivity training. UHA plans to continue to provide cultural and linguistically appropriate education on how to reduce the stigma of mental health or substance use disorder, work with providers to operate with an "open door" policy, to ensure that members are assisted with services rather than dismissed from providers. These efforts include care coordinators advocating for the members at the provider's offices. Additionally, during the care planning process, care coordinators will work with members and their families to identify the cultural and linguistic needs for the individuals and ensure care plans identify relevant goals, supports, and interventions to address these needs.

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.

UHA is contracted with Adapt who provides MAT at four different locations within Douglas County. UHA helped support Adapt, UHA's contracted SUD provider, to open a local OTP. Members are now able to be served locally in Roseburg and no longer require long daily drives to locations such as Grants Pass, Eugene, and Bend. UHA is also contracted with Serenity Lane and other clinics, such as Umpqua Community Health Center and Cow Creek, who also offer MAT. Having multiple service providers allows our members to have multiple options when choosing a provider for SUD services.

UHA is dedicated to developing our existing workforce through provider training and career advancement opportunities. UHA continues to promote buprenorphine waiver training, which UHA hosted this year at the Umpqua Valley Arts Association. There was no cost to providers to attend. We advertised this training through our provider newsletter and web page. UHA co-sponsored the HOPE Summit, which included Narcan/Naloxone training for its community partners.

UHA recognizes there will be continued growth in utilization of SUD services. To address this growth, UHA will continue to monitor its workforce capacity by reviewing ratios, gaps in service, and key performance indicators. UHA will also meet this growing demand for SUD treatment by increasing its workforce which would include additional care coordinators, THWs, and support staff. UHA has a strategic initiative in place to invest in training and educational opportunities in its current workforce to further develop skills and competencies.

E.1.e. Coordinate with Providers to have as many eligible Providers as possible be DATA Waived so they can prescribe MAT drugs.

Currently UHA is contracted with Adapt, to provide the full continuum of opioid use disorder treatments including Office Based Opioid Treatment (OBOT) MAT integrated with Motivational Stepped Care. Adapt provides MAT services to the majority of members needing these services. However, if Adapt is not able to provide members with MAT services UHA is also contracted with a local SUD provider, Serenity Lane, who also provides MAT services. There are 21 providers within Douglas County that are DATA Waivered. UHA will continue to work with its provider community to help identify additional opportunities in order to get more waiver providers. Also, through the Community Behavioral Health Task Force, UHA will work with stakeholders to identify and policy, funding, or support barriers to establish more waivered

providers to reduce any undue administrative or financial barriers.

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.

The CMHP currently has a rapid access coordinator embedded in the local hospital emergency department (ED) to expedite services for members in need of MAT or detoxification/ residential services. The rapid response coordinator collaborates with UHA case management and local partners for placement. This includes utilization review of service to ensure members are provided with services at the appropriate level of care. UHA will continue to follow the member though each transition of care to ensure that wrap around services are implemented as appropriate for the member. The UHA care coordinator is part of the IDT team meeting with the residential facility or provider of services and will create an individualized care plan that incorporates the member and the member's family with interventions, goals, and anticipated outcomes.

The CMHP also has a crisis team that ride shares with local law enforcement; this collaboration deters members from being placed into custody and, when appropriate, it provides timelier access to care. The CMHP crisis team will coordinate services with the UHA care coordinator to ensure the member and the member's family are incorporated into the care planning process. The same process for care coordination is followed: the member will be assigned to a UHA care coordinator, the care coordinator will complete an assessment and collaborate with the providers of service. The CMHP will create an individualized care plan that includes the member and member's family with interventions, goals, and anticipated outcomes.

UHA care coordinators collaborate with the certified peer support providers, housing coordinators, and other local partners in the community through ongoing IDT meetings and referrals. The UHA care coordinator assigned to the member will create an individualized care plan and follow the same process at each transition of care.

E.1.g. Additional efforts to address opioid use disorder and dependency shall also include:

Implementation of comprehensive treatment and prevention strategies

UHA is represented at the opioid task force coalitions, hosted by Douglas Public Health Works. The goal of the task force is to bring public awareness to community members and stakeholders by providing education in the community about the impact of the opioid epidemic, this includes education on the use of Narcan/ Naloxone, motivational interviewing and providing trauma informed care and to expand access to prevention, treatment and recovery services.

UHA provides provider education and training for community partners, local agencies, and schools on prescribing and receiving waivers for Suboxone. UHA hopes to reduce opioid prescribing and use in Douglas County. UHA intends to continue to provide education to local law enforcement, first responders, and local community partners on prevention and treatment of substance use disorder. An example of this is the HOPE summit that UHA co-sponsored this year, which was attended by over 200 community partners and members. The Hope Summit was opened to all community members and addressed the opioid epidemic, provided education on proper use of Narcan/Naloxone, and taught strategies to mitigate the opioid crisis.

Care coordination and transitions between levels of care, especially from high levels of care

such has hospitalization, withdrawal management and residential

UHA care coordinators are notified through the Prior Authorization and concurrent review process of members that are hospitalized in network and out of network. Upon notification of admission, a UHA care coordinator is assigned to complete the utilization review process to ensure the member is receiving the appropriate level care at the right service level. The UHA care coordinator will assess the member through a face-to-face meeting at the local hospital and a phone interview for the out-of-area facilities to establish a rapport with the member. The assessment will include the member and or the member's family on treatment options when and if appropriate. The UHA care coordinator will reach out to CMHP or other contracted providers for assistance with transitioning the member to the next level of care, such as detoxification and or inpatient residential services. The UHA care coordinator will maintain contact with the member during treatment through the IDT meetings at the facility and will update the members care plan accordingly. UHA care coordinator will assist with transition to IOP service and or outpatient treatment and assist member with coordinating physical and oral healthcare needs.

For hospitalized members that are not ready to engage in abstinence programs at the time of discharge, the UHA care coordinator will coordinate services, and create an individualized care plan with alternative treatments plans. Plans may include assigning a peer support specialist, community health worker from the CMHP, or connecting the member with other community resources. The UHA care coordinators will attempt to engage member in other services, such as support groups, family counseling or mental health services with a long-term goal to encourage abstinence.

Adherence to Treatment Plans

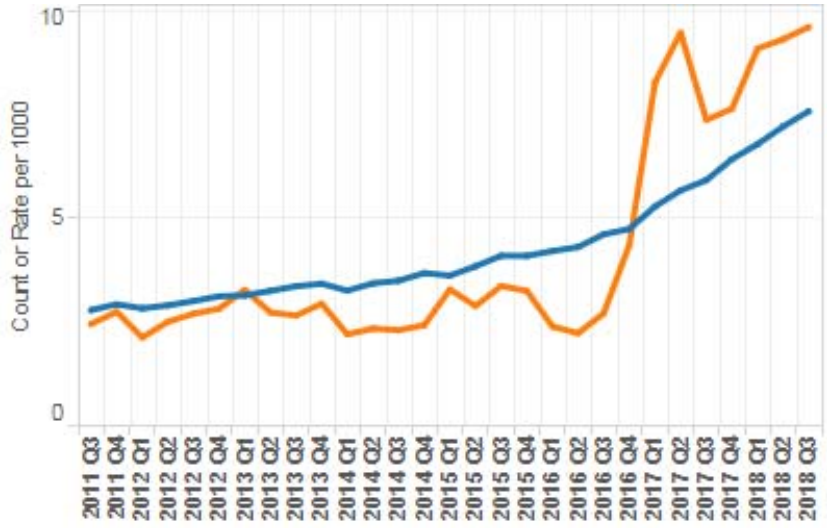
The UHA supported MAT/OTP programs at Adapt have specific protocols, based on Motivational Stepped Care, designed to maximize adherence to treatment plans and minimize potentials harms from noncompliance. However, UHA will provide ongoing support services to members regardless of their adherence to treatment plans. While UHA will promote positivity in goal setting, members may stumble through treatment and require additional support to re-engage and remained engaged in services. For members that are not ready for conventional treatment through abstinence programs, the care coordinator will offer alternative treatment plans, such as pairing the person with a peer support specialist, or community health worker, or other community resources or cognitive behavioral therapy. UHA's philosophy is members that are involved in their own care are more willing to comply with the program to reduce substance use. UHA will provide ongoing services, such as care coordination, to members regardless of their ability to abstain for substance use; it is important to continue to engage and treat the member lifelong with small steps. The long-term goal is to eventually encourage the member to abstain from substances by providing positive reinforcement over a period of time.

Increase rates of identification, initiation, and engagement

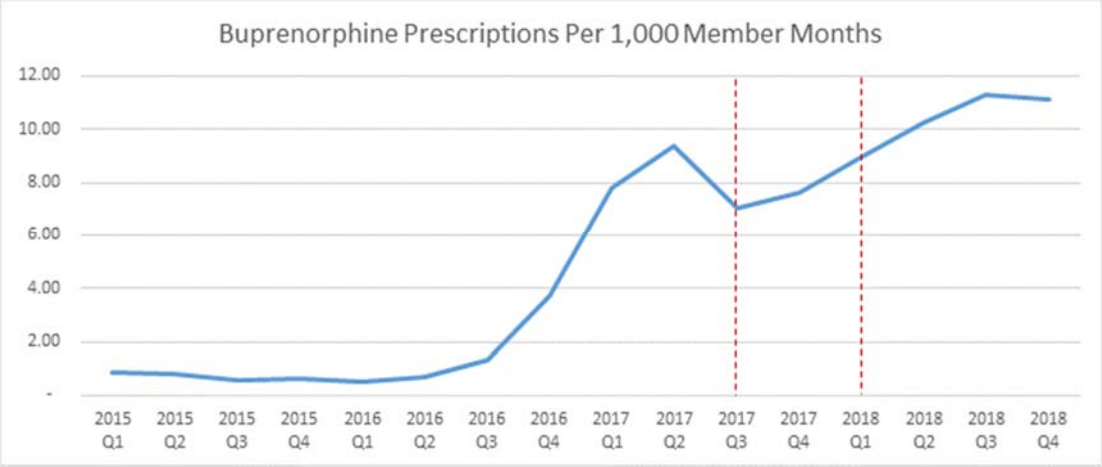
UHA has processes in place to continually improve member engagement with SUD services. For example, in 2016, UHA's pain committee reviewed OHA's Data Dashboard, which showed a low utilization of buprenorphine and buprenorphine/naloxone among Douglas County residents compared to Oregon State, despite a higher use of opioids. Interviews with community stakeholders informed us that our buprenorphine/naloxone prior authorization edit was creating a barrier to treatment. In September 2017, prior authorization criteria for these medications were reviewed and several criteria were removed to improve access. The graph below shows Douglas

County had lower buprenorphine/naloxone utilization compared to the rest of the state prior to 2017, and improved rates in recent years.

Buprenorphine/naloxone utilization per 1,000 residents, Douglas County vs Oregon State, 2011-2018



After adjusting the Prior Authorization requirements, UHA's Pharmacy and Therapeutics committee was still concerned that any restrictions may hinder SUD treatment access. To address this, the prior authorization requirement was removed from generic buprenorphine/naloxone on 4/1/2018. Since our goal is to increase utilization of these agents, we measured the rate of buprenorphine and buprenorphine/naloxone utilization per 1000 members per month over time. The rate of buprenorphine and buprenorphine/naloxone utilization continued to rise in 2018. The dotted red lines below show when restrictions were reduced and then subsequently removed altogether.



As expected, removing restrictions and barriers to these medications have been successful in ensuring access to SUD treatment. We will continue to look for ways to increase access to SUD treatment. We are reviewing the long-acting SUD injectable medications at our next Pharmacy and Therapeutics committee meeting to minimize barriers to these treatments. UHA is reviewing

the benefits associated with SUD injectable medications, such as compliance to treatment and aid in adherence.

Reduction in overdoses and overdose related deaths

UHA is represented at the HIV alliance coalition which supports training of the local law enforcement, first responders and schools on the proper use of Narcan/Naloxone. UHA is actively engaged with the opioid drug task force which provides the community with resources and education on the opioid epidemic in Douglas County and state wide. UHA will continue to provide education and tools to providers to reduce the prescribing of narcotics, provide recommended taper reduction dose for person with chronic opioid use and promote buprenorphine waiver for providers. UHA will engage in a media campaign to promote abstinence programs with the schools and local after school programs.

E.2. <u>Prioritize Access for Pregnant Women and Children Ages Birth through Five Years</u>
Applicant will prioritize access for pregnant women and children ages birth through five years to health services, developmental services, Early Intervention, targeted supportive services, and Behavioral Health treatment.

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?

UHA contracts with local pediatric providers who see young patients frequently, and who are equipped to address both the needs of the child, as well as their families. UHA makes an effort to inform all pediatric providers of the needed social-emotion screening, as well as its support program, New Beginning. This information will be communicated to providers through UHA's Quality and Provider Network Department. Providers will be given information on how to refer children if adverse items are identified during the screening process. Providers are also in a position to refer families to our New Day Program, which was created to address the needs of pregnant patients who could benefit from a behavioral assessment and/or management throughout the pregnancy, as well as post-partum screenings for six weeks beyond birth. In the event that concerns show further testing should be implemented, our New Beginnings Program seamlessly transitions the child and family into a program extending into the early years of the child's life, to provide screenings, support, and resources to promote healthy living.

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?

UHA is promoting the use of the ACE screening assessment tool with the local CMHP, pediatricians, and family medicine providers. UHA recognizes the importance of standardized screening of children and addressing ACEs. UHA will be providing access and support to providers to complete an ACE assessment on all UHA children. Adapt's Rapid Access team will collaborate with UHA care coordinators to work with our members, medical providers, and social service agencies to identify treatment needs, explore treatment options, and assist with referrals and authorizations to help families get the care they need. Once there are indications of ACEs, additional tools help providers assess the member's resilience using additional screening tools, such as the Resilience Trump Aces questionnaire, that provides a resilience score.

UHA will collaborate with the providers to create a care plan that includes completing the ACE

assessment and follow up with the Resilience Trump Aces questionnaire. UHA will update and monitor the care plan for completion of these interventions. UHA will ensure the ACEs assessment and the Resilience Trump ACEs questionnaire is completed by providers and part of the member's medical records.

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?

UHA will support the providers in screening all pregnant women for behavioral health needs by providing continuing education on how to use and incorporate the SBIRT screening tool into every day practice. UHA prenatal providers currently use this tool and refer directly to substance use providers and UHA care coordinators. UHA will implement a standardized process with providers to ensure the member is screened at least once during the pregnancy. UHA currently monitors all new pregnant enrollees, screens these members for needed service through a chart review process, and reaches out to the member or the provider to offer services through our New Day program. UHA has a dedicated care coordinator that specializes in assisting pregnant women through SUD during pregnancy. UHA's care coordinator works with the member to establish a family birthing plan, coordinate treatment, such as MAT or inpatient residential care, and supports the member in retaining the child in the home when child services is involved.

The New Day program is a service of UHA designed to help pregnant women struggling with substance abuse or other challenges. The target population for New Day is CCO members whom are pregnant with any past or present SUD, mental illness and/or two or more social determinants of health (SDOH) risks. UHA is able to establish support and close monitoring of women referred to this program throughout the pregnancy and six (6) weeks after birth. In efforts to support our community providers and positively impact the health outcomes of these pregnant women and their newborn babies, UHA has determined early identification and care coordination through member engagement in the New Day Program will reduce barriers and improve access to treatment and services for behavioral and physical healthcare needs.

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?

UHA will ensure clinical staff providing post-partum care have a standardized process in place to screen members and refer members to behavioral health services. This process will include a referral to UHA care coordinators to help the member engage services. The care coordinator will use provider assessment to create a care plan set goals and interventions and engage the member in the appropriate level of service.

We will assess each patient for basic resource needs, mental health and substance use issues, and safety and environmental factors. UHA provides the following:

- Assess barriers to care
- Assist in engaging the patient in treatment
- Connect patients with community support and resources
- Provide education about behavioral risk factors (i.e. smoking, nutrition)

- Encourage healthy and realistic goal setting
- Provide on-going support throughout the pregnancy
- Work as a liaison between medical and community providers

UHA has clinical engagement teams available to meet with the provider's patients in their practice or in the New Day office to ensure that they have the proper tools for the ACE program.

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?

PCIT is offered by our contracted behavioral health provider and a few of our independent providers as well. UHA will provide community education on PCIT, and increase awareness of service availability through member handbook, member website, and the provider newsletter and provider website. UHA care coordinators monitor children placed in foster care and or children involved with DHS. Children with multiple placements and other social determinants of health risks will be referred to CMHP providers for assessment into their PCIT program or referred to a local independent provider. Children that are at risk are children with two or more social determinants of health risks and demonstrating emotional anxiety, disruptive behavior, or have ADHD. Providing this service to the family will reduce exacerbation of disruptive, antisocial behaviors and give the parents or guardian the tools to needed to provide a safe learning environment for their child.

UHA case managers coordinate with the member, member's care team, and member's parents and/or caregivers to encourage participation in dyadic treatment and identify and eliminate barriers that may prevent participation, such as transportation and lodging.

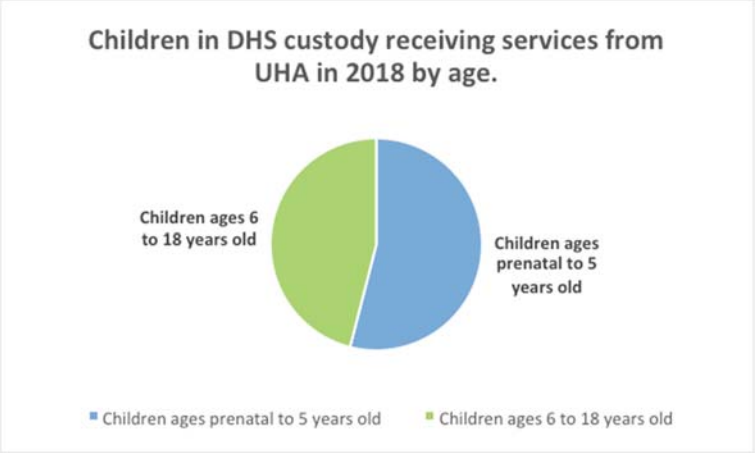
E.2.f. How will Applicant ensure that Providers conduct in-home Assessments for adequacy of Family Supports, and offer supportive services (for example, housing adequacy, nutrition and food, diaper needs, transportation needs, safety needs and home visiting)?

UHA will ensure that providers are screening members for needed services through their assessments and that they are aware of resources available to conduct in-home assessments for family supports (i.e. supportive services such as nutrition; transportation needs; safety needs, such as home health agencies or APD/AAA). UHA care coordinators will help coordinate services, provide resources, and provide transportation services. For example, health-related services (HRS) funds can be used for transportation to the grocery store, temporary housing at the local motel, and clothing. UHA care coordinators are available to assess members in their homes.

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.

The early years of a child's life, specifically prenatal to age five, has a significant impact on physical and social development. For children affected by chronic SDOH issues, poverty, mental health issues, violence, substance use, or lack of stable housing and nutritious food, their ability to develop the needed skills to succeed in school and cope socially are negatively impacted. The additional effects of being raised in situations of excessive stress result in the lack of adaptive

behaviors needed to solve simple problems that are reflected in the child's readiness for Kindergarten. These challenges also decrease their lifelong health trajectory causing dental issues, chronic health problems, and increased health risk factors, especially in those whom are a part of the foster care system.



UHA has a program called New Beginnings focused on children, prenatal to five years, with indications of ACEs and high complexity due to one or more of the following: multi-system involvement, two or more caregiver's placements within the past six months, moderate to severe behavior challenges, at risk of losing current caregiver placement, or school or daycare placement. The New Beginnings program was created to transform the way health care providers and our community programs work together. Referrals will be received from providers, and DHS along with the Ace Assessment. UHA will identify eligible members based on two or more caregiver placements in the last six months, moderate to severe behavioral challenges, and are at risk of losing current caregiver placement or school/daycare placement. UHA staff will engage the identified candidates via outreach by letter and phone calls. They will also coordinate with the member's current provider team and community partners. Once the member and the family or caregiver is engaged, a UHA care coordinator will develop flexible and unique coordinated care plans to optimize health outcomes for the child and their families, including referral to the PCIT program. Coordination includes the following: timely and appropriate referrals to needed services; identification and problem-solving around barriers; elimination of redundancy of services; and ensuring communication with the family and their care team. This collaboration with community partners and primary care providers will facilitate team services across health and social care boundaries. We anticipate this program can lower the barriers of social determinants and positively impact the health outcomes of these vulnerable children.

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?

UHA case managers follow all children who are receiving high levels of care, such as Psychiatric Residential Treatment Services (PRTS), and collaborate with the CMHP case manager, the facility where the member is receiving services, and the member's family and/or caregiver whenever possible to facilitate dyadic treatment. UHA case managers assigned to a member attend all possible meetings that involve care coordination or care planning for the member, which includes multidisciplinary meetings with the member's care team, and regular meetings

with the CMHP case management team. UHA case managers coordinate with the member, member's care team, and member's parents and/or caregivers to encourage participation in dyadic treatment and identify and eliminate barriers that may prevent participation, such as transportation and lodging. UHA is contracted with Bay Cities Ambulance to provide transportation to all UHA members and if appropriate, members' families. Additionally, UHA can provide lodging using HRS funds to maximize family involvement in dyadic treatment.

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.

UHA's entire organization is committed to improving the health, wellbeing, behavioral health, and the lives of our members within our community. We work with Trauma Informed Oregon, which is a collaboration of university, public and private partners, individuals with lived experience, youth and family members that are committed to creating and sustaining a trauma informed system of care in Oregon. UHA is looking at several avenues that will support our efforts to specially focus on the Behavioral Health side of care.

Provider and Staff Training

UHA embraces the collaborations of the Douglas County community partners to ensure that we can best fulfill our commitment to educate and train our providers. UHA uses a learning platform to administer automated annual training to the employees and providers of UHA. This training consists of cultural and linguistic training using the national CLAS standards. Trauma-informed training uses the nationally recognized principles of Trauma Informed Care (TIC) and are in alignment with SAMSHA's concept of trauma and guidance for a trauma-informed approach.

- We offer providers resources related to specific Behavioral Health fields or topic areas, including schools, health care, clinical practice, suicide prevention, and others. UHA has videos and training materials for our network in addition to literature that our staff and providers can reference for help.
- UHA is working with an ACEs assessment training program within its rural community.
- UHA regularly offers training to our staff and medical providers on the importance of trauma approaches and practices. Each quarter UHA holds provider network meetings that include training and approaches and interventions that guide our network on training and CME opportunities. These trainings promote healing from trauma and describe the support that UHA offers for our staff and community providers. An example of training is the Reliance Summit Conference of 2018, which was open to all community members. Last year, UHA was a sponsor for this event to bring awareness to the medical community on steps providers could take to best integrate ACEs awareness within individual practices.
- UHA focuses on the physical, behavioral and dental health care of our members, and we believe the best way to do that is to approach healthcare by looking at the needs of a member as a whole. Investing in the integration of trauma informed care now will not only impact our members but will help influence their overall health for the rest of their lives. ACEs determine the likelihood of the 10 most common causes of death in the United States. Locally, 40 percent of UHA members report four or more ACEs, the

highest percentage out of any Coordinated Care Organization.

- UHA's goal is to meet monthly with each PCP and Specialty offices and schedule hands on training following the Trauma Informed training approach. These provider tools will also add to the guidance with our customer service support and any information on ACE and trauma best practices.
- UHA has put in place monthly educational folders where we can discuss issues with our network and also encourage hand-in-hand efforts to jointly make sure we are meeting the same goals for our Behavioral Health patient population.

UHA Targeted Interventions

The New Day and New Beginnings programs (described above) have had a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunities. These programs positively impact the health outcomes of pregnant women and their newborn babies. The New Beginnings program is transforming the way health care providers and our community programs work together for better health outcomes for our youngest members. New Beginnings will be focusing on the prenatal to age five populations of about 3,125 lives or 12% of our total membership (26,759 lives). The New Day program for pregnant women with a history of SUD is using early identification, care coordination, and member engagement to reduce barriers and improve access to treatment and services for behavioral and physical healthcare needs. Our goal is to continue making strides with our community partners, to create a system of care that better serves our members.

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.

E.3.a. Describe Applicant's screening and stratification processes for Care Coordination.

1. How will Applicant determine which enrollees receive Care Coordination services?

UHA identifies members needing Care coordination through health risk assessment (HRA) process, referrals from providers, and claims data analytics. All UHA members are eligible for care coordination services and members will not be denied assistance at any time.

HRA surveys are mailed out to all new enrollees. Upon receipt of the completed health risk assessment, UHA care coordinators will reach out to the members via phone call to offer care coordination services. These services include providing resources, assisting with appointments, or arranging transportation. The care coordinator will assess each member engaging in care coordination, and the assessment and care plan will be shared with applicable providers.

All providers are able to refer identified members to a UHA care coordinator through a referral process. The referral and instructions for submission are located on the provider website. Providers may also call directly to the Care Coordination department for service. The Care coordinator specialist will complete the referral form and send it to a care coordinator for follow up. The care coordinator will reach out to the member within 24 hours of receipt of a referral.

The care coordinator will offer services and complete an assessment and care plan that will be shared with applicable providers.

In addition to the above referral process, claims data mining is used to identify SPMI members, high utilizers, and newly diagnosed SPMI members. Once SPMI members are identified they are tracked through a cohort group in PreManage. PreManage is a program that enables the care coordinator to locate and assist members when they present to the emergency department or are admitted to the hospital. Care coordinators also attempt to contact the members via phone calls and will try to coordinate service through the primary care physician's office.

2. How will Applicant ensure that enrollees who need Care Coordination are able to access these services?

UHA care coordinators will reach out to members that are identified as high utilizers of services, have multiple hospitalization, or are identified by member services for multiple changes in primary care physicians (members that have difficulty sustaining a relationship with their chosen provider). UHA recognizes that members with frequent changes in primary care physicians maybe having difficulties navigating the healthcare continuum. A care coordinator reaches out by phone or mail in attempt to offer coordination services to the member.

UHA also makes receiving a referral request for care coordination services as easy as possible. It is part of the member service website, members' welcome packet, and members can call the Member Service office and request a care coordinator to assist them with resources and services. Members can also request care coordinator services in other languages using interpreter services. UHA has fliers in key areas of the community, such as the emergency department, the local hospital, and local mental health provider offices. UHA has a provider network liaison that provides ongoing education to the community and its providers on available services, including care coordination.

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?

UHA has monthly utilization management meetings with the leadership team to review over- and under-utilization of services. UHA has created a monthly Care Management Utilization report of new members that identifies members who have not utilized services in their first six months of enrollment. This report is provided to the care coordinator specialists. A referral will be opened in the case management system and a care coordinator will be assigned to each member on this list. The care coordinator will continue to attempt to reach the member via phone and mailers to help the member become established with their PCP or any other needed services. Care coordinators will also reach out to the assigned PCP to request assistance with engaging the member. Our case management system will keep these members on the care coordinators task list as long as they are eligible with UHA. Our goal is to assist members in becoming established with their assigned primary care physician.

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).

A referral can be received via fax, phone or email. As soon as it is received, the case management specialist or case manager on call creates a referral in our operating system, with a

high priority email alert letting the case manager know this is an ICC case. ICC cases require a reach out to the member within 24 hours of receipt. UHA case managers are also on call after hours and on weekends. Each case manager is equipped with a laptop and cell phone and are required to check the case management efax and case management email three times a day for referrals. Additionally, UHA has a 24/7 nurse line that is instructed to call the case manager on call if a member needs immediate assistance with coordinating care or transitional care coordination. The case management specialist or case manager on call will follow up with the assigned case manager and assist in contacting the member.

Once that case manager contacts the member, he or she completes a case management assessment, which will generate a care plan. The care plan will be implemented and shared with the primary care provider. All of our Special Health Care Needs members are flagged in our operating system and in PreManage. This allows for accurate follow up to any changes in condition that would require care coordinated services. To ensure general assessment and the care plan are completed and updated in a timely way, the case management operating system generates a monthly error/missing data report, which is shared with the care coordinator with an expected completion date. Random audits are performed by key personal to ensure care plans and assessments are completed and appropriate for meeting the member's needs.

E.3.c. Please describe Applicant's proposed process for developing, monitoring the implementation of and for updating Intensive Care Coordination plans.

UHA has implemented a tier system for members with three tiers. The first tier consists of members that require ICC, which is defined as members with overutilization of services (such as ED visits), chronic conditions, co-morbidities, and social determinants of health equity, such as homelessness. These members will have a case manager assigned to them and will be discussed at our twice weekly IDT department meetings with a detailed assessment and care plan. The second tier are members that require coordination of services, assistance with appointments with specialists, and connections to resources but do not require intensive services like the population in the first tier. The third tier are members that have a support person and are considered stabilized in their environment, such as members placed in foster care, or long-term care. These members will continue to be followed through the PreManage system but require less active case management interventions. They will have their care plans reviewed and updated as needed or on an annual basis.

Each care plan is built to meet the individual needs of the member. The care plans have a list of prioritized goals for a member; establish timeframes for reevaluations of goals; and provide resources that might benefit the patient, including a recommendation as to the appropriate level of care. The care plan will include continuity of care, including assistance in making the transition from one care setting to another and is a collaborative approach to health awareness. The care plan includes family and/or support person participation. The guidelines used to create a care plan are as follows: the care plan should enhance the patient's treatment plan by providing a list of identified health conditions or problems with a corresponding prioritized list of interventions to meet the patient's goals. The care plan is prioritized based on Maslow's Hierarchy of needs.

Once a member with special health care needs is identified, for example a member at high risk for readmission or an adverse medical event, the case manager will complete an assessment. The assessment criteria are based on the needs of the member. UHA uses the Care Coordination

module from InterQual for its assessments. The initial assessment will open screening tools based upon the member's condition. Some of the screening tools incorporated into the assessment include: Cognitive screening, Missouri Alliance for Home Care (MAHC) 10, Patient Health Questionnaire-9 (PHQ-9 depression screening, Health-Related Quality of Life (HRQOL), Katz activities, Two-Item Conjoin Screen (TICS). Each of these tools will be available as the member answers relate to the screening need. Once the assessment is completed, the responses will generate a care plan for the member. The case manager will be able to add relative goals and interventions and prioritize them to fit the member needs.

The goal development in the care plan uses SMART goals: Specific, Measurable, Achievable, and Relevant Treatment goals. The case manager then can prioritize the goals, identify barriers to goal obtainment, and create interventions to meet set goals. Each goal that is created will require the member and case manager to set target dates, then each target date will be flagged in UHA's operating system for follow up. The case manager will update the care plan at each target date. To ensure the case managers are updating the care plans in a timely and efficient manner, the case management operating system will send alerts to the case manager on overdue tasks and monthly auditing will be completed by supervisor. UHA's operating system produces a monthly report of missing/overdue tasks which will be monitored for corrections by the care coordinators. UHA's policy is to have care plans reviewed annually, or when there are changes to a member's health status. This timeline is for members that are experiencing stabilization within the community and have completed their interventions and have met their goals.

E.3.d. How does Applicant plan to provide cost-effective integrated Care Coordination (including all health and social support systems)?

UHA's integrated Care Coordination programs are currently structured in the following domains:

- Intensive Case Management Case Management/Care Coordination
- New Day and New Beginning Program
- Behavioral Health Case Management/Care Coordination
- Chronic Disease Case Management/Care Coordination
- Transitional Care Program

The above-mentioned programs integrate care coordination through the concurrent review process, Community IDT meetings, discharge planning, and care coordinator referrals. The care coordinator will initiate contact with members at the local hospital, transition of care office, providers' office or at home. This process allows for a face-to-face visit that provides the member with a point person to assist with discharge planning and transition of care to lower levels of services. The process ensures the member will transition timely and efficiently to the next service level. UHA's care coordinators will assist with coordinating services with primary care physicians and specialist, SUD services, and behavioral health services.

UHA is working with Adapt, City of Roseburg, Douglas County, Mercy Medical Center, Douglas County Mental Health Court, and the local public safety coordinating council, to establish a 24-hour crisis resolution center. The crisis center will consist of a QMHP to be on duty 24 hours a day seven days a week to provide face-to-face assessments and crisis counseling. The QMHP will also provide telephone triage, support, and referrals to providers. QMHA will assist the QMHP to gather information, monitor clients, and provide support and practical

assistance. This process will ensure that patient in crisis will be placed in the right level of service and start treatment as early as possible. This group also is in discussion for a sobering center, which may be co-located with the crisis center.

UHA will continue to host the monthly Community IDT meetings. These meetings consist of community members, such as Advantage Dental (DCO), Mercy Case Managers, Compass ACT team, Wraparound coordinator and behavioral health coordinator, Local home health agencies, DHS- ADP and case managers, Adapt-SUD coordinator, South River navigator, and Harvard Clinic navigator to name a few. If the community IDT meeting continues to grow, we will expand to meet every two weeks. This meeting ensures that services for members are not being duplicated and the member is receiving the right care and the right level.

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?

UHA uses a learning platform to administer automated annual training to the employees and providers of UHA. This training consists of cultural and linguistic training using the national CLAS standards. Trauma informed training uses the nationally recognized principles of Trauma Informed Care (TIC) and are in alignment with SAMSHA's concept of trauma and guidance for a trauma informed approach. UHA offers continued education through webinars, speakers and hosts events to ensure the community is culturally responsive and trauma informed.

At UHA, we believe it is our responsibility to provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The members we serve come from culturally diverse backgrounds. We strive to provide the best care possible to all our members and patients with awareness of their unique needs related to their gender, ethnicity, race, color, language, socio-economic status, education level, age, religion, sexual orientation, and physical and mental ability. Our goal is to advance health equity at every point of contact. To this end, UHA has developed CLAS tools and strategies for our organization and our provider network.

Our member services and clinical engagement teams have translation services available as needed. UHA's alternate format and Language Access Service policy is fundamental to ensuring equity in the delivery of healthcare. The goal is to reduce health disparities for UHA's limited English proficient (LEP), deaf, hard of hearing, speech impaired, and blind members. UHA periodically reviews the effectiveness of this service through a self-assessment process. We also provide certified language support services that our providers and sub-contractors can access to assist our members. Our member services department runs a weekly query to identify members with LEP so that they can be flagged for the appropriate language support services. We routinely send member materials in English and Spanish but print materials can be provided in other languages as needed.

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?

UHA does delegate some care coordination services outside of the organization, specifically with Adapt/Compass and with the DCO. UHA has specific language in its contract with the provider on coordinated services, policy and procedures, quality measures and expected outcomes. UHA

maintains oversight of these delegated services through the Community IDT meetings, steering committee, and weekly care coordination meetings for members engaged with intensive case management services. UHA will maintain oversight and will conduct annual audits to ensure policy and procedures are being followed and to review quality services are being provided.

UHA delegated these services to CMHP to ensure Oregon Health Authority specialized services such as, ACT team services, choice model, Wraparound services and crisis intervention services, are provided by qualified experts in this field of service.

E.3.g. For Fully Dual Eligibles, describe any specific Care Coordination partnerships with your Affiliated Medicare Advantage plan for Behavioral Health issues.

UHA is affiliated with ATRIO Medicare Advantage plan for care coordinated services, utilization review services and behavioral health care services. UHA has a dedicated team to assist dual eligible members. The purpose of this team is to assist members in bridging care, reduce barriers and reduce social determinants of health equity. The intensive care coordinator is responsible for coordinating services with providers, pharmacies, durable medical equipment suppliers, care facilities, hospitals, home health care companied, mental health organizations, chemical dependency agencies and any other community services. The intensive care coordinator is a member advocate and is a liaison between dual eligible members and or caregivers and providers. The care coordinator is part of the monthly IDT team meeting and coordinate services with APD/AAA for members in need of these types of services. The intensive care coordinator will participate in home visits to ensure members are receiving services and needs are being met. The intensive care coordinator will complete health risk assessment, create a care plan that is provided to the member and their provider, and assist with transitions of care. Dual eligible members have the same access to mental health and SUD as any other UHA member.

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?

UHA's strategy to engage specialized and intensive care coordination services are particular to the populations being served. For expecting mothers with SUD and or social determinants of health equity, UHA will continue to provide education to the community through such events as the community baby shower, creating a universal referral system with the community and its providers, and increasing the use of health risk assessment funds to reduce or mitigate social determinant of health equity. UHA will continue to educate providers to reduce the stigma of SUD during pregnancy and increase OB/GYN engagement in receiving waiver for prescribing buprenorphine.

UHA's strategy for engaging children in specialized and intensive care coordination is to increase availability of Wraparound services. UHA will continue to collaborate with DHS on placement of children, providing streamlined transitions of care, and encourage and support families staying together though behavioral health services, such as the PCIT program. UHA will continue to imbed behavioral health providers in schools.

UHA's strategies for engaging SPMI members in intensive care coordination is to build a rapport with the member, by meeting the patient face-to-face and making information available to them. UHA can use health risk assessment funds to assist members with immediate needs, such as cell phone, temporary placement, transportation, or food vouchers for the local farmer's market. UHA plans to address barriers for our SPMI members by expanding the care coordination

department, includes incorporating Traditional Health workers, to assist with member engagement. UHA will coordinate services with the CMHP to help members receive skills training, job training, and to coordinate housing application with local UCAN partners.

Lastly, UHA is in the process of adding THWs into its Care Coordination program. The strategy behind this approach is to deploy THWs with members with engagement or other barriers to care. Working in conjunction with care coordinators, the THWs will be used as a resource to help the ICC population engage in services and care coordination.

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.

UHA does not discharge members from care coordination or ICC services. UHA has implemented a tiered system for care coordination. Members receiving intensive care coordination will be transitioned first to lower intensity services. Members that require less services are those with a permanent placement, stabilized support services, and have developed a self-sufficient routine; they will continue to be monitored for changes of condition, or relapse. When members transition from intensive care coordination to maintained care coordination (low level), the care coordinator will meet with the member face-to-face two times during the week of transition. The member will be provided a treatment plan and instructions, and the face-to-face meeting will occur at the physician/providers office to ensure a warm hand off. The care coordinator will then follow up after the transition to lower level of care within three days of transition to physician/provider in order to continue to support the member through the transitional period. Members who choose not to engage or to participate in in their own discharge planning will be followed on a low intensive service plan, which includes a continued reach out to the member at a minimum of every six months.

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?

UHA partners with Compass who utilizes several specialized programs to address the needs of the SPMI population. Each of these programs provide care coordination through Coordinated Multidisciplinary Community meetings, IDT meetings either in-person or via telephone/Skype participation with acute, State Hospital, SRTF, RTF/RTH and AFH placements within and outside of the geographic service locations to support the member population enrolled in the various programs. Compass Crisis, Forensics, EASA and ACT programs provide services to members within the Douglas County jail to coordinate services and assess risk status. Mental Health specialized services (Assertive Community Treatment, Early Assessment and Support Alliance, IPS Supported Employment, Forensics Programs (Mental Health Court, Jail Diversion, ORS 161.370 Aid and Assist support, Psychiatric Security Review Board), Crisis, Healthy Transitions, Choice Model, Clinical Case Management (to include Peer Support and Skills Training), Crisis Services, Therapeutic Learning Classroom and Wraparound primarily provide members services within the geographical area of Douglas County in lieu of office based services.

Choice Model (Enhanced Needs Care Coordinators) provides coordination support to and from higher levels of care (Oregon State Hospital, SRTF, RTF/RTH, AFH and Personal Care

Assistant 20) transitions related to Mental Health within Douglas County and across the State of Oregon.

When members are placed out of area, the care coordinators work with placement agencies to identify the additional needs and services that the member will need in the out-of-area placement. The care coordinator will then update the care plan to include finding additional provider, resources, services, and support in order for the member to receive the same level and access to care and he/she would if they were residing in their local community.

E.3.k. How will Applicant manage discharge planning, knowing that good discharge planning begins from the moment a Member enters services?

UHA case managers are engaged with the member's care from notification of admission. The case managers are responsible for coordinating services with the social worker or case worker for all members in each level of care (i.e., from inpatient services to intensive out-patient services). UHA intends to advocate for the member to receive necessary treatment at all levels of care. This advocacy includes providing out-of-network services if necessary. UHA contacts case workers or social workers at each level to coordinate care. UHA will ensure members are discharged to the appropriate level of care through the Utilization Review process, ensure the members receives timely follow up with the primary care physician, help members eliminate perceived barriers to services, and assist members with transportation, medication adherence, and treatment plan compliance after discharge. Lastly, UHA will work with the discharging facility in producing a relevant and meaningful discharge instructions that can be given to the member and their provider, to ensure an appropriate transition of care.

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)?

UHA partners with Compass, the CMHP, who uses several specialized programs to address the needs of the SPMI population. Each of these programs provides care coordination through Coordinated Multidisciplinary Community meetings. The IDT meetings are held either in-person or via telephone/Skype participation with acute, State Hospital, SRTF, RTF/RTH and AFH placements within and outside of the geographic service locations to support the member population enrolled in the various programs. Compass Crisis, Forensics, EASA and ACT programs provide services to members within the Douglas County jail to coordinate services and assess risk status. Mental Health specialized services (Assertive Community Treatment, Early Assessment and Support Alliance, IPS Supported Employment, Forensics Programs (Mental Health Court, Jail Diversion, ORS 161.370 Aid and Assist support, Psychiatric Security Review Board), Crisis, Healthy Transitions, Choice Model, Clinical Case Management (to include Peer Support and Skills Training), Crisis Services, Therapeutic Learning Classroom and Wraparound primarily provide members services within the geographical area of Douglas County in lieu of office based services. The Choice Model's Enhanced Needs Care Coordinators provide coordination support to and from higher levels of care (Oregon State Hospital, SRTF, RTF/RTH, AFH and Personal Care Assistant 20) for transitions related to Mental Health within Douglas County and across the State of Oregon.

E.3.m. Describe how Applicant will ensure ICC Care Coordinators will maintain the 15:1 caseload requirement.

Per addendum #6, question number five, the OAR has not been updated to include this requirement. If OHA implements this requirement, UHA will make the necessary adjustments to meet the levels specified in the new OAR. We will evaluate options which could include expanding the care coordination department; reviewing current tier level criteria for care coordination services; or redefining intensive (high) care coordination services versus moderate (medium) care coordination service and maintenance (low) care coordinating services.

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?

In addition to regular treatment team meetings, UHA will use various screening tools to determine level of need and progress within routine service provision and specialized programs. These tools help determine the level of care coordination needed between our community partners.

UHA's community providers use Mental Health evidence-based and specialized screening tools that are embedded Electronic Medical Record's Mental Health Assessment and attached to specialized programs (ACT, EASA, and Wraparound). The following screening tools are included in all Mental Health Assessments for SPMI populations to assess and guide service treatment:

- ACEs
- Alcohol Use Disorders Identification Test
- General Anxiety Disorders-7
- Patient Health Questionnaire-9
- World Health Organization Disability Assessment Schedule 2.0
- EASA
- All individuals age 15-25 the Mental Health Assessment with PQ-B (Prodromal Questionnaire-Brief) is used to screen for early psychosis as well as the above screenings.
- Structured Clinical Interview for DSM-% Disorders (SCID-5-CV)
- Structured Interview for Prodromal Syndromes (SIPS)
- ACT
- Utilizes the ACT Transition to Readiness scale on a quarterly basis to guide continued ACT support and/or determine Readiness to transition to less intensive services.
- Wraparound
- Child and Adolescent Needs and Strengths (CANS)
- Choice Model
- Level of Service Inventory (LSI)
- Level of Care Utilization System (LOCUS)

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?

Our internal staff, providers, and community partners have access to a Business Intelligence (BI) platform, Inteligenz, which provides rich analytics and reporting. Inteligenz includes a Provider Portal as well as a CCO Metrics Manager that provides rich and meaningful data, including member-level reports and higher-level population health or quality metric reports.

UHA staff and our provider network also have access to PreManage, which alerts providers of hospital or ED events in real time. We are able to include notes in PreManage to inform providers of the name and contact information of the case manager assigned to the member. The case manager operates as the primary point of contact, coordinating the flow of information between the providers, member, and other community partners.

Additionally, our CCO built and implemented the EMR platform used by the majority of the providers in our community. EMR integration has been a major mechanism that has supported the flow of information among providers and our CCO. This allows providers to freely access each other's medical records and allows for effective care coordination.

Lastly, all members who are enrolled in Care Coordination will have a care plan that is developed in conjunction with the member, their family, and their care team. Care plans are then distributed to the providers that care for the members, so they are aware of the goals and interventions that are established during the care planning process.

E.4. Severe and Persistent Mental Illness (SPMI)

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?

UHA has a close working relationship with the local CMHP that provides mental health services to UHA members with SPMI. UHA will host monthly IDT meetings with the local CMHP, DHS, and various other local agencies to identify areas of improvement to services and treatments for members with SPMI. Additionally, UHA, in collaboration with the LMHA, plans to form a Community Behavioral Health Task Force that will incorporate community mental health and SUD agencies, DHS, and the CMHP. The task force will perform a community needs assessment similar to the CHA and develop a Behavioral Health Improvement Plan based on the findings of the community needs assessment. See the planning timeline above in Section 11.C.1.

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?

UHA will enroll members to the Choice Model program when referred to state hospital and are on civil commitment. They will be in contact with the outside agencies and the local CCO to ensure care coordination and discharge planning is happening even before admission. IDT

meetings are essential and will be attended by care coordinators for the entire admission duration either via telephone/Skype or with face-to-face participation. Communication with them will start as soon as the client is referred to higher level of care and continue the duration of the hospital stay.

Level of service inventory (LSI) will determine the clinically appropriate level of care the client will require upon discharge (SRTF, RTF/RTH, AFH, PCA20, ACT, EASA, Clinical Case Management, Peer Support, Therapy, and Medication Management Support as appropriate). The coordinator will review and research options within that identified level of care to find the most appropriate and least restrictive environment. The Choice Model Manager through the CMHP provides treatment teams, community partner agencies, and the CCO with updates regarding appropriate placements and resources in the community to assist with decreased duration of higher level of care if resources in the community can be obtained for a safe discharge. Beginning at the time of referral and continuing through stabilization, the care coordinators will attend IDTs and continue to communicate with the social workers, requesting clinical documentation to assess the level of care need and reviewing appropriate discharge planning options for the individual in care to ensure members are placed in the least restrictive environment in the community.

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?

The UHA Care Coordination team attempts to contact all members who are identified with SPMI to assess the member's needs for care coordination. Part of this assessment includes identifying the member's living situation and helping them find appropriate housing. Additionally, if a member with SPMI is receiving services from the local CMHP, the CMHP will also provide the member with case management services that include assisting the member with finding appropriate housing. In the past, the organization has used flexible funds to provide short-term housing by paying for hotel nights during times of transitions for certain SPMI members. Additionally, Care Coordinators have also helped coordinate housing by completing rental application and using flexible funds to pay for rental applications.

On a systemic level, the organization will also work through the Community Behavioral Health Task Force to identify the housing options that are available in the community, and what barriers exist that prevent sustainable and supported housing. Additionally, UHA is a part of the Housing Subcommittee of the Douglas County Local Public Safety Coordinating Council (LPSCC). The Housing Subcommittee creates an environment where there is active care coordination to eliminate any barriers.

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?

UHA will work internally with its Care Coordinators as well as the local CMHP (Compass) to identify the specific housing needs of members with SPMI. After identifying the appropriate housing needs based on the member's treatment goals and clinical needs, the Care Coordinator team will help the member obtain and complete housing application forms, and assist the member with the application cost if he or she is not able to afford the fees. UHA and Compass work closely with the Housing Authority of Douglas County (HADCO) and a local United

Community Action Network (UCAN) to assist members with housing needs. UCAN has specific services for members with SPMI that can assist with obtaining and keeping affordable housing, such as education on leases, tenant/landlord mediation, peer support, help with move-in arrangements, rental assistance, and deposit assistance.

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?

UHA ACT services are currently being offered by the local CMHP (Compass). Compass maintains a Fidelity based certificate issued by OHA which is reviewed annually through the Oregon Center of Excellence Assertive Community Treatment (OCEACT). Members are reviewed for eligibility based on Compass Behavioral Health Eligibility Criteria Referral. All eligible members are admitted to ACT services upon discussion with the member who must consent to treatment as ACT is a voluntary program. For those who are not interested in ACT services or who are not easily engaged, the ACT team provides assertive engagement techniques over a 90-day period to attempt to encourage the member into admission of ACT. If the ACT team is unable to get the member to engage in services, the referring agency or provider will be notified, and the member will be offered other services available through Compass. If the member does engage in ACT services, they are provided the full-scope of ACT services until the member can successfully establish community integration and stabilization based on the ACT Transition to Readiness Scale.

For OAR 309-019-0250 compliance, UHA will work in collaboration with the CMHP to successfully transition members receiving ACT services to a less intensive level of services. Specifically, UHA will work with the CMHP to make certain that members transition when the following occur:

- Have successfully reached individually established goals for transition;
- Have successfully demonstrated an ability to function in all major role areas including but not limited to work, social, and self-care without ongoing assistance from the ACT provider;
- Requests discharge or declines or refuses services;
- Moves outside of the geographic area of the ACT program's responsibility.

UHA will also work with the CMHP to ensure reporting requirement are met in accordance with OAR 309-019-0255.

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?

If a member is eligible for ACT and is agreeable to receiving ACT services, then the member will not be denied admission. If a member is not eligible or does not wish to participate in ACT, the referring provider with be notified and the member will be referred to other intensive care coordination services.

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?

Any member that is eligible for ACT but declines to participate can be referred to the Compass Crisis team for short-term crisis stabilization when needed, the Compass Clinical Case Management team for care coordination and continued attempts to get member involved with ACT, and the UHA Care Coordination Team for ongoing case management. Members receiving case management with Compass or UHA are assisted with identifying the barriers that are preventing them from participating in ACT and developing a plan to help remove those barriers.

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?

If a member declines to participate in ACT services, the referring agency and UHA are notified and the member is assigned to the Clinical Case Management team with Compass. Members can also access other programs within Compass such as outpatient adult therapy and crisis support, in addition to receiving intensive care coordination through UHA if the member agrees to participate.

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?

UHA works in conjunction with Compass to deploy an ICC coordinator for members who need placement into a SRTF. While in the SRTF the coordinator attends monthly IDT meeting and is actively involved in the discharge planning from the beginning of placement. Recognizing that discharge planning starts the minute a member in place in a SRTF, the coordinator plays an active role in building rapport and establishing a care plan that meets the member and their family needs. This is done in conjunction with the member's care team. The coordinator will work with the member, his/her family, and care team to ensure that the most appropriate integrated setting is available once the member no longer needs SRTF. The coordinator will look for integrating settings as well as other support services that the member will need post-SRTF to ensure a stable and smooth transition.

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?

UHA is a part of the Housing Subcommittee of the Douglas County Local Public Safety Coordinating Council (LPSCC). Other agencies that are involved with the Housing Subcommittee are UCAN (local supportive housing), the Housing Authority of Douglas County (HADCO), the local CMHP (Compass) and Adapt SUD services division, DHS, Cow Creek Tribe, the Juvenile Department, and community members. The Housing Subcommittee has a large focus on members with SPMI and provides them with all around care coordination to eliminate any barriers that may prevent members with SPMI from obtaining housing such as assistance with filling out and paying for applications, negotiating and mediating with landlords, cost for moving and security deposits, and assistance with rent on a short-term basis.

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.

UHA has put significant resources to ensure appropriate coverage and services for SPMI members in acute care settings. UHA recently has worked with Vituity, who provides ED services at Mercy Medical Center, to operationalize a telepsychiatry program that can be deployed within the ED. The service will ensure that a psychiatrist is always available to assist SPMI members when they present into the ED. Additionally, UHA has embedded care coordinators. UHA will ensure a UHA care coordinator is assigned to members with SPMI in acute psychiatric care, the emergency department, and engaged with peer directed services. The coordinator will collaborate with CMHP to ensure all SPMI members are assessed for ACT services. For the SPMI members that are not engaged with ACT, the UHA care coordinator will collaborate with CMHP on creating an engaging alternative care plan to elicit the member's participation. UHA care coordinator will inform members of available services such as peer delivered services, peer wellness specialists, and family and youth support specialists. UHA care coordinators will make every attempt to engage the member when in the emergency department to ensure the member has appropriate connection to community-based services and will work with the rapid response coordinator from the CMHP to coordinate these services.

Compass also supplies a Crisis Team who regularly communicates with local emergency department discharge planners and acute psychiatric care discharge planners to coordinate aftercare appointments and plan for Members' engagement with Compass and community resources.

For SPMI members that are in an acute setting, UHA will assign an ICC coordinator to the member who will ensure the appropriate coverage and services are available to the member. The coordinator will complete a care plan to address the goals and interventions that are needed to ensure services are being delivered in an appropriate manner.

E.5. Emergency Department

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.

It is UHA's policy and procedure that care coordinators review all high ED utilizers, specifically SPMI members with two or more ED visits within six months. Members that are identified as high ED utilizers are entered in Pre-Manage, assigned to a care coordinator and a referral is entered in our operating system. The care coordinators will attempt to meet the patient at the ED or hospital to complete an assessment. When the member cannot be reached, the care coordinator will call the member at home. UHA provides cell phones during the Health Risk Assessment (through Health Related Service's flexible spending), that helps to establish a rapport with the member. UHA has also placed members in temporary lodging pending ACT

assessment. The care coordinator will offer our services and assistance with making appointments, arranging transportation and coordinating care. The care coordinator will work with the member to see their primary care physician. If the physician is unavailable, the member will be scheduled for a follow up appointment at UHA's transitional care office within three days of discharge from the emergency department.

E.6. Oregon State Hospital

E.6.a. How will Applicant coordinate with system partners as needed regarding Oregon State Hospital discharges for all adult Members with SPMI?

UHA has a process in place for CMHP providers and State hospital to notify the CCO when members are transitioning from one level of service to the next, UHA care coordinators collaborate with the CMHP provider and State Hospital discharge planner in arranging transportation. UHA will ensure through the utilization process that members are transitioning to the most appropriate, independent and integrated community-based setting.

UHA will work in partnership with Compass, hospital representatives, and other system partners to design strategies for effective discharge planning. This coordination will be happen through IDT meetings while members are residing in the State Hospital. Consistent with contract requirements, UHA will provide care coordination, case management, and discharge planning for these members to ensure a smooth and successful transition of care. UHA will arrange for all services that will need to be provided post-discharge and will ensure they are done in a timely manner. Additionally, UHA will work with the State Hospital and future providers in exchanging data, medical records, and discharge summaries to ensure an effective transition of care.

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?

UHA is notified by CMHP or the State Hospital though the Utilization Review process, or the IDT process. UHA care coordinators will request periodic updates from the State Hospital in order to prepare for and provide discharge planning assistance. The updates will be consistent with the needs of the member. For example, if a member requires a minimum of 30 days in the state hospital, the care coordinator may ask for a clinical update a week prior to ensure the member is on target for discharge planning. The UHA care coordinator will collaborate with the CMHP to ensure members are assessed to determine eligibility for ACT and the UHA care coordinator in collaboration with the CMHP will ensure alternative intensive services for individuals discharged from Oregon State Hospital who refuse ACT services. Upon notification that a potential UHA member will be discharging from the Oregon State Hospital, UHA in conjunction with its partner, Compass will deploy an ICC coordinator. The coordinator will reach out to hospital representatives and begin working on a care plan to assist the member after discharge. A coordinator will utilize the Choice Model when members are residing at the state hospital to plan for discharge. UHA will assist the State Hospital and future providers in exchanging medical records and discharge summaries to ensure appropriate and effective transitions of care.

E.7. Supported Employment Services

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.

UHA works with a contracted Behavioral Health provider to provide all eligible members access to Individual Placement and Support (IPS) Supported Employment services. Services may be requested by self-referral or service providers. Questions on employment status and desire to work are built into Mental Health Assessment to prompt clinicians to discuss referral and send referral to IPS Lead when a client states they would like to participate.

The IPS Supported Program follows the IPS Fidelity model of zero exclusion; all clients interested in working have access to supported employment services regardless of job readiness factors, substance abuse, symptoms, history of violent behavior, cognitive impairments, treatment non-adherence, and personal presentation. IPS Supported Employment works with the Oregon Supported Employment Center for Excellence (OSECE) for continued training and yearly review for fidelity adherence, requiring a minimum score of 100. In the case of not meeting minimum score, the IPS program works with OSECE to create an action plan and receives a 90-day follow-up review to ensure fidelity adherence.

IPS Supported Employment works in coordination with Vocational Rehabilitation (VR) to provide additional vocational supports to participants. The IPS Supported Employment Team and VR Counselor meet monthly to discuss and coordinate supports for shared clients. Employment Specialists working in the IPS Supported Employment Program receive continued on-site and monthly technical call trainings through OSECE, Job Developer Training through DHS/VR, and IPS Practitioner certification through the IPS Employment Center.

Each Employment Specialist carries out all phases of employment services listed in OAR 309-019-0275, in accordance with the fidelity standard. Participants are provided with follow along supports for a year after starting employment unless participant chooses to transition to lower level supports at an earlier time.

IPS Supported Employment services only end early after either client requests to terminate service or client disengagement with the following attempts to re-engage:

- Outreach by phone and mail
- Community Outreach
- Outreach to natural supports (when appropriate authorization is on file)
- Coordination to meet at other treatment team members' appointments.

Participant may be closed from services if 60 calendar days have passed from last substantial interaction and these varied outreach attempts have been made.

A fidelity report from December 20, 2018 by the OSECE scored areas in staffing, organization, and services. The following ratings were determined:

Element	Rating
Caseload size	4
Employment services staff	5
Vocational generalists	4
Integration of rehabilitation with mental health through team assignment	5
Integration of rehabilitation with mental health through frequent team member contact	4
Collaboration between employment specialists and vocational rehabilitation counselors	5
Vocational unit	3
Role of employment supervisor	5
Zero exclusion criteria	4
Agency focus on competitive employment	5
Executive team support for supported employment	4
Work incentive planning	5
Disclosure	4
Ongoing, work-based vocational assessment	3
Rapid job search for competitive job	5
Individualized job search	3
Job development – Frequent employer contact	4
Job development – Quality of employer contact	4
Diversity of job types	5
Diversity of employers	5
Competitive jobs	5
Individual follow-along supports	3
Time-unlimited follow-along supports	3
Community-based services	3
Assertive engagement and outreach by integrated treatment team	5

UHA's Behavioral Health provider achieved a total score of 106 out a possible 125 on the IPS Fidelity Scale, achieving the state benchmark. The report identified areas of excellence for the

role of employment supervisor, work incentives planning, and collaboration between employment specialist and VR rehabilitation counselors. The program continues to develop an increasingly robust collaboration with the treatment team and community partners to support members.

Furthermore, UHA will work in conjunction with Compass to make sure reporting requirements associated with OAR 309-019-0295 are met. Specifically, UHA will work to have the following items reported quarterly, in accordance with OAR 309-019-0295:

- All individuals who received supported employment in the reporting quarter;
- Individuals who received supported employment services who are employed in competitive integrated employment;
- Individuals who discontinued receiving supported employment services and are employed in competitive integrated employment; and
- Individuals who received supported employment services as a part of the Assertive Community Treatment program.

E.8. Children's System of Care

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.

E.8.a. What Community resources will Applicant be using or collaborating with to support a fully implemented System of Care?

UHA maintains oversight and is highly involved with process development and community involvement. Currently, several Community resources are collaborating to support a fully implemented System of Care. These resources include Douglas County Juvenile Department, Umpqua Community Health Center, Community Living Case Management, Department of Human Services Child Welfare, Douglas CARES, Cow Creek, Roseburg School District, Adapt, CASA, UCAN, Douglas ESD, Ford Family Foundation, and Casa de Belen.

E.8.b. Please provide detail on how Applicant will utilize the practice level work group, advisory council, and executive council.

UHA plays a key role for our members in each governance structure for System of Care (SOC). Currently the SOC is being restructured so there is clear separation of the levels of governance, this process will be completed by the third quarter of 2019. At that time the SOC will have three different functioning bodies: Review committee, Practice Level Workgroup/Advisory committee, and the Executive committee.

The Review committee which will also function as the Practice level workgroup, will consist of youth and family and different community partners including case managers from UHA and Compass. Their role will be to review referrals for Wraparound assessment and select members that meet the established criteria. This committee will also be responsible for tracking the participating members and will review all members that are exiting out of the Systems of Care Wraparound Initiative (SOCWI) to ensure a smooth transition.

The Advisory committee will identify, track, and remove barriers at the practice level for effective Wraparound practice. These group will consist of mangers from multiple community partners including UHA, Compass, Douglas County School District, DHS Child Welfare, the

Juvenile Department, and youth and family. This committee will contribute to policy development, allocating resources, assessing community needs, and reviewing outcomes of the SOCWI. Additionally, they will communicate with the Executive committee to provide information on any unresolved barriers and suggestions for changes in policy.

The Executive committee will consist of executive level leadership that have the control to make decisions regarding funding and policy changes within their organization. Agencies that will be involved at this level will include UHA, Compass, Douglas County School District, DHS Child Welfare, the Juvenile Department, the Douglas County Education Service Districts, and youth leadership. The main function of this committee is to provide one unified voice to communicate and report to the State level SOC.

E.8.c. How does Applicant plan to track submitted, resolved, and unresolved barriers to a SOC?

In the past UHA has delegated the Systems of Care to the Douglas County CMHP, Compass, but has maintained involvement in each level of governance. However, in 2020, UHA will begin to bring back the System of Care under UHA. UHA however will be mindful in not disrupting the success of the current functioning of the Systems of Care committee. Currently, UHA and Compass are jointly responsible for tracking any barriers that are identified either by a community partner, internal source, or a youth or family. Anyone who identifies a barrier can report their findings to the Systems of Care Coordinator by submitting a Barrier Submission form. Each barrier is presented to the Advisory committee to review and determine the actions needed to remove the identified barrier. The person that submitted the form will be invited to attend the Advisory committee meeting to further explain the barrier and help with finding the best possible solution. All identified, resolved, and unresolved barriers are manually tracked by the System of Care Coordinators and reviewed monthly by the Advisory committee. Any barriers that are not able to be resolved by the Advisory committee will be sent to the Executive committee for further review and will be reported to OHA if needed.

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?

UHA is working with Compass and Oregon Healthy Transition (OR-HT) to increase the involvement of youths throughout Douglas County. OR-HT will focus on marginalized youths and youths that are disconnected or at risk of being disconnected from services. By working with OR-HT UHA and Compass can continue to increase the number of youths and families involved in the System of Care (SOC). Currently the SOC has consistent involvement from local agencies and community partners including UHA, Compass, Douglas County Juvenile Department, Umpqua Community Health Center, Community Living Case Management, Department of Human Services Child Welfare, Douglas CARES, Cow Creek, Roseburg School District, Adapt, CASA, UCAN, Douglas ESD, Ford Family Foundation, and Casa de Belen.

E.9. Wraparound Services

Applicant is required to ensure Wraparound Services are available to all children and young adults who meet criteria.

E.9.a. Provide details on how Applicant plans to ensure administration of the Wraparound Fidelity Index Short Form (WFI-EZ)?

UHA oversees the administration of the Wraparound Fidelity Index Short Form (WFI-EZ) survey that is provided to the member by the Douglas County CMHP (Compass). UHA maintains the responsibility of reviewing and submitting the completed surveys to OHA. UHA will use Care Coordinators not involved in the CFT to administer the WFI-EZ. Each Care Coordinator will be trained on the form and will focus on engagement and participation when administering the WFI-EZ. The thinking is that Care Coordinator will be more effective in gaining honest feedback as he/she are not part of the CFT. After the youth and family have completed the survey, the Wraparound Supervisor collects the surveys and sends them to UHA for review and to be reported to OHA.

Compass will administer the WFI-EZ survey to members receiving Wraparound services every six months. UHA will ensure the WFI-EZ is a completed for all members engaged in wraparound services and will audit Compass's compliance to ensure WFI-EZs are completed 100% of the time.

E.9.b. How will Applicant communicate WFI-EZ and other applicable data to the System of Care Advisory Council?

The WFI-EZ survey will be administered to the Wraparound Child and Family teams every 6 months by Wraparound Care Coordinators in conjunction with the local CMHP (Compass). The completed surveys will be collected by the Wraparound Supervisor at Compass and the results will be presented and discussed at the following SOC Advisory committee in addition to being sent to UHA to be reviewed and reported to OHA.

E.9.c. How does Applicant plan to receive a minimum of 35 percent response rate from youth?

The surveys are administered by a Wraparound Care Coordinator who is trained in the administration of the WFI-EZ. Completed surveys are sent to UHA for review and to be reported to OHA. When UHA receives the completed surveys, the amount completed will be verified to ensure that at least 35 percent of youth responded. If the response rate is less than 35 percent, UHA will work with Wraparound Care Coordinators to identify the issues and barriers for participation. This will be reported to the System of Care Committee to assist in developing strategies to increase participation.

E.9.d. How will Applicant's Wraparound policy address:

1. How Wraparound services are implemented and monitored by Providers?

UHA's Wraparound Policy addresses the use of Wraparound Care Coordinators (WCC) that will assist members throughout the Wraparound process. Each member accepted into Wraparound services will be assigned to a WCC who will ensure that members receive wraparound services from providers who are involved with the Systems of Care (SOC). SOC providers will administer the appropriate Wraparound services to members and monitor the progress towards meeting the member's established goals throughout their involvement with the member. Each

WCC will be responsible for coordinating with SOC providers to ensure that Wraparound services are being implemented and monitored appropriately.

2. How Applicant will ensure Wraparound services are provided to Members in need, through Applicant's Providers?

UHA's Wraparound Policy states that all referrals for members to be entered into Wraparound services are reviewed by the Wraparound Review committee within the System of Care. Each member that meets the established criteria for Wraparound services will be assigned to a Wraparound Care Coordinator (WCC) who will help identify the needed services for the member and obtain those services. WCCs will connect members to services that are most appropriate for each individual member and attempt to establish members within UHA's network of providers. However, if the needed services are not available within the UHA provider network, the member will be approved to receive those services from outside of the network.

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.

UHA is in the process of expanding its Behavioral Health team to include multiple Wraparound trained Care Coordinators to greatly increase the availability for members to receive Wraparound services. Additionally, the Wraparound Review committee frequently evaluates members enrolled in Wraparound services for readiness to be transferred out of services to ensure maximum availability for new members. By adding more Care Coordinators and ensuring that members who no longer need Wraparound services are transferred out, there will be enough availability to prevent members who meet criteria from being placed onto a waitlist.

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).

UHA is committed to implementing Wraparound in compliance with National Wraparound Initiative processes and documents, Oregon Wraparound Initiative Core Values and Principles, the State of Oregon Best Practices Guidelines, and the OHA System of Care Wraparound Initiative (SOCWI) guidance. UHA is in the process of adding additional Behavioral Health Care Managers that will be trained on Wraparound principles. UHA will utilize materials and available trainings including those through the State of Oregon, Portland State University and the National Wraparound Initiative to achieve a well-defined approach for training, supervision, and coaching of Wraparound staff and other team members, including:

- Clinical and peer support will be provided to family and youth partners Wraparound Care
- Coordinators receive consultation from a qualified Wraparound Coach Wraparound Care
- Coordinators are credentialed by the Praed Foundation for administering the CANS Oregon.

UCAA Proforma Financial Statements

Health

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

Umpqua Health Alliance, LLC

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana
☐	AL	Alabama	☐	NC	North Carolina
☐	AR	Arkansas	☐	ND	North Dakota
☐	AS	American Samoa	☐	NE	Nebraska
☐	AZ	Arizona	☐	NH	New Hampshire
☐	CA	California	☐	NJ	New Jersey
☐	CO	Colorado	☐	NM	New Mexico
☐	CT	Connecticut	☐	NV	Nevada
☐	DC	District Of Columbia	☐	NY	New York
☐	DE	Delaware	☐	OH	Ohio
☐	FL	Florida	☐	OK	Oklahoma
☐	GA	Georgia	☑	OR	Oregon
☐	GU	Guam	☐	PA	Pennsylvania
☐	HI	Hawaii	☐	PR	Puerto Rico
☐	IA	Iowa	☐	RI	Rhode Island
☐	ID	Idaho	☐	SC	South Carolina
☐	IL	Illinois	☐	SD	South Dakota
☐	IN	Indiana	☐	TN	Tennessee
☐	KS	Kansas	☐	TX	Texas
☐	KY	Kentucky	☐	UT	Utah
☐	LA	Louisiana	☐	VA	Virginia
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands
☐	MD	Maryland	☐	VT	Vermont
☐	ME	Maine	☐	WA	Washington
☐	MI	Michigan	☐	WI	Wisconsin
☐	MN	Minnesota	☐	WV	West Virginia
☐	MO	Missouri	☐	WY	Wyoming
☐	MS	Mississippi			

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

above.

Updated: 10/07/2016

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
----------			
1. Bonds			
2. Stock			
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	23,152	27,739	30,659
7. Aggregate write in for assets	11,884	11,884	11,884
8. Total Assets(1+2+3+4+5+6+7)	**35,036**	**39,623**	**42,543**
Liabilities			
----------			
9. Losses (Unpaid Claims for Accident and Health Policies)	10,514	10,914	11,285
10. Unpaid claims adjustment expenses	332	344	356
11. Reserve for Accident and Health Policies	542	563	582
12. Ceded Reinsurance Payable		-	
13. Payable to Parents, Subsidiaries & Affiliates		-	
14. MLR rebates	-	-	
15. Premiums received in advanced	-	-	
16. All other Liabilites	9,134	10,297	9,895
17. Total Liabilities (9+10+11+12+13+14+15+16)	**20,523**	**22,118**	**22,118**
Capital and Surplus			
----------			
18. Capital Stock	2,000	2,000	2,000
19. Gross Paid In and Contributed Surplus	-		
20. Surplus Notes	-		
21. Unassigned Surplus	12,513	15,505	18,424
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	14,513	17,505	20,424
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$6,800.43	$6,140.33	$6,345.57

25. Calculated Risk-Based Capital (23/24)	213.4%	285.1%	321.9%

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	343	344	343
2. Net Premium Income	153,081	158,632	163,835
3. Fee for Service	-	-	-
4. Risk Revenue	-	-	-
5. Change in unearned premium reserves	-	-	-
6. Aggregate write in for other health related revenue	-	-	-
7. Aggregate write in for other non-health related revenue	-	-	-
8. Total (L2+L3+L4+L5+L6+L7)	**153,081**	**158,632**	**163,835**
Hospital and Medical:			
9. Hospital/Medical Benenfits	59,028	61,035	63,111
10. Other professional Services	46,345	47,921	49,550
11. Prescription Drugs	18,010	18,623	19,256
12. Aggregate write ins for other hospital/medical	8,870	9,172	9,484
13. Subtotal (L9+L10+L11+L12)	**132,254**	**136,751**	**141,401**
Less:			
14. Reinsurance recoveries	1,168	1,207	1,248
15. Total hospital and Medical (L13 -L14)	131,087	135,544	140,152
16. Non health claims	6,949	7,202	7,436
17. Claims adjustment expenses	333	344	356
18. General admin expenses	12,247	12,691	13,107
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**150,615**	**155,781**	**161,051**
21. Net underwriting gain or loss (L8 -L20)	2,466	2,852	2,784
22. Net investment income earned	121	139.35	136.04
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes			
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**2,586**	**2,991**	**2,920**
28. Prior YE Surplus	9,927	14,513	17,505
29. Net Income	2,586	2,991	2,920
30. Capital Increases	2,000		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**14,513**	**17,505**	**20,424**

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	153,081	158,632	163,835
2. Benefits Paid	131,087	135,544	140,152
3. Underwriting Expenses Paid	19,528	20,237	20,899
4. Total Cash From Underwriting (L1-L2-L3)	**2,466**	**2,852**	**2,784**
5. Net Investment Income	121	139	136
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered			
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**2,586**	**2,991**	**2,920**
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	2,000		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**2,000**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	4,586	2,991	2,920

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	153,081							153081.3			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**153,081**	**-**	**-**	**-**	**-**	**-**	**-**	**153,081**	**-**	**-**	**-**
8. Hospital/medical benefits	59,028							59028.49			
9. Other professional services	55,216							55215.54			
10. Prescription Drugs	18,010							18010.36			
11. Aggregatae writes for other hospital/ medical/health	6,949							6948.944			XXX
12. Subtotal (8+9+10+11)	**139,203**	**-**	**-**	**-**	**-**	**-**	**-**	**139,203**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1167.518			
14. Total hospital and medical (12-13)	**138,036**	**-**	**-**	**-**	**-**	**-**	**-**	**138,036**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	333							332.987			
17. General admin expenses	12,247							12246.5			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**150,615**	**-**	**-**	**-**	**-**	**-**	**-**	**150,615**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,466**	**-**	**-**	**-**	**-**	**-**	**-**	**2,466**	**-**	**-**	**-**

Nationwide
Year 2

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	158,632							158632.4			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX

6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**158,632**	**-**	**-**	**-**	**-**	**-**	**-**	**158,632**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	61,035							61035.46			
9. Other professional services	47,921							47920.83			
10. Prescription Drugs	18,623							18622.72			
11. Aggregate write ins for other hospital/ medical/health	16,374							16373.94			XXX
12. Subtotal (8+9+10+11)	**143,953**	**-**	**-**	**-**	**-**	**-**	**-**	**143,953**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1207.213			
14. Total hospital and medical (12-13)	142,746	-	-	-	-	-	-	142,746	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	344							344.31			
17. General admin expenses	12,691							12690.59			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**155,781**	**-**	**-**	**-**	**-**	**-**	**-**	**155,781**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,852**	**-**	**-**	**-**	**-**	**-**	**-**	**2,852**	**-**	**-**	**-**

Nationwide
Year 3

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	163,835							163834.9			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**163,835**	**-**	**-**	**-**	**-**	**-**	**-**	**163,835**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	63,111							63110.67			XXX
9. Other professional services	49,550							49550.14			XXX
10. Prescription Drugs	19,256							19255.89			XXX
11. Aggregatae writes for other hospital/ medical/health	16,920							16919.73			XXX
12. Subtotal (L8+L9+L10+L11)	**148,836**	**-**	**-**	**-**	**-**	**-**	**-**	**148,836**	**-**	**-**	
13. Net reinsurance recoveries	1,248							1248.258			
14. Total hospital and medical (L12-L13)	147,588	-	-	-	-	-	-	147,588	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX

and health contracts	-											XXX
19. Aggregate write in for Other Expenses	-											
20. Total underwriting deductions (L14 : L19)	**161,051**	**-**	**-**	**-**	**-**	**-**	**-**	**161,051**	**-**	**-**	**-**	
21. Net underwriting Gain (Loss) (L7-L20)	**2,784**	**-**	**-**	**-**	**-**	**-**	**-**	**2,784**	**-**	**-**	**-**	

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	154,420,979		1,339,728	153,081,250
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	154,420,979	-	1,339,728	153,081,250

Nationwide
Year 2

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	160,042,341		1,409,984	158,632,357
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	160,042,341	-	1,409,984	158,632,357

Nationwide
Year 3

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	165,241,098		1,406,230	163,834,869
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	165,241,098	-	1,406,230	163,834,869

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$ 154,420.98						154,421
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes	$ -						-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**154,421**	**-**	**-**	**-**	**-**	**-**	**154,421**
6. Incurred claims excluding prescription drugs	**96068.82488**						96,069
7. Prescription drugs	18119.07928						18,119
8. Pharmaceutical rebates	108.7144757						109
9. State stop loss, market stabilization and claim/census based assessments	0						-
10. Incurred medical incentive pools and bonuses	18175.20576						18,175
11. Total incurred claims (L6+L7-L8-L9+L10)	**132,254**	**-**	**-**	**-**	**-**	**-**	**132,254**
12. Deductible abuse detection/recovery expenses	**-**						**-**
13. Improved health outcomes	3474.472026						3,474
14. Activities to prevent hospital readmissions	1737.236013						1,737
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses	1737.236013						1,737
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**6,949**	**-**	**-**	**-**	**-**	**-**	**6,949**
19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 2

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	160042.3406						160,042
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**160,042**	**-**	**-**	**-**	**-**	**-**	**160,042**

8. Pharmaceutical rebates	112.4107678						112
9. State stop loss, market stabilization and claim/census based assessments							-
10. Incurred medical incentive pools and bonuses	**18793.16275**						18,793
11. Total incurred claims (L6+L7-L8L-9+L10)	**136,751**	**-**	**-**	**-**	**-**	**-**	**136,751**
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes	3600.952665						3,601
14. Activities to prevent hospital readmissions	1800.476332						1,800
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses	1800.476332						1,800
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**7,202**	**-**	**-**	**-**	**-**	**-**	**7,202**
19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 3

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	165241.0984						165,241
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes	0						-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (1-2-3-4)	**165,241**	**-**	**-**	**-**	**-**	**-**	**165,241**
6. Incurred claims excluding prescription drugs	**102712.5605**						102,713
7. Prescription drugs	19372.12232						19,372
8. Pharmaceutical rebates	116.2327339						116
9. State stop loss, market stabilization and claim/census based assessments	0						-
10. Incurred medical incentive pools and bonuses	**19,432**						19,432
11. Total incurred claims (6+7-8-9+10)	141,401	-	-	-	-	-	141,401
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes	3,717.92						3,718
14. Activities to prevent hospital readmissions	1,858.96						1,859
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses	1,858.96						1,859
18. Total expenses incurred for improving							

19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

State
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	156,699,518		1,339,728	155,359,789
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**156,699,518**	**-**	**1,339,728**	**155,359,789**

State
Year 2

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	162,403,825	-	1,409,984	160,993,841
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**162,403,825**	**-**	**1,409,984**	**160,993,841**

State
Year 3

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	167,679,292		1,406,230	166,273,062
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**167,679,292**	**-**	**1,406,230**	**166,273,062**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

P&L

Premium basis on Douglas @ 100% of projections with 3.4% annual increase to match trend assumptions.
IBNR assumptions is % of run rate at YE 2018/2019 avgeraged
Medical Trend is 3.4% for all years.
Care Coordination Fee expense is 4.5% of premium
Administration Expense based on 8% of premium

Balance Sheet

B/S assumptions is forecasted based on the budget and 2018 audited financial results.
There is a Year 1 Capital infusion to meet RBC requirements.
RBC requirements are met for Years 1, 2 and 3.

UCAA Proforma Financial Statements

Health

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

Umpqua Health Alliance, LLC

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana
☐	AL	Alabama	☐	NC	North Carolina
☐	AR	Arkansas	☐	ND	North Dakota
☐	AS	American Samoa	☐	NE	Nebraska
☐	AZ	Arizona	☐	NH	New Hampshire
☐	CA	California	☐	NJ	New Jersey
☐	CO	Colorado	☐	NM	New Mexico
☐	CT	Connecticut	☐	NV	Nevada
☐	DC	District Of Columbia	☐	NY	New York
☐	DE	Delaware	☐	OH	Ohio
☐	FL	Florida	☐	OK	Oklahoma
☐	GA	Georgia	☑	OR	Oregon
☐	GU	Guam	☐	PA	Pennsylvania
☐	HI	Hawaii	☐	PR	Puerto Rico
☐	IA	Iowa	☐	RI	Rhode Island
☐	ID	Idaho	☐	SC	South Carolina
☐	IL	Illinois	☐	SD	South Dakota
☐	IN	Indiana	☐	TN	Tennessee
☐	KS	Kansas	☐	TX	Texas
☐	KY	Kentucky	☐	UT	Utah
☐	LA	Louisiana	☐	VA	Virginia
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands
☐	MD	Maryland	☐	VT	Vermont
☐	ME	Maine	☐	WA	Washington
☐	MI	Michigan	☐	WI	Wisconsin
☐	MN	Minnesota	☐	WV	West Virginia
☐	MO	Missouri	☐	WY	Wyoming
☐	MS	Mississippi			

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

above.

Updated: 10/07/2016

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds			
2. Stock			
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	27,799	35,697	43,406
7. Aggregate write in for assets	10,000	10,000	10,000
8. Total Assets(1+2+3+4+5+6+7)	**37,799**	**45,697**	**53,406**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	13,143	13,643	14,106
10. Unpaid claims adjustment expenses	415	430	445
11. Reserve for Accident and Health Policies	678	704	728
12. Ceded Reinsurance Payable		-	
13. Payable to Parents, Subsidiaries & Affiliates		-	
14. MLR rebates	-	-	
15. Premiums received in advanced	-	-	
16. All other Liabilites	6,403	10,021	13,579
17. Total Liabilities (9+10+11+12+13+14+15+16)	**20,639**	**24,798**	**28,858**
Capital and Surplus			
18. Capital Stock	4,000	4,000	4,000
19. Gross Paid In and Contributed Surplus	-		
20. Surplus Notes	-		
21. Unassigned Surplus	13,160	16,899	20,549
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	17,160	20,899	24,549
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$ 8,378	$ 7,527	$ 7,785

25. Calculated Risk-Based Capital (23/24)	204.8%	277.7%	315.4%

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	429	430	429
2. Net Premium Income	191,352	198,290	204,794
3. Fee for Service	-	-	-
4. Risk Revenue	-	-	-
5. Change in unearned premium reserves	-	-	-
6. Aggregate write in for other health related revenue	-	-	-
7. Aggregate write in for other non-health related revenue	-	-	-
8. Total (L2+L3+L4+L5+L6+L7)	**191,352**	**198,290**	**204,794**
Hospital and Medical:			
9. Hospital/Medical Benenfits	73,786	76,294	78,888
10. Other professional Services	57,931	59,901	61,938
11. Prescription Drugs	22,513	23,278	24,070
12. Aggregate write ins for other hospital/medical	11,088	11,465	11,855
13. Subtotal (L9+L10+L11+L12)	**165,318**	**170,939**	**176,751**
Less:			
14. Reinsurance recoveries	1,459	1,509	1,560
15. Total hospital and Medical (L13 -L14)	163,859	169,430	175,190
16. Non health claims	8,686	9,002	9,295
17. Claims adjustment expenses	416	430	445
18. General admin expenses	15,308	15,863	16,383
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**188,269**	**194,726**	**201,314**
21. Net underwriting gain or loss (L8 -L20)	3,082	3,565	3,480
22. Net investment income earned	151	174	170
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes			
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**3,233**	**3,739**	**3,650**
28. Prior YE Surplus	9,927	17,160	20,899
29. Net Income	3,233	3,739	3,650
30. Capital Increases	4,000		
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**17,160**	**20,899**	**24,549**

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	191,352	198,290	204,794
2. Benefits Paid	163,859	169,430	175,190
3. Underwriting Expenses Paid	24,411	25,296	26,123
4. Total Cash From Underwriting (L1-L2-L3)	**3,082**	**3,565**	**3,480**
5. Net Investment Income	151	174	170
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered			
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**3,233**	**3,739**	**3,650**
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus	4,000		
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**4,000**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	7,233	3,739	3,650

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	191,352							191351.6			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**191,352**	**-**	**-**	**-**	**-**	**-**	**-**	**191,352**	**-**	**-**	**-**
8. Hospital/medical benefits	73,786							73785.62			
9. Other professional services	69,019							69019.42			
10. Prescription Drugs	22,513							22512.96			
11. Aggregatae writes for other hospital/ medical/health	8,686							8686.18			XXX
12. Subtotal (8+9+10+11)	**174,004**	**-**	**-**	**-**	**-**	**-**	**-**	**174,004**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1459.397			
14. Total hospital and medical (12-13)	**172,545**	**-**	**-**	**-**	**-**	**-**	**-**	**172,545**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	416							416.2338			
17. General admin expenses	15,308							15308.13			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**188,269**	**-**	**-**	**-**	**-**	**-**	**-**	**188,269**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**3,082**	**-**	**-**	**-**	**-**	**-**	**-**	**3,082**	**-**	**-**	**-**

Nationwide
Year 2

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	198,290							198290.4			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX

6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**198,290**	**-**	**-**	**-**	**-**	**-**	**-**	**198,290**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	76,294							76294.33			
9. Other professional services	59,901							59901.04			
10. Prescription Drugs	23,278							23278.4			
11. Aggregate write ins for other hospital/ medical/health	20,467							20467.42			XXX
12. Subtotal (8+9+10+11)	**179,941**	**-**	**-**	**-**	**-**	**-**	**-**	**179,941**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								1509.016			
14. Total hospital and medical (12-13)	178,432	-	-	-	-	-	-	178,432	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	430							430.3857			
17. General admin expenses	15,863							15863.24			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**194,726**	**-**	**-**	**-**	**-**	**-**	**-**	**194,726**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**3,565**	**-**	**-**	**-**	**-**	**-**	**-**	**3,565**	**-**	**-**	**-**

Nationwide
Year 3

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	204,794							204793.6			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**204,794**	**-**	**-**	**-**	**-**	**-**	**-**	**204,794**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	78,888							78888.34			XXX
9. Other professional services	61,938							61937.68			XXX
10. Prescription Drugs	24,070							24069.86			XXX
11. Aggregatae writes for other hospital/ medical/health	21,150							21149.66			XXX
12. Subtotal (L8+L9+L10+L11)	**186,046**	**-**	**-**	**-**	**-**	**-**	**-**	**186,046**	**-**	**-**	
13. Net reinsurance recoveries	1,560							1560.323			
14. Total hospital and medical (L12-L13)	184,485	-	-	-	-	-	-	184,485	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX

and health contracts	-											XXX
19. Aggregate write in for Other Expenses	-											
20. Total underwriting deductions (L14 : L19)	**201,314**	**-**	**-**	**-**	**-**	**-**	**-**	**201,314**	**-**	**-**	**-**	
21. Net underwriting Gain (Loss) (L7-L20)	**3,480**	**-**	**-**	**-**	**-**	**-**	**-**	**3,480**	**-**	**-**	**-**	

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	193,026,224		1,674,661	191,351,563
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	193,026,224	-	1,674,661	191,351,563

Nationwide
Year 2

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	200,052,926		1,762,480	198,290,446
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	200,052,926	-	1,762,480	198,290,446

Nationwide
Year 3

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	206,551,373		1,757,787	204,793,586
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	206,551,373	-	1,757,787	204,793,586

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$ 193,026.22						193,026
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes	$ -						-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**193,026**	**-**	**-**	**-**	**-**	**-**	**193,026**
6. Incurred claims excluding prescription drugs	$ 120,086.03						120,086
7. Prescription drugs	$ 22,648.85						22,649
8. Pharmaceutical rebates	$ 135.89						136
9. State stop loss, market stabilization and claim/census based assessments	0						-
10. Incurred medical incentive pools and bonuses	$ 22,719.01						22,719
11. Total incurred claims (L6+L7-L8-L9+L10)	**165,318**	**-**	**-**	**-**	**-**	**-**	**165,318**
12. Deductible abuse detection/recovery expenses	**-**						**-**
13. Improved health outcomes	$ 4,343.09						4,343
14. Activities to prevent hospital readmissions	$ 2,171.55						2,172
15. Improve patient safety and reduce medical errors	$ -						-
16. Wellness and health promotion activities	$ -						-
17. QI Health information technology expenses	$ 2,171.55						2,172
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**8,686**	**-**	**-**	**-**	**-**	**-**	**8,686**
19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 2

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$ 200,052.93						200,053
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**200,053**	**-**	**-**	**-**	**-**	**-**	**200,053**

8. Pharmaceutical rebates	$	140.51						141
9. State stop loss, market stabilization and claim/census based assessments								-
10. Incurred medical incentive pools and bonuses	$	23,491.45						23,491
11. Total incurred claims (L6+L7-L8L-9+L10)		**170,939**	**-**	**-**	**-**	**-**	**-**	**170,939**
12. Deductible abuse detection/recovery expenses								**-**
13. Improved health outcomes	$	4,501.19						4,501
14. Activities to prevent hospital readmissions	$	2,250.60						2,251
15. Improve patient safety and reduce medical errors								-
16. Wellness and health promotion activities								-
17. QI Health information technology expenses	$	2,250.60						2,251
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)		**9,002**	**-**	**-**	**-**	**-**	**-**	**9,002**
19 Prelimary MLR (L11+L12+L18/L5)		**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 3

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

		Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$	206,551.37						206,551
2. Federal taxes/Federal asessments		0						-
3. State insurance, premium, and other taxes		0						-
4. Regulatory authority license and fees		0						-
5. Adjusted premium earned (1-2-3-4)		**206,551**	**-**	**-**	**-**	**-**	**-**	**206,551**
6. Incurred claims excluding prescription drugs	$	128,390.70						128,391
7. Prescription drugs	$	24,215.15						24,215
8. Pharmaceutical rebates	$	145.29						145
9. State stop loss, market stabilization and claim/census based assessments		0						-
10. Incurred medical incentive pools and bonuses	$	24,290.16						24,290
11. Total incurred claims (6+7-8-9+10)		176,751	-	-	-	-	-	176,751
12. Deductible abuse detection/recovery expenses								**-**
13. Improved health outcomes	$	4,647.41						4,647
14. Activities to prevent hospital readmissions	$	2,323.70						2,324
15. Improve patient safety and reduce medical errors								-
16. Wellness and health promotion activities								-
17. QI Health information technology expenses	$	2,323.70						2,324
18. Total expenses incurred for improving								

19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

State
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	193,026,224		1,674,661	191,351,563
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**193,026,224**	**-**	**1,674,661**	**191,351,563**

State
Year 2

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	200,052,926	-	1,762,480	198,290,446
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**200,052,926**	**-**	**1,762,480**	**198,290,446**

State
Year 3

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	206,551,373		1,757,787	204,793,586
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**206,551,373**	**-**	**1,757,787**	**204,793,586**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

Enrollment
All enrollment is in Douglas County
Maximum enrollment is projected at 25% higher than current base assumptions.

P&L
Premium basis on Douglas @ 100% of projections with 3.4% annual increase to match trend assumptions.
IBNR assumptions is % of run rate at YE 2018/2019 avgeraged
Medical Trend is 3.4% for all years.
Care Coordination Fee expense is 4.5% of premium
Administration Expense based on 8% of premium

Balance Sheet
B/S assumptions are forecasted beginning with YE 2019 budget and 2018 annual audited financials.
Capital is infused in Year 1 to meet RBC requirements.
RBC requirements are met for Year 1, 2 and 3.

UCAA Proforma Financial Statements

Health

Instructions

1. Enter the Applicant Company Name below
2. Enter the first full year of the proformas (start with 1st full year of operation).
3. Select the states to be completed for proformas by clicking the check boxes on the right and then click on the "Create Selected State Worksheets" button below.
4. Complete all sections of the proforma statements contained on each tab below.
5. Note that several tabs contain worksheets for 3 years of data. Be sure to complete all years of data.
6. Do not "Cut" and "Paste" cells in the worksheets. Use "Copy" and "Paste" instead.

Enter the Applicant Company Name:

Umpqua Health Alliance, LLC

Year 1: 2020

Year 2: 2021

Year 3: 2022

☐	AK	Alaska	☐	MT	Montana
☐	AL	Alabama	☐	NC	North Carolina
☐	AR	Arkansas	☐	ND	North Dakota
☐	AS	American Samoa	☐	NE	Nebraska
☐	AZ	Arizona	☐	NH	New Hampshire
☐	CA	California	☐	NJ	New Jersey
☐	CO	Colorado	☐	NM	New Mexico
☐	CT	Connecticut	☐	NV	Nevada
☐	DC	District Of Columbia	☐	NY	New York
☐	DE	Delaware	☐	OH	Ohio
☐	FL	Florida	☐	OK	Oklahoma
☐	GA	Georgia	☑	OR	Oregon
☐	GU	Guam	☐	PA	Pennsylvania
☐	HI	Hawaii	☐	PR	Puerto Rico
☐	IA	Iowa	☐	RI	Rhode Island
☐	ID	Idaho	☐	SC	South Carolina
☐	IL	Illinois	☐	SD	South Dakota
☐	IN	Indiana	☐	TN	Tennessee
☐	KS	Kansas	☐	TX	Texas
☐	KY	Kentucky	☐	UT	Utah
☐	LA	Louisiana	☐	VA	Virginia
☐	MA	Massachusetts	☐	VI	U.S. Virgin Islands
☐	MD	Maryland	☐	VT	Vermont
☐	ME	Maine	☐	WA	Washington
☐	MI	Michigan	☐	WI	Wisconsin
☐	MN	Minnesota	☐	WV	West Virginia
☐	MO	Missouri	☐	WY	Wyoming
☐	MS	Mississippi			

If states were added to this spreadsheet in error:

1. Select the states to be deleted by clicking the check boxes on the right.
2. Click on the "Delete Selected State Worksheets" button above.

above.

Updated: 10/07/2016

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Thousands)

	2020	2021	2022
Admitted Assets			
1. Bonds			
2. Stock			
3. Real Estate/Mortgage Investments			
4. Affiliated Investments			
5. Affiliated Receivables			
6. Cash/Cash Equivalents	22,506	24,749	26,939
7. Aggregate write in for assets	9,884	9,884	9,884
8. Total Assets(1+2+3+4+5+6+7)	**32,389**	**34,632**	**36,822**
Liabilities			
9. Losses (Unpaid Claims for Accident and Health Policies)	10,514	10,914	11,285
10. Unpaid claims adjustment expenses	332	344	356
11. Reserve for Accident and Health Policies	542	563	582
12. Ceded Reinsurance Payable		-	
13. Payable to Parents, Subsidiaries & Affiliates		-	
14. MLR rebates	-	-	
15. Premiums received in advanced	-	-	
16. All other Liabilites	9,134	8,701	8,299
17. Total Liabilities (9+10+11+12+13+14+15+16)	**20,522**	**20,522**	**20,522**
Capital and Surplus			
18. Capital Stock	-		
19. Gross Paid In and Contributed Surplus	-		
20. Surplus Notes	-		
21. Unassigned Surplus	11,867	14,110	16,300
22. Other Items(elaborate)			
23. Total Capital and Surplus(18+19+20+21+22)	11,867	14,110	16,300
Risk-Based Capital Analysis			
24. Authorized Control Level Risk-Based Capital	$4,645.88	$4,735.79	$4,957.49

25. Calculated Risk-Based Capital (23/24)	255.4%	297.9%	328.8%

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Thousands)

	2020	2021	2022
1. Member months	258	258	257
2. Net Premium Income	114,811	118,974	122,876
3. Fee for Service	-	-	-
4. Risk Revenue	-	-	-
5. Change in unearned premium reserves	-	-	-
6. Aggregate write in for other health related revenue	-	-	-
7. Aggregate write in for other non-health related revenue	-	-	-
8. Total (L2+L3+L4+L5+L6+L7)	**114,811**	**118,974**	**122,876**
Hospital and Medical:			
9. Hospital/Medical Benenfits	44,271	45,777	47,333
10. Other professional Services	34,759	35,941	37,163
11. Prescription Drugs	13,508	13,967	14,442
12. Aggregate write ins for other hospital/medical	6,653	6,879	7,113
13. Subtotal (L9+L10+L11+L12)	**99,191**	**102,563**	**106,050**
Less:			
14. Reinsurance recoveries	876	905	936
15. Total hospital and Medical (L13 -L14)	98,315	101,658	105,114
16. Non health claims	5,212	5,401	5,577
17. Claims adjustment expenses	250	258	267
18. General admin expenses	9,185	9,518	9,830
19. Increase in reserves for accident and health contacts			
20. Total underwriting deductions (L15+L16+L17+L18+L19)	**112,961**	**116,835**	**120,788**
21. Net underwriting gain or loss (L8 -L20)	1,849	2,139	2,088
22. Net investment income earned	90	105	102
23. Aggregate write in for other income or expenses			
24. Federal Income Taxes			
25. Net Realized Capital Gains (Losses)			
26. Less Capital Gains Tax			
27. Net Income (L21+L22+L23-L24+L25)	**1,940**	**2,243**	**2,190**
28. Prior YE Surplus	9,927	11,867	14,110
29. Net Income	1,940	2,243	2,190
30. Capital Increases			
31. Other Increases (Decreases)			
32. Dividends to Stockholders			
33. YE Surplus (L28+L29+L30+L31-L32)	**11,867**	**14,110**	**16,300**

Umpqua Health Alliance, LLC
(Health Company)
Pro Forma Statutory Cash Flow Statement
(In Thousands)

	2020	2021	2022
Cash From Operations			
1. Premiums Collected Net of Reinsurance	114,811	118,974	122,876
2. Benefits Paid	99,191	102,563	106,050
3. Underwriting Expenses Paid	13,771	14,272	14,738
4. Total Cash From Underwriting (L1-L2-L3)	**1,849**	**2,139**	**2,088**
5. Net Investment Income	90	105	102
6. Other Income			
7. Dividends to Policyholders			
8. Federal and Foreign Income Taxes (Paid) Recovered			
9. Net Cash From Operations (L4+L5+L6-L7+L8)	**1,940**	**2,243**	**2,190**
Cash From Investments			
10. Net Cash from Investments			
Cash From Financing and Misc Sources			
11. Capital and paid in Surplus			
12. Surplus Notes			
13. Borrowed Funds			
14. Dividends			
15. Other Cash Provided (Applied)			
16. Net Cash from Financing and Misc Sources (L11+L12+L13-L14+L15)	**-**	**-**	**-**
17. Net Change in Cash, Cash Equivalents and Short -Term Investments (L9+L10+L16)	1,940	2,243	2,190

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines Business
1. Net Premiums (All Business)	114,811							114810.9			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**114,811**	**-**	**-**	**-**	**-**	**-**	**-**	**114,811**	**-**	**-**	**-**
8. Hospital/medical benefits	44,271							44271.37			
9. Other professional services	41,412							41411.65			
10. Prescription Drugs	13,508							13507.77			
11. Aggregatae writes for other hospital/ medical/health	5,212							5211.708			XXX
12. Subtotal (8+9+10+11)	**104,403**	**-**	**-**	**-**	**-**	**-**	**-**	**104,403**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								875.6382			
14. Total hospital and medical (12-13)	**103,527**	**-**	**-**	**-**	**-**	**-**	**-**	**103,527**	**-**	**-**	**-**
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	250							249.7403			
17. General admin expenses	9,185							9184.875			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**112,961**	**-**	**-**	**-**	**-**	**-**	**-**	**112,961**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**1,849**	**-**	**-**	**-**	**-**	**-**	**-**	**1,849**	**-**	**-**	**-**

Nationwide
Year 2

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	118,974							118974.3			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX

6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (1+2+3+4+5+6)	**118,974**	**-**	**-**	**-**	**-**	**-**	**-**	**118,974**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	45,777							45776.6			
9. Other professional services	42,820							42819.65			
10. Prescription Drugs	13,967							13967.04			
11. Aggregate write ins for other hospital/ medical/health	5,401							5401.429			XXX
12. Subtotal (8+9+10+11)	**107,965**	**-**	**-**	**-**	**-**	**-**	**-**	**107,965**	**-**	**-**	**-**
	-										
13. Net reinsurance recoveries								905.4099			
14. Total hospital and medical (12-13)	107,059	-	-	-	-	-	-	107,059	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		
16. Claims adjustment expenses	258							258.2314			
17. General admin expenses	9,518							9517.941			
18. Increase in reserves for accident and health contracts	-										
19. Aggregate write in for Other Expenses	-										
20. Total underwriting deductions (14 to19)	**116,835**	**-**	**-**	**-**	**-**	**-**	**-**	**116,835**	**-**	**-**	**-**
21. Net underwriting Gain (Loss) (7-20)	**2,139**	**-**	**-**	**-**	**-**	**-**	**-**	**2,139**	**-**	**-**	**-**

Nationwide
Year 3

Umpqua Health Alliance, LLC
(Health Company)
Analysis of Operations by Line of Business
(In Thousands)

	Total	Comprehensive	Medicare Supplement	Dental	Vision	Federal Employees plan	Medicare	Medicaid	Other health	Other non-health	Aggregate of All Other Lines
1. Net Premiums (All Business)	122,876							122876.2			
2. Change in unearned premium reserve	-										
3. Fee for service	-										XXX
4. Risk revenue	-										XXX
5. Aggregate write ins for other health related revenues	-										XXX
6. Aggregate write ins for other non-health related revenues	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX
7. Total Revenue (L1+L2+L3+L4+L5+L6)	**122,876**	**-**	**-**	**-**	**-**	**-**	**-**	**122,876**	**-**	**-**	**-**
	-										
8. Hospital/medical benefits	47,333							47333			XXX
9. Other professional services	44,276							44275.52			XXX
10. Prescription Drugs	14,442							14441.92			XXX
11. Aggregatae writes for other hospital/ medical/health	5,577							5576.887			XXX
12. Subtotal (L8+L9+L10+L11)	**111,627**	**-**	**-**	**-**	**-**	**-**	**-**	**111,627**	**-**	**-**	
13. Net reinsurance recoveries	936							936.1938			
14. Total hospital and medical (L12-L13)	110,691	-	-	-	-	-	-	110,691	-	-	-
15. Non health claims	-	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX		XXX

and health contracts	-											XXX
19. Aggregate write in for Other Expenses	-											
20. Total underwriting deductions (L14 : L19)	**120,788**	**-**	**-**	**-**	**-**	**-**	**-**	**120,788**	**-**	**-**	**-**	
21. Net underwriting Gain (Loss) (L7-L20)	**2,088**	**-**	**-**	**-**	**-**	**-**	**-**	**2,088**	**-**	**-**	**-**	

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	115,815,734		1,004,796	114,810,938
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	115,815,734	-	1,004,796	114,810,938

Nationwide
Year 2

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	120,031,755		1,057,488	118,974,268
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	120,031,755	-	1,057,488	118,974,268

Nationwide
Year 3

Umpqua Health Alliance, LL
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	123,930,824		1,054,672	122,876,151
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	123,930,824	-	1,054,672	122,876,151

Nationwide
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$ 115,815.73						115,816
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes	$ -						-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**115,816**	**-**	**-**	**-**	**-**	**-**	**115,816**
6. Incurred claims excluding prescription drugs	$ 72,051.62						72,052
7. Prescription drugs	$ 13,589.31						13,589
8. Pharmaceutical rebates	$ 81.54						82
9. State stop loss, market stabilization and claim/census based assessments	0						-
10. Incurred medical incentive pools and bonuses	$ 13,631.40						13,631
11. Total incurred claims (L6+L7-L8-L9+L10)	**99,191**	**-**	**-**	**-**	**-**	**-**	**99,191**
12. Deductible abuse detection/recovery expenses	**-**						**-**
13. Improved health outcomes	$ 2,605.85						2,606
14. Activities to prevent hospital readmissions	$ 1,302.93						1,303
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses	$ 1,302.93						1,303
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)	**5,212**	**-**	**-**	**-**	**-**	**-**	**5,212**
19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 2

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	$ 120,031.76						120,032
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes							-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (L1-L2-L3-L4)	**120,032**	**-**	**-**	**-**	**-**	**-**	**120,032**

8. Pharmaceutical rebates	$	84.31						84
9. State stop loss, market stabilization and claim/census based assessments								-
10. Incurred medical incentive pools and bonuses	$	14,094.87						14,095
11. Total incurred claims (L6+L7-L8L-9+L10)		**102,563**	**-**	**-**	**-**	**-**	**-**	**102,563**
12. Deductible abuse detection/recovery expenses								**-**
13. Improved health outcomes	$	2,700.71						2,701
14. Activities to prevent hospital readmissions	$	1,350.36						1,350
15. Improve patient safety and reduce medical errors								-
16. Wellness and health promotion activities								-
17. QI Health information technology expenses	$	1,350.36						1,350
18. Total expenses incurred for improving health quality (L13+L14+L15+L16+L17)		**5,401**	**-**	**-**	**-**	**-**	**-**	**5,401**
19 Prelimary MLR (L11+L12+L18/L5)		**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

Nationwide
Year 3

Umpqua Health A
(Health Company)
Preliminary MLR
(In Thousands)

	Individual Comprehensive	Small group comprehensive	Large Group comprehensive	Individual mini-med	Small group mini-med	Large Group mini-med	Total
1. Premiums earned	123930.8238						123,931
2. Federal taxes/Federal asessments	0						-
3. State insurance, premium, and other taxes	0						-
4. Regulatory authority license and fees	0						-
5. Adjusted premium earned (1-2-3-4)	**123,931**	**-**	**-**	**-**	**-**	**-**	**123,931**
6. Incurred claims excluding prescription drugs	77034.4204						77,034
7. Prescription drugs	14529.09174						14,529
8. Pharmaceutical rebates	87.17455046						87
9. State stop loss, market stabilization and claim/census based assessments	0						-
10. Incurred medical incentive pools and bonuses	14574.09771						14,574
11. Total incurred claims (6+7-8-9+10)	106,050	-	-	-	-	-	106,050
12. Deductible abuse detection/recovery expenses							**-**
13. Improved health outcomes	2788.443535						2,788
14. Activities to prevent hospital readmissions	1394.221767						1,394
15. Improve patient safety and reduce medical errors							-
16. Wellness and health promotion activities							-
17. QI Health information technology expenses	1394.221767						1,394
18. Total expenses incurred for improving							

19 Prelimary MLR (L11+L12+L18/L5)	**0.90**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.90**

State
Year 1

Umpqua Health Alliance, LLC
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	115,815,734		1,004,796	114,810,938
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**115,815,734**	**-**	**1,004,796**	**114,810,938**

State
Year 2

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Direct Premiums	Assumed Premiums	Ceded Premiums	Net Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	120,031,755		1,057,488	118,974,268
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**120,031,755**	**-**	**1,057,488**	**118,974,268**

State
Year 3

Umpqua Health Alliance, L
(Health Company)
Planned Premium Volume by Line of Business
(Amounts in Whole Dollars)

Description	Premiums	Premiums	Premiums	Premiums
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Plan				
6. Medicare				
7. Medicaid	123,930,824		1,054,672	122,876,151
8. Other health				
9. Total (L1+L2+L3+L4+L5+L6+L7+L8)	**123,930,824**	**-**	**1,054,672**	**122,876,151**

UCAA Proforma Financial Statements Assumptions

List all of the relevant assumptions used to create the proformas.
Note, assumptions enclosed within the Plan of Operation need not be disclosed again here.

Enrollment

All Enrollment is in Douglas County.
The Minimum Enrollment Projections assume a 25% decrease in enrollment over the baseline enrollment.

P&L

Premium basis on Douglas @ 100% of projections with 3.4% annual increase to match trend assumptions.
IBNR assumptions is % of run rate at YE 2018/2019 avgeraged
Medical Trend is 3.4% for all years.
Care Coordination Fee expense is 4.5% of premium
Administration Expense based on 8% of premium
Reinsurance Expense includes 2018 / 2019 basis plus 5% growth and stable in Year 3

Balance Sheet

B/S assumptions are forecasted beginning with YE 2019 budget and 2018 annual audited financials.
RBC requirements are met for Year 1, 2 and 3 without required capital infusion.

			Professional					Institutional					Dental				Pharmacy				
	Number of Professional Encounters Submitted	Billed Submission Amount	Rejection Total	Rejection Amount	Number of Accepted Professional Claims Encountered	Billed Amount of Professional Encounters Accepted	Number of Institutional Encounters Submitted	Billed Submission Amount	Rejection Total	Rejection Amount	Number of Accepted Institutional Claims Encountered	Billed Amount of Institutional Encounters Accepted	Number of Dental Encounters Submitted	Billed Submission Amount	Rejection Total	Rejection Amount	Number of Accepted Dental Claims Encountered	Billed Amount of Dental Encounters Accepted	Number of Pharmacy Encounters Submitted	Rejection Total	Number of Accepted Pharmacy Claims	Number of Eligible Members
January	39,977	$10,592,276	0	$0	39,977	$10,592,276	5,810	$27,449,129	22	$981,370	5,781	$26,451,515	2,016	$565,019	0	$0	2,016	$565,019	24,396	34	24,362	27,146
February	70,426	$16,676,322	5	$2,364	70,421	$16,673,957	6,740	$9,161,462	3	$134,968	6,737	$9,026,495	2,446	$702,414	0	$0	2,446	$702,414	24,174	0	24,174	27,175
March	45,702	$9,672,576	2	$4,920	45,700	$9,667,656	1,162	$12,401,998	3	$50,370	1,159	$12,351,628	1,544	$427,923	0	$0	1,544	$427,923	35,825	0	35,825	
April																						
May																						
June																						
July																						
August																						
September																						
October																						
November																						
December																						

**Please see Item 1 in Notes*

Legend

Source Data- Ph-Tech and MedImpact

Description-
Once claims have been fully processed UHA and Ph-Tech are then required to submit those claims for encounter to the Oregon Health Authority. There are 4 types of Claims/Encounters; Professional, Institutional, Dental, and Pharmaceutical. Ph-Tech submits all encounter data with the exception of pharmacy encounters which is submitted by UHA. In order to have complete transparency Ph-Tech sends UHA a report which is broken down by submission total, Submission amount, Rejection Total, Rejection Amount, Total approved for encounter as well as total amount paid. The data off of the report received is then placed into the chart above.

Objective:

•Tracking the number of encounters submitted verses encounters accepted by service type. (institutional, Professional, Dental, Pharmacy)

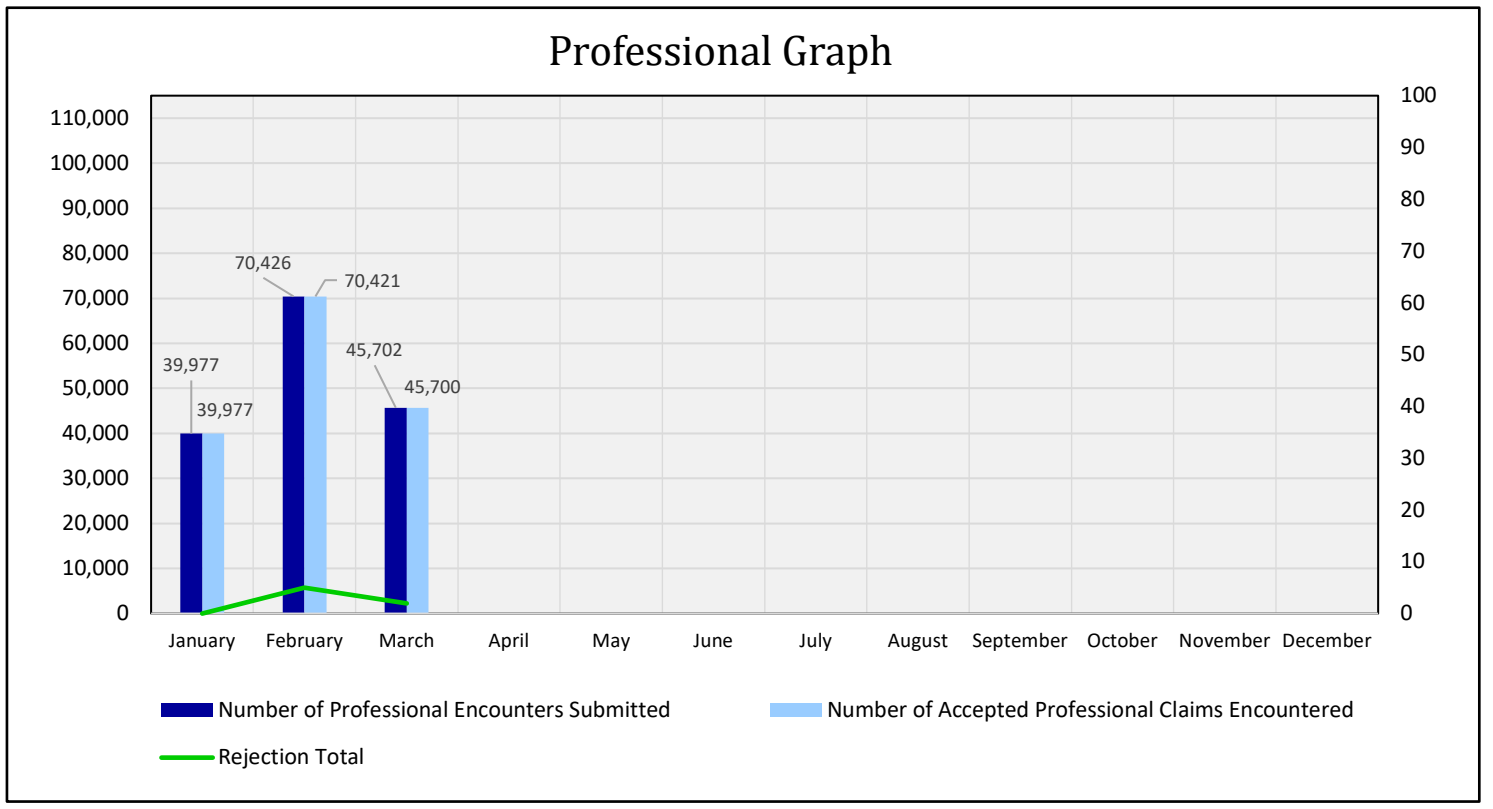
•Tracking the number of rejections or pending encounters

•Tracking the number of claims not encounterable

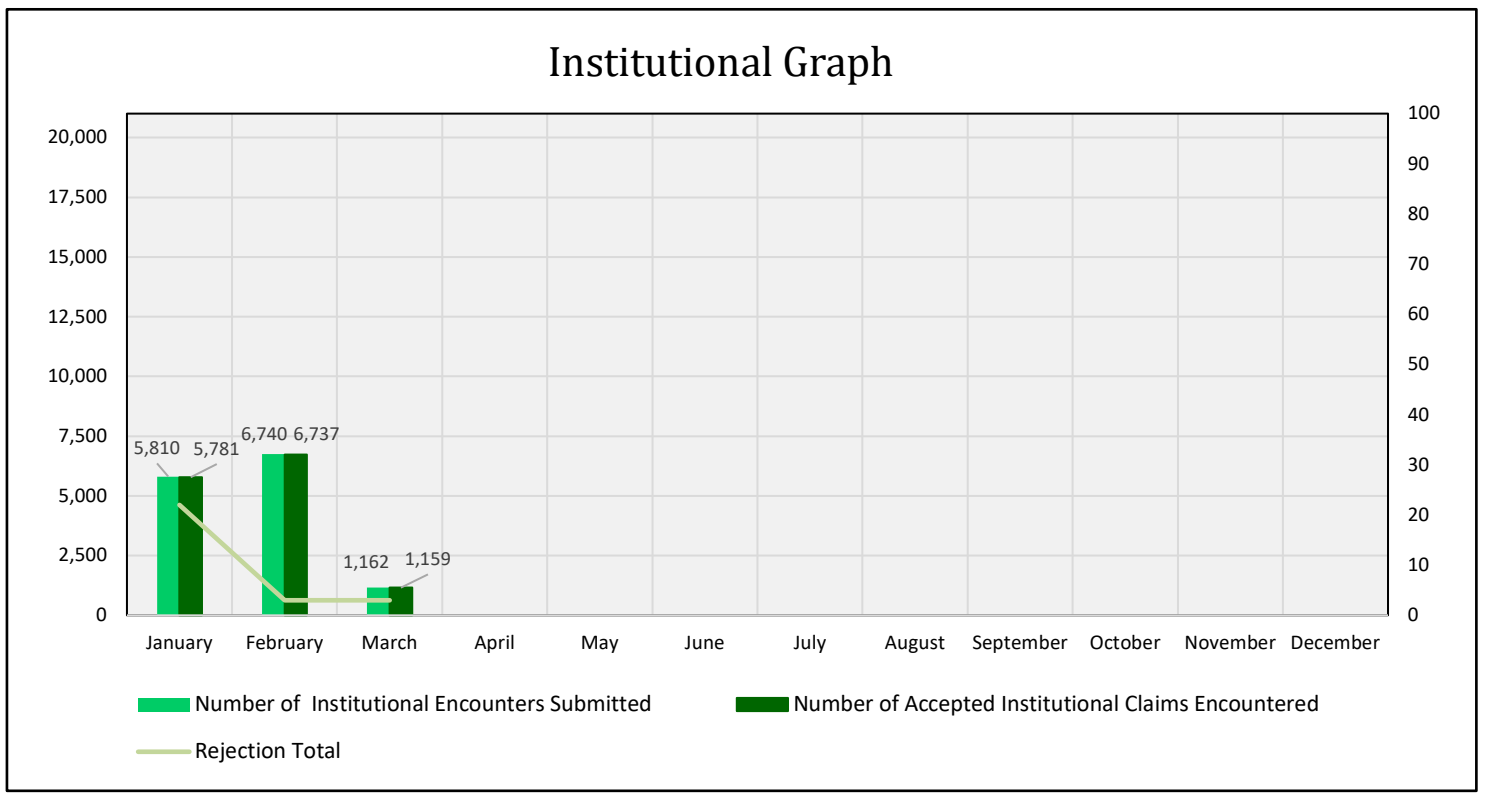
•Comparing the number of claims processed to the number of claims encountered/unencounterable in a given month.

•Tracking Acceptance Rate- The Reconciliation Analyst is responsible for tracking the acceptance rate. An Acceptance rate of 95% is considered acceptable. Any notable data
quality issues are reported to the COO and Compliance manager (Policy Number: CA2). The percentage totals can be found on Sheet 2 (Graphs) and Sheet 3 (Combined Overview) and Sheet 4 (Combined Graphs)

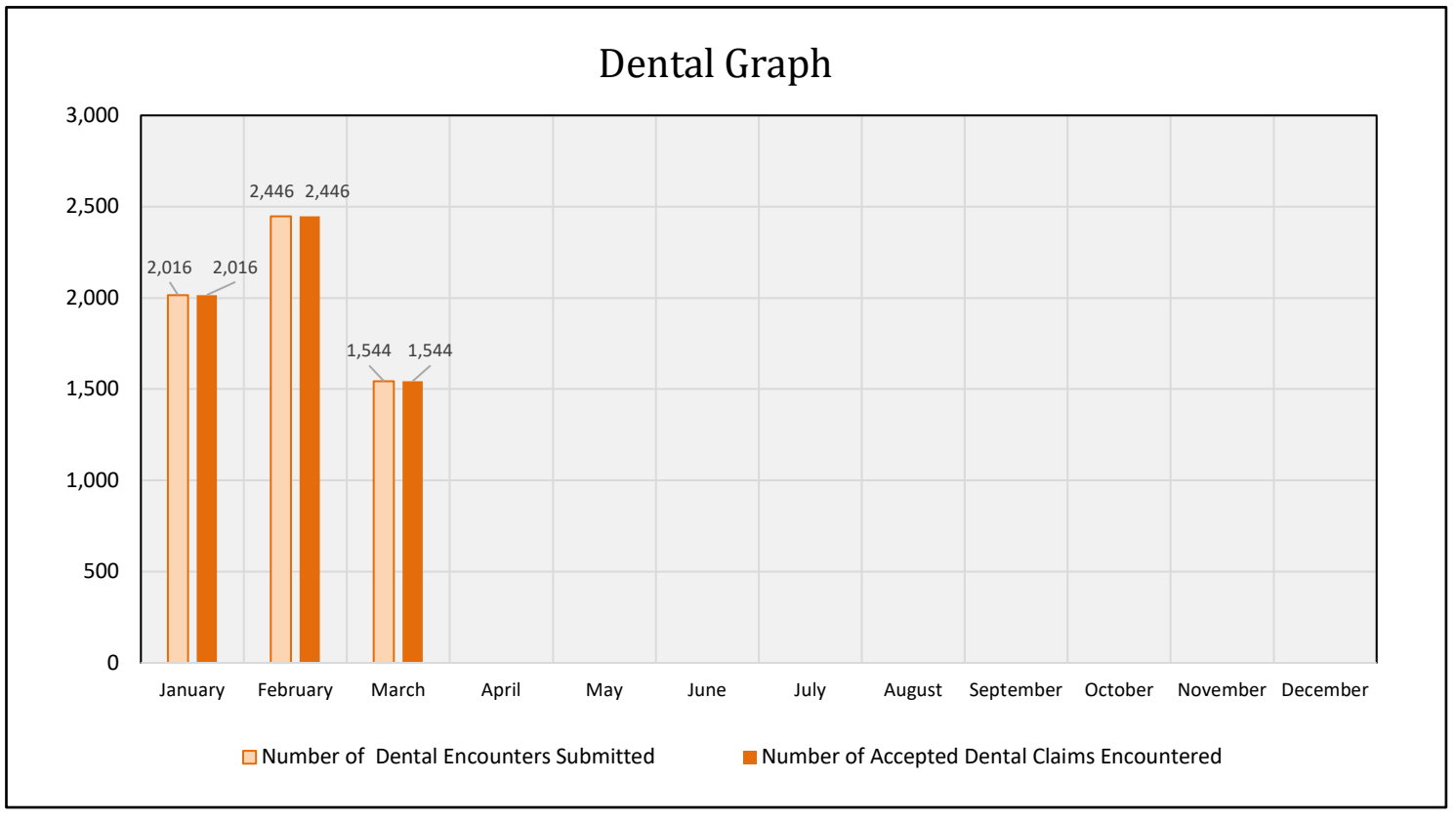
Notes-
Item 1- UHA is actively investigating why Advantage Dental has no denied Encounters for 2019.



Notes-



Notes-



Notes-

Encounter Data Tracking Sheet- Draft
Umpqua Health Alliance
Year 2019

	Total Number of Encounters Submitted	Billed Submission Amount	Initially Non-accepted Encounters	Initially Non-accepted Amount	Rejection Rate Percentage	Number of Accepted Claims Encountered	Billed Amount of Encounters Accepted	Number of Elgible Members
January	72,199	$38,606,424	56	$981,370	0.08%	72,136	$37,608,810	27,146
February	103,786	$26,540,198	8	$137,332	0%	103,778	$26,402,866	27,175
March	84,233	$22,502,497	5	$55,290	0%	84,228	$22,447,207	
April								
May								
June								
July								
August								
September								
October								
November								
December								

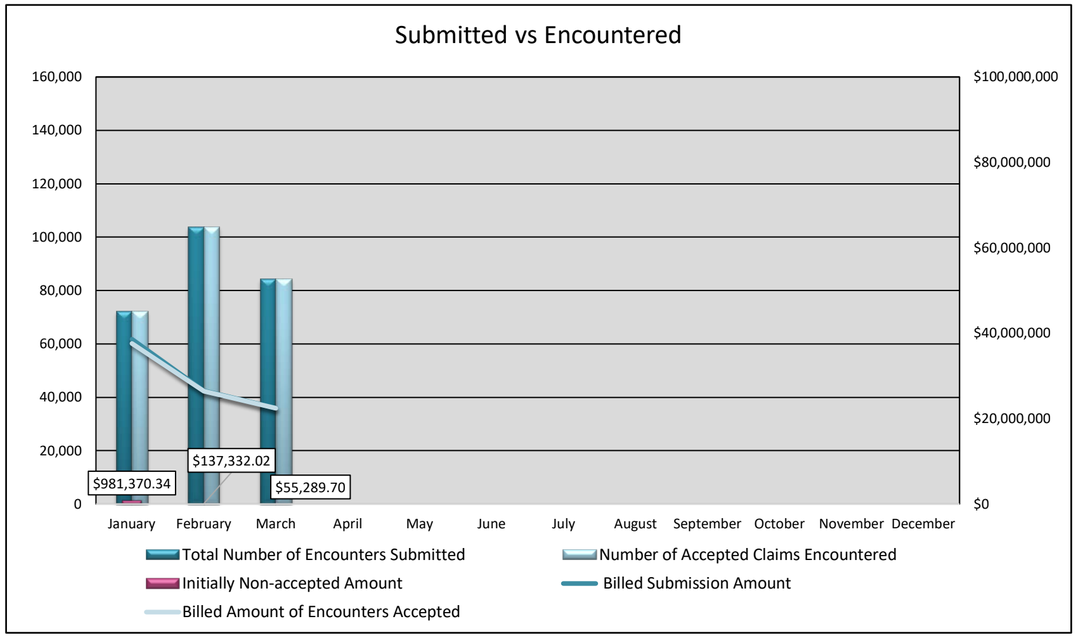
Legend-

The chart above will reflect combined totals based on the data from Tab 1 (Submission Data).

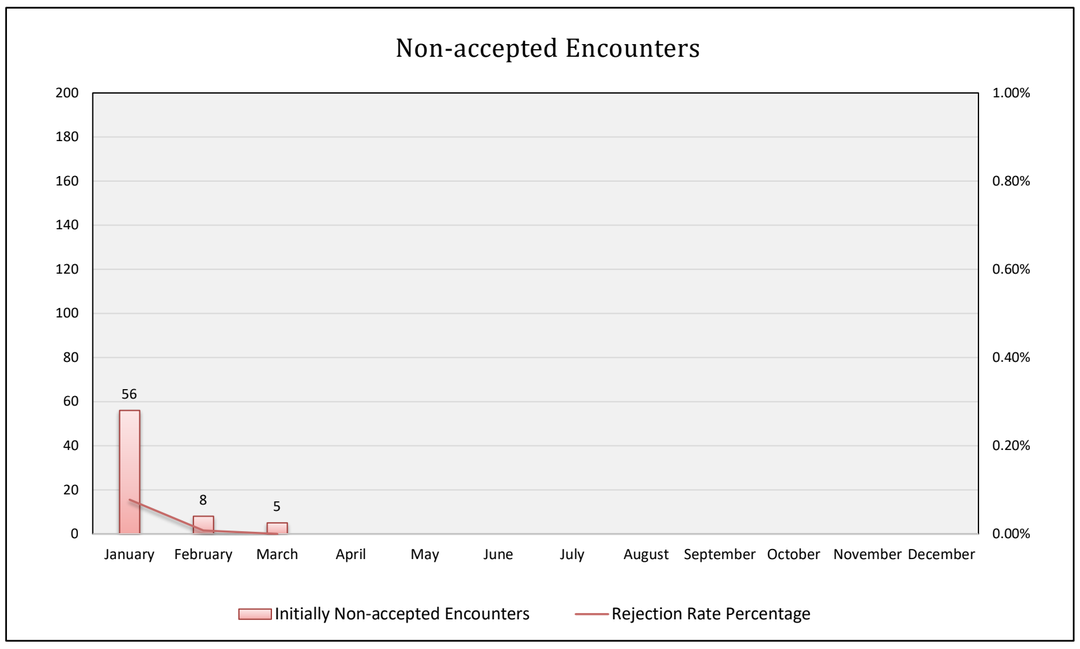
Objective-

- It allows UHA the ability to track total encounters submitted in a given month.

- The combined overview will give UHA and the submitter's transparency over the totals and dollar amounts for submitted, initially non-accepted, and accepted Encounters



Notes-



Notes-

* OHA Requires an Acceptance rate of 95%. Notable data quality issues of 5% and higher will be reported and researched.

	Rejected Liability Professional	Rejected Liability Institutional	Rejected Liability Dental	Failed Adjustments Professional	Failed Adjustments Institutional	Failed Adjustments Dental	Duplicates	
January	8%	12%	15%	0%	0%	0%	0%	
February	5%	8%	8%	0%	0%	0%	0%	
March	24%	42%	29%	0%	1%	0%	0%	*
April								
May								
June								
July								
August								
September								
October								
November								
December								

Notes:

***March-** Is under active invesigation due to the high rejected Liability rates.

Legend

Data Source- Oregon Health Authority

Desciption-
Some Encounters may require a correction in MMIS if pended by OHA. Once the encounter contains correct and acceptable information. It is then processed manually in MMIS to override an encounter's pend which changes the status to accepted/approved. Also, the pended encounter may be corrected by voiding it and resubmitting a new encounter once the

Examples of Pended Encounters:

- Duplicate Claim/Service
- Questionable data in a field (invalid character)
- The provider does not have a DMAP number
- If OHA updates and adds a new code for submitting. The encounters submitted with the old code will pend with OHA until they can be reprocessed and adjusted in MMIS to meet OHA's updated code.

Definitions:

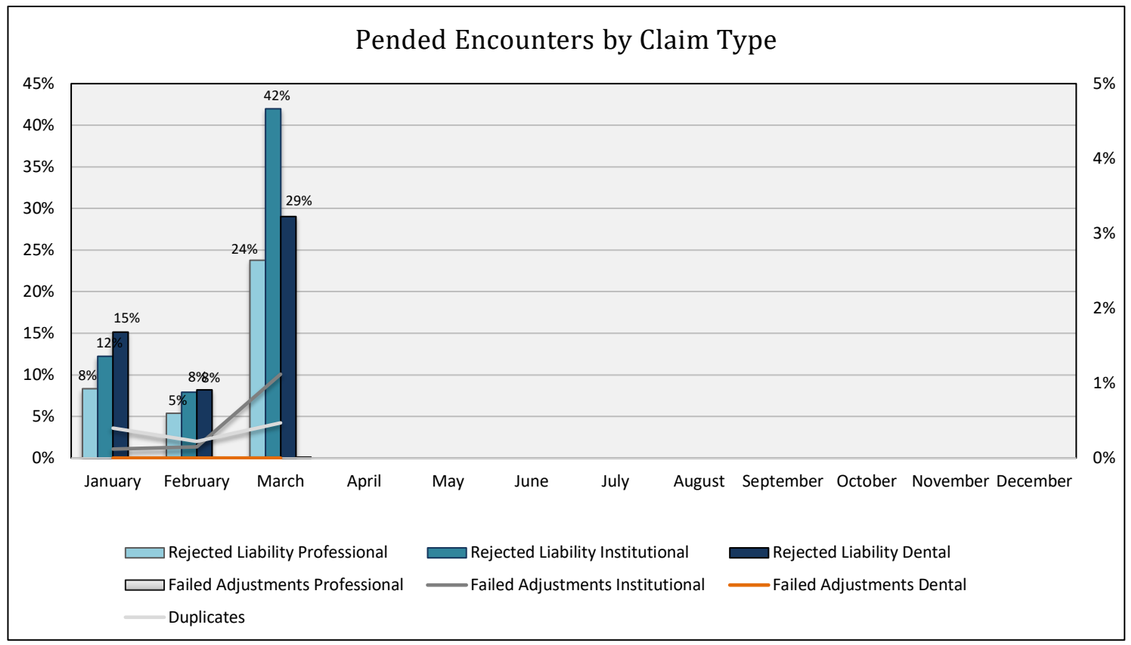
Rejected Liability- Rejected Liability claims are Pending Encounters that are corrected and resubmitted by our subcontractors.

Failed Adjustments-Appear on your 835 with an ICN that begins with Region 20 and contains Adjustment Reason Code 129.

Causes-

- ICN used on adjustment has already been adjusted
- Adjustment was attempting to change claim type (from inpatient to outpatient)
- Adjustment was attempting to change the plan ID number.

*please note, most of these adjustments are facility claims due to TOB that cancels a previous claim.



Rejected Liability- are encounters pending with OHA that must be corrected and resubmitted until accepted.

Failed Adjustments-Appear on your 835 with an ICN that begins with Region 20 and contains Adjustment Reason Code 129.

Causes-

- ICN used on adjustment has already been adjusted
- Adjustment was attempting to change claim type (from inpatient to outpatient)
- Adjustment was attempting to change the plan ID number.

*please note, most of these adjustments are facility claims due to TOB that cancels a previous claim.

Duplicate Encounters-These are encounters received by OHA and denied for Duplicate.

Example- a claim initially processed as primary and then reprocessed as secondary.

Notes-

*March- Is actively being investigated due to the high Rejected Liability Rates.

Institutional & Professional

	Check Run Total	Net Amount	Encounter Submission Total	Billed Amount of Encounter Submissions	999 Rejections	Claims Not Encountered	Percentage of Claims Submitted for Encounter
January	78,474	$5,682,116	45,787	$38,041,405	11	2,005	
Running Total:	78,474		45,787		11	2,005	56%
February	51,115	$3,300,422	77,166	$25,837,784	4	1,137	
Running Total:	129,589		122,953		15	3,142	92%
March	80,048	$6,303,306	46,864	$22,074,574	5	1,171	
Running Total:	209,637		169,817		20	4,313	79%

Dental

Pharmacy

	Advantage Dental Submissions	Advantage Dental Billed Amount	PH-Techs Submission Amount	PH-Techs Billed Amount	Percentage of Claims Submitted for Encounter	Pharmacy Submissions	Pharmacy Billed Amount	Pharmacy Acceptance Rate
January	2,374	$678,410.00	2,016	$565,019.00	84.92%	24,396	$3,067,148.61	99.86%
February	2,654	$713,600.00	2,446	$702,414.17	92.16%	24,174	$3,465,205.87	100%
March								
April								
May								
June								
July								
August								
September								
October								
November								
December								

Legend- Institutional and Professional

Description- The data within this chart provides UHA the ability to track and compare the Check Run totals to the Encounter Submission totals. The Submission of encounters begin after check run. In order to correctly reflect the submissions, the data is placed on a running total chart. Please See *Item 1* in notes for the causes of encounter data not aligning with the check run totals on a month to month basis.

Definitions-

999 Rejections- the EDI Transaction set acknowledging receipt of an 837 file submission and identifying full file error rejections and claim error rejections. Some example of 999 rejections are:

- structure errors in the 837 file
- when the 837 file contains errors that prohibit further processing of the file
- when an invalid sender ID is reported
- The 837 file can be corrected and then encountered successfully.

Claims Not Encountered- Is the total of claims that did not get submitted due to being unencounterable. Some example are;

- Duplicate Claim
- Missing Provider DMAP Number
- Questionable data in 837 file (invalid Character)

Notes-

Item 1- Below lists the causes as to why the check run doesn't match the submission totals for Encounter;

- Encounters are submitted approximately one week or up to 45 days after each check run.
- Encounter pending with the state for up to 63 days.
- Recoupments and Refunds
- Claims that are paid in one month but submitted for encounter the next.
- The Running totals should increase overtime.

Item 2- Quarter 1- Ph-Tech held claims for providers with new contracts in 2019, thus causing a lower number of claims paid.

- ❖ Most notable- Mercy Medical Center Claims

Applicant Company Name : Umpqua Health Alliance

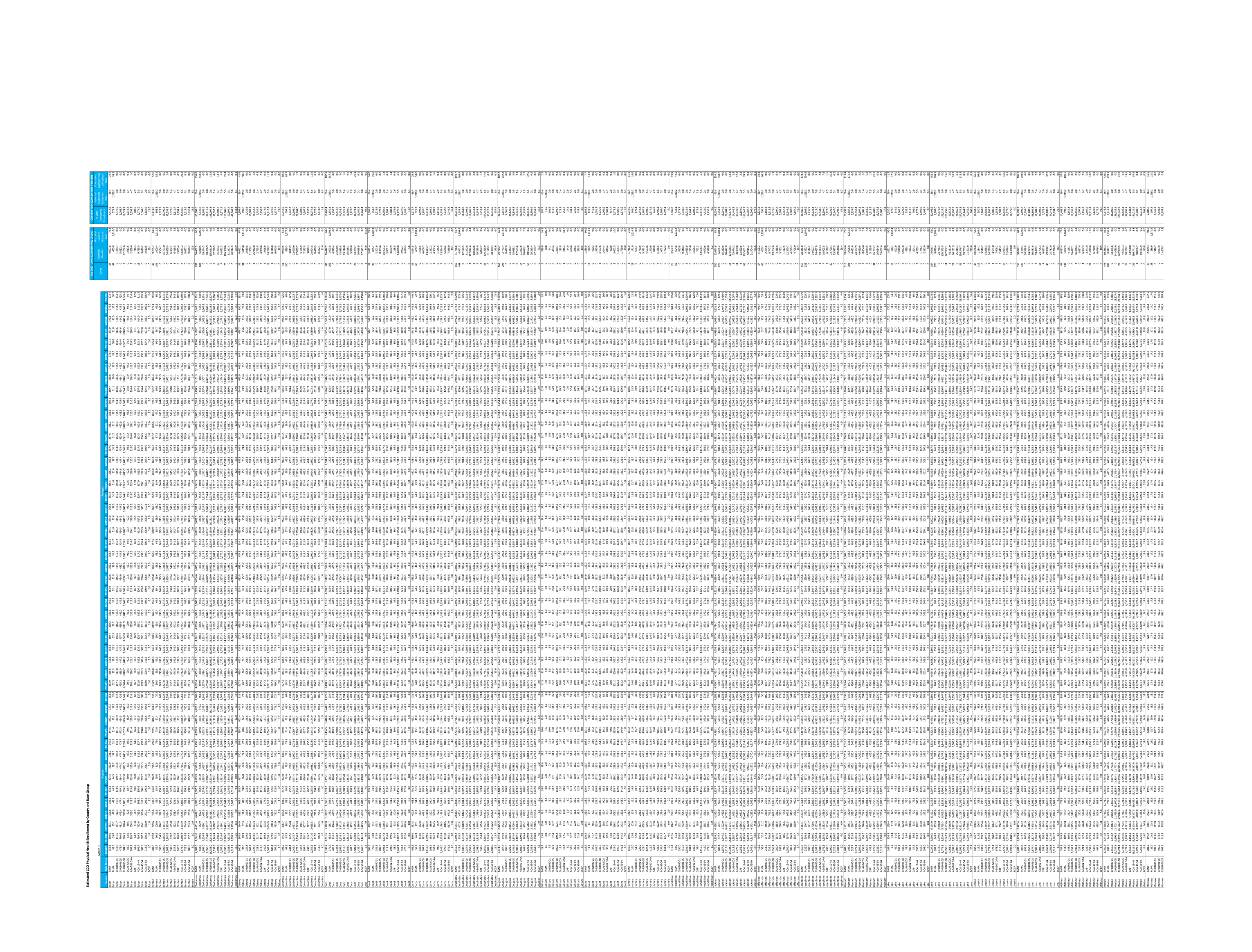
NAIC No. _____

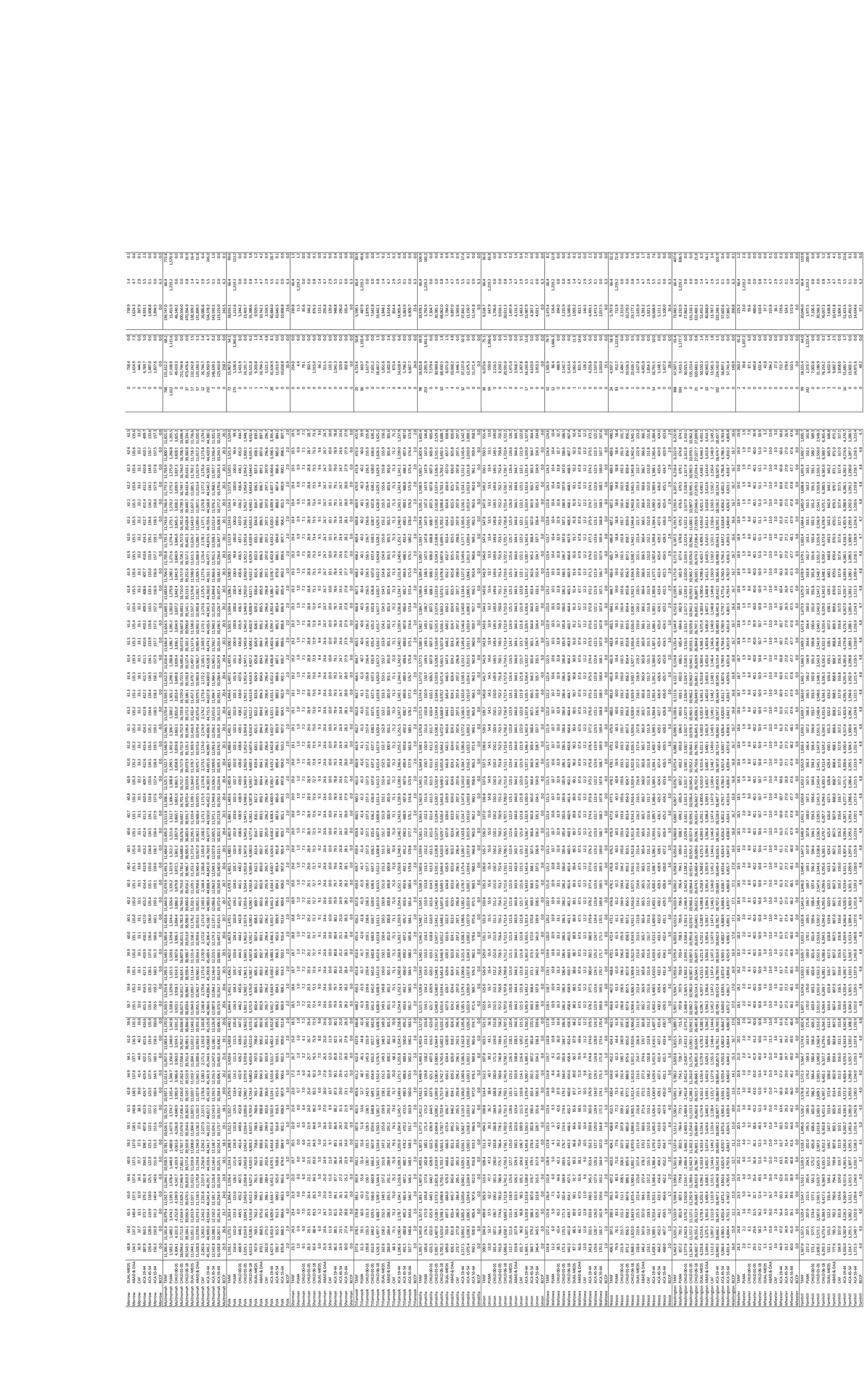
FEIN: 46-1250214

BIOGRAPHICAL AFFIDAVIT

[redacted]

Estimated CCO Physical Health Enrollment by County and Rate Group





Estimated CCO Behavioral Health Enrollment by County and Rate Group

Month ->

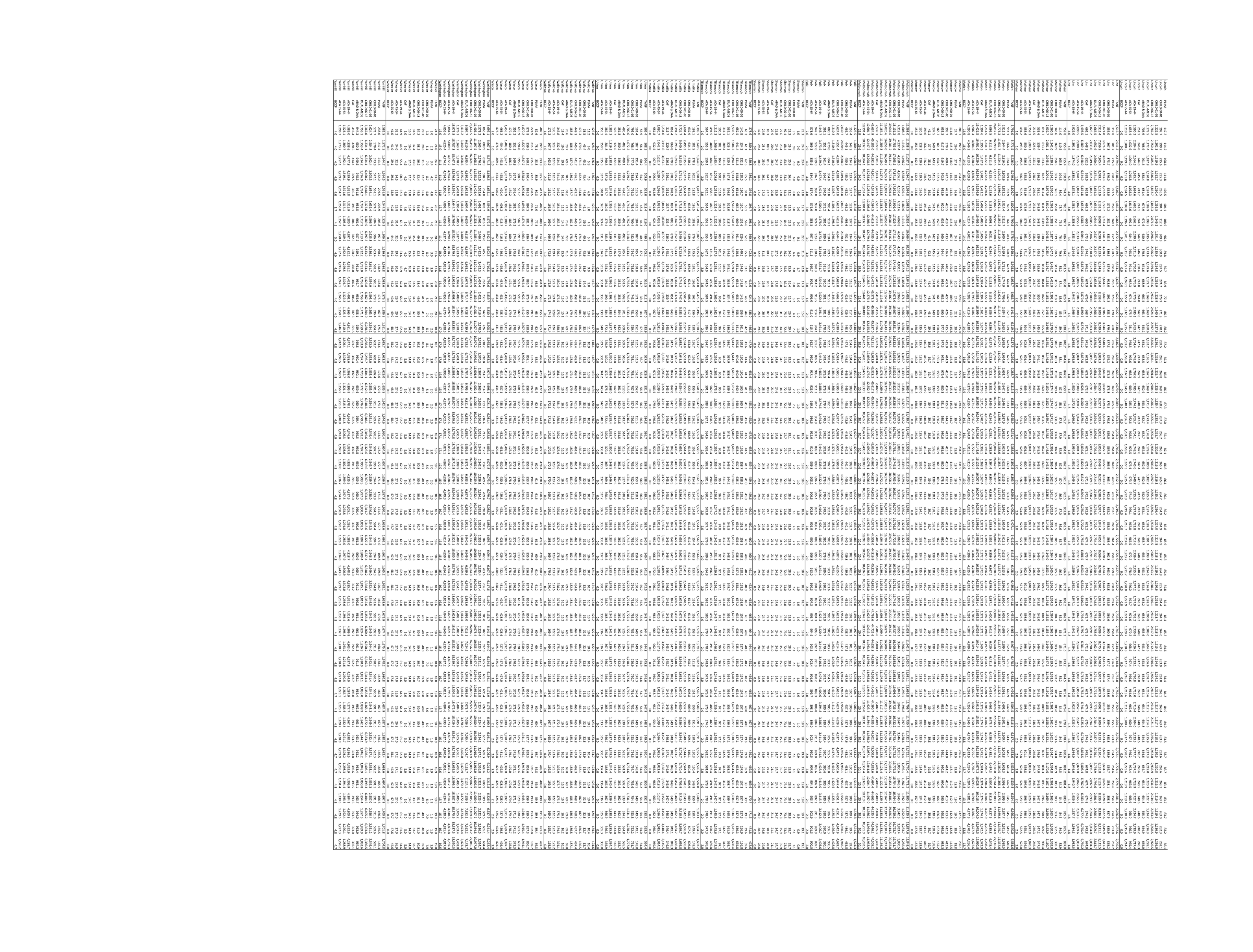
		Actuals													Forecast															
County	Rate Group	201707	201708	201709	201710	201711	201712	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101	202102	202103	202104	202105	202106
Baker	TANF	357.8	353.0	356.1	353.6	336.7	334.2	325.1	332.0	332.0	346.6	345.5	344.1	348.7	353.9	354.9	356.6	357.8	359.3	360.7	361.3	362.5	363.5	364.0	363.8	364.1	364.7	364.6	365.1	365.0	365.8	366.4	366.5	367.3	367.9	368.0	368.6	369.2	369.7	370.1	370.8	370.8	371.8	372.0	372.1	373.0	373.6	373.8	374.5
Baker	PLMA	38.5	39.0	35.2	47.0	48.2	45.9	44.3	38.7	34.0	31.5	32.2	31.1	33.6	32.6	32.3	32.3	32.1	32.1	32.3	32.2	32.2	32.2	32.2	32.1	31.9	31.9	31.9	31.7	31.8	31.6	31.6	31.7	31.6	31.6	31.6	31.3	31.2	31.2	31.1	31.1	31.0	30.9	31.0	31.0	30.8	30.7
Baker	CHILD 00-01	114.0	112.5	112.0	112.3	110.6	114.8	111.7	109.6	110.4	112.1	113.1	114.9	112.4	117.4	117.1	117.0	116.8	116.6	116.6	116.2	116.0	115.8	115.6	115.2	115.1	115.2	115.2	115.2	115.2	115.2	115.3	115.0	115.0	114.9	114.6	114.5	114.4	114.5	114.7	114.6	114.6	114.8	114.7	114.5	114.6	114.5	114.2	114.1
Baker	CHILD 01-05	479.4	482.7	484.5	478.4	478.4	466.5	468.4	478.2	477.1	475.7	475.3	468.5	461.7	444.2	443.6	443.4	443.3	443.0	443.1	442.1	441.6	441.2	440.5	439.4	439.0	439.4	439.6	439.9	439.9	440.2	440.7	440.0	440.0	439.7	438.7	438.4	438.2	438.6	439.3	439.4	439.6	440.3	440.4	439.8	440.0	439.8	438.6	438.6
Baker	CHILD 06-18	988.9	989.1	983.4	1,002.0	1,010.3	999.9	1,007.0	1,027.0	1,054.6	1,065.6	1,063.3	1,070.5	1,052.6	1,047.0	1,046.4	1,046.7	1,047.7	1,048.2	1,048.8	1,047.9	1,047.5	1,047.5	1,046.5	1,044.2	1,043.5	1,044.7	1,045.5	1,046.6	1,047.7	1,049.1	1,050.6	1,049.6	1,049.8	1,049.8	1,047.8	1,047.1	1,046.8	1,048.0	1,049.8	1,050.7	1,052.0	1,054.1	1,054.6	1,053.7	1,054.4	1,054.3	1,052.3	1,051.5
Baker	DUAL-MEDS	356.8	352.7	351.3	344.1	340.2	340.8	335.4	336.3	340.6	337.4	339.0	341.3	342.0	347.1	347.6	348.4	348.8	349.2	349.9	350.2	350.9	351.5	352.1	352.5	353.1	353.7	354.2	354.8	355.2	355.5	356.1	356.4	357.0	357.6	358.0	358.5	359.0	359.5	360.0	360.6	360.9	361.2	361.7	361.9	362.6	363.1	363.5	363.9
Baker	ABAD & OAA	219.2	217.6	219.3	221.3	227.1	228.8	227.1	229.6	229.9	232.2	231.0	230.9	225.9	225.9	225.8	225.8	225.8	225.6	225.6	225.7	225.7	225.6	225.7	225.7	225.6	225.7	225.7	225.8	225.8	225.8	225.9	226.0	226.1	226.2	226.1	226.2	226.3	226.2	226.3	226.2	226.3	226.2	226.3	226.2	226.3	226.2	226.3	226.3
Baker	CAF	73.1	75.0	75.3	74.2	73.8	74.1	72.8	75.7	74.6	76.0	78.5	80.5	78.0	77.1	77.1	77.3	77.3	77.3	77.3	77.3	77.2	77.2	77.1	77.1	77.2	77.3	77.3	77.4	77.4	77.4	77.4	77.4	77.4	77.4	77.5	77.5	77.5	77.5	77.5	77.5	77.5	77.5	77.4	77.4	77.4	77.4	77.4	77.4
Baker	ACA 19-44	806.4	794.0	799.6	794.9	808.2	811.5	804.9	817.3	821.9	833.7	851.0	855.8	832.2	827.5	824.9	823.2	828.8	834.1	830.8	828.2	824.8	823.1	822.2	820.8	819.2	816.9	815.1	813.8	819.5	825.1	822.7	819.9	818.5	817.8	816.5	815.5	814.8	813.1	811.7	809.8	815.5	822.8	819.7	817.2	816.7	816.0	814.5	813.8
Baker	ACA 45-54	307.2	311.7	307.1	309.6	314.9	308.6	291.7	295.3	295.1	297.7	300.8	298.6	299.0	300.9	299.9	299.3	301.4	303.3	302.1	301.2	299.9	299.3	299.0	298.4	297.9	297.0	296.4	295.9	298.0	300.0	299.1	298.1	297.6	297.4	296.9	296.5	296.3	295.6	295.1	294.4	296.6	299.2	298.1	297.2	297.0	296.7	296.2	295.9
Baker	ACA 55-64	317.5	302.4	303.9	303.1	301.1	303.0	306.6	301.4	303.0	304.4	305.8	310.5	306.6	313.0	312.0	311.4	313.5	315.5	314.3	313.3	312.0	311.4	311.0	310.5	309.9	309.0	308.3	307.9	310.0	312.1	311.2	310.2	309.6	309.4	308.9	308.5	308.2	307.6	307.0	306.3	308.5	311.3	310.1	309.1	308.9	308.7	308.1	307.8
Baker	BCCP	1.0	1.0	1.0	1.0	1.1	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Benton	TANF	788.7	800.8	787.9	773.7	749.8	742.8	753.0	741.4	768.8	799.3	800.5	817.1	815.0	833.5	835.9	839.8	842.8	846.2	849.5	850.9	853.9	856.2	857.4	856.9	857.7	858.9	858.7	859.9	859.8	861.6	863.0	863.3	865.0	866.4	866.8	868.2	869.6	870.7	871.7	873.3	873.4	875.6	876.2	876.5	878.5	880.0	880.5	882.1
Benton	PLMA	93.7	92.8	102.0	94.5	88.4	86.0	82.6	85.4	88.3	79.0	77.4	72.9	80.0	73.2	72.5	72.5	72.1	72.0	72.5	72.2	72.3	72.3	72.1	71.6	71.5	71.6	71.2	71.4	70.9	70.9	71.3	70.9	71.0	70.8	70.3	70.2	70.1	69.9	69.8	69.8	69.3	69.5	69.5	69.3	69.5	69.5	69.1	69.0
Benton	CHILD 00-01	338.5	334.5	326.2	323.8	304.3	297.2	279.7	269.9	269.4	264.4	256.0	263.3	263.8	255.5	254.9	254.6	254.3	253.9	253.8	253.0	252.4	252.0	251.5	250.8	250.6	250.7	250.7	250.8	250.6	250.6	250.8	250.3	250.2	250.0	249.3	249.1	249.0	249.1	249.5	249.4	249.3	249.7	249.6	249.1	249.3	249.1	248.5	248.3
Benton	CHILD 01-05	1,320.9	1,295.6	1,320.8	1,330.6	1,320.3	1,307.7	1,324.9	1,323.1	1,315.3	1,338.1	1,349.9	1,352.0	1,347.0	1,328.8	1,327.4	1,327.2	1,327.4	1,327.8	1,325.8	1,324.6	1,323.9	1,322.2	1,319.0	1,318.1	1,319.4	1,320.2	1,321.2	1,321.8	1,323.2	1,324.8	1,323.1	1,323.2	1,322.8	1,319.9	1,319.0	1,318.6	1,319.9	1,322.0	1,322.7	1,323.8	1,326.1	1,326.5	1,324.9	1,325.8	1,325.4	1,322.7	1,321.7
Benton	CHILD 06-18	2,920.8	2,899.5	2,881.0	2,911.3	2,928.9	2,899.8	2,892.9	2,887.4	2,923.5	2,978.6	2,970.3	2,952.8	2,939.1	2,951.9	2,951.5	2,953.6	2,958.0	2,961.4	2,963.9	2,963.1	2,963.4	2,964.8	2,962.7	2,956.6	2,955.0	2,958.7	2,961.7	2,965.5	2,969.8	2,974.6	2,979.3	2,977.6	2,978.8	2,979.4	2,974.5	2,972.6	2,971.7	2,975.6	2,981.2	2,984.2	2,989.3	2,995.8	2,997.9	2,995.9	2,998.4	2,998.5	2,993.0	2,991.0
Benton	DUAL-MEDS	857.2	866.6	864.1	855.1	861.7	867.4	870.0	870.6	876.7	875.2	886.1	893.7	899.0	900.7	902.0	903.8	905.0	905.8	907.5	908.4	910.0	911.7	913.1	914.2	915.6	917.2	918.4	920.0	920.8	921.7	923.1	924.0	925.5	926.9	927.9	929.2	930.6	931.8	933.0	934.5	935.2	936.1	937.2	937.9	939.5	940.8	941.7	942.9
Benton	ABAD & OAA	543.1	545.1	541.4	538.9	541.4	545.5	542.0	546.4	548.2	545.3	542.6	546.1	545.3	549.9	549.8	550.0	549.8	549.4	549.6	549.2	549.1	549.2	549.2	548.9	549.1	549.3	549.3	549.7	549.4	549.2	549.5	549.2	549.3	549.4	549.3	549.6	549.7	549.9	550.3	550.0	550.0	550.0	549.8	550.1	550.2	550.1	550.1	550.2
Benton	CAF	216.6	216.3	218.7	221.1	224.2	224.0	222.4	227.2	232.8	227.0	230.3	223.6	225.9	231.9	232.0	232.5	232.5	232.5	232.6	232.5	232.3	232.2	232.0	231.9	232.2	232.5	232.6	232.9	232.8	232.8	232.9	232.8	232.8	232.6	232.3	232.3	232.6	232.8	233.0	233.2	233.1	233.3	233.1	233.1	233.2	233.1	232.8	232.9
Benton	ACA 19-44	3,613.8	3,595.7	3,504.4	3,565.9	3,628.8	3,586.8	3,643.5	3,746.9	3,798.9	3,833.5	3,869.6	3,852.5	3,820.9	3,789.7	3,777.5	3,770.1	3,795.7	3,819.9	3,804.6	3,793.0	3,777.2	3,769.5	3,765.5	3,758.8	3,751.8	3,741.0	3,732.8	3,727.1	3,752.9	3,778.8	3,767.7	3,754.9	3,748.4	3,745.2	3,739.2	3,734.7	3,731.4	3,723.5	3,717.2	3,708.4	3,734.9	3,768.3	3,754.0	3,742.6	3,740.2	3,736.9	3,730.2	3,726.8
Benton	ACA 45-54	728.4	724.4	721.8	717.3	717.2	718.5	713.3	726.5	744.5	750.7	755.5	763.0	764.8	775.1	772.6	771.1	776.3	781.3	778.1	775.8	772.5	770.9	770.1	768.8	767.3	765.1	763.5	762.3	767.6	772.9	770.6	768.0	766.6	766.0	764.8	763.8	763.2	761.6	760.3	758.5	763.9	770.7	767.8	765.5	765.0	764.3	762.9	762.2
Benton	ACA 55-64	809.3	798.7	795.3	787.8	784.1	792.9	807.7	819.1	828.1	839.8	825.3	821.9	818.4	817.3	814.7	813.1	818.6	823.8	820.5	818.0	814.6	812.9	812.1	810.6	809.1	806.8	805.0	803.8	809.3	814.9	812.5	809.8	808.4	807.7	806.4	805.4	804.7	803.0	801.6	799.7	805.5	812.7	809.6	807.1	806.6	805.9	804.5	803.7
Benton	BCCP	2.0	2.0	2.0	2.0	2.4	2.0	2.0	1.1	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Clackamas	TANF	4,717.9	4,690.3	4,681.1	4,702.1	4,735.4	4,714.9	4,657.5	4,614.6	4,690.1	4,814.2	4,823.0	4,841.6	4,804.3	4,883.3	4,897.7	4,920.6	4,937.9	4,957.6	4,977.3	4,985.2	5,002.9	5,016.4	5,023.6	5,020.3	5,025.1	5,032.5	5,030.9	5,038.3	5,037.3	5,047.9	5,056.4	5,058.1	5,068.1	5,076.5	5,078.2	5,087.0	5,094.9	5,101.3	5,107.3	5,116.5	5,117.3	5,130.2	5,133.8	5,135.1	5,146.8	5,155.8	5,158.8	5,167.9
Clackamas	PLMA	656.7	606.7	599.6	617.6	583.0	570.1	589.5	576.8	555.2	545.0	527.4	506.6	482.1	472.8	467.8	467.9	465.3	464.9	468.2	466.3	467.0	466.9	465.4	462.0	461.8	462.2	460.0	460.8	457.5	458.0	460.0	457.7	458.1	457.4	453.8	453.0	452.5	451.4	450.6	450.7	447.7	448.7	448.9	447.2	449.0	448.9	446.0	445.5
Clackamas	CHILD 00-01	1,694.0	1,662.7	1,654.1	1,625.9	1,631.4	1,632.6	1,639.5	1,616.1	1,623.1	1,618.0	1,605.5	1,579.6	1,555.2	1,542.2	1,539.1	1,537.3	1,535.8	1,533.3	1,532.8	1,528.3	1,525.2	1,522.8	1,519.9	1,515.6	1,514.3	1,515.4	1,515.6	1,515.8	1,514.8	1,515.3	1,516.6	1,513.5	1,512.9	1,511.5	1,507.5	1,506.2	1,505.7	1,506.7	1,508.7	1,508.6	1,508.3	1,510.3	1,510.1	1,507.3	1,508.0	1,507.0	1,503.4	1,502.3
Clackamas	CHILD 01-05	6,999.8	6,888.9	6,919.1	7,006.6	7,087.4	7,041.8	7,007.2	7,001.9	6,909.5	6,965.1	6,928.7	6,919.8	6,854.3	6,880.9	6,874.9	6,874.5	6,877.9	6,878.2	6,880.9	6,871.6	6,866.4	6,864.1	6,856.0	6,839.7	6,835.1	6,842.2	6,846.7	6,852.5	6,856.8	6,864.3	6,873.2	6,865.2	6,865.6	6,871.6	6,864.8	6,887.4	6,879.6	6,884.3	6,882.6	6,868.6	6,863.8
Clackamas	CHILD 06-18	16,435.4	16,215.4	16,169.1	16,382.2	16,420.2	16,297.1	16,263.8	16,239.1	16,293.9	16,391.6	16,330.2	16,334.1	16,224.0	16,079.5	16,081.2	16,096.4	16,125.2	16,149.3	16,165.6	16,166.5	16,172.3	16,184.2	16,174.8	16,143.4	16,135.0	16,156.1	16,174.4	16,197.6	16,225.4	16,254.1	16,281.4	16,274.9	16,282.6	16,288.6	16,263.5	16,253.6	16,248.9	16,271.5	16,302.9	16,321.9	16,353.4	16,390.5	16,404.1	16,395.2	16,409.3	16,411.3	16,382.6	16,371.7
Clackamas	DUAL-MEDS	5,257.0	5,284.8	5,240.0	5,248.4	5,242.1	5,203.4	5,206.0	5,213.7	5,247.9	5,258.5	5,302.0	5,330.0	5,337.1	5,345.4	5,355.0	5,368.0	5,377.1	5,384.4	5,396.5	5,404.2	5,416.0	5,427.9	5,438.7	5,447.1	5,457.5	5,468.4	5,477.2	5,488.6	5,495.0	5,501.7	5,512.1	5,518.8	5,530.0	5,540.2	5,547.9	5,557.0	5,566.4	5,575.3	5,584.0	5,593.7	5,599.6	5,606.1	5,614.1	5,618.9	5,630.9	5,640.3	5,647.4	5,655.6
Clackamas	ABAD & OAA	2,947.8	2,952.6	2,987.5	3,009.3	3,010.0	3,001.9	3,008.7	2,997.6	2,997.8	3,003.8	2,986.7	2,963.9	2,952.0	2,939.4	2,939.1	2,940.9	2,940.0	2,938.3	2,939.5	2,937.7	2,937.9	2,938.7	2,939.0	2,937.9	2,939.4	2,940.6	2,941.1	2,943.2	2,942.2	2,941.5	2,942.9	2,941.7	2,942.6	2,943.6	2,943.2	2,947.8	2,949.8	2,948.8	2,949.4	2,948.6	2,948.0	2,948.2	2,950.9	2,951.6	2,950.9	2,951.6
Clackamas	CAF	1,467.6	1,476.9	1,498.1	1,506.2	1,507.3	1,517.0	1,521.1	1,509.5	1,510.1	1,515.7	1,500.1	1,497.3	1,504.8	1,507.2	1,507.9	1,510.6	1,510.8	1,510.7	1,511.5	1,510.8	1,509.6	1,509.0	1,507.9	1,507.2	1,509.0	1,510.9	1,511.5	1,513.5	1,512.6	1,512.9	1,513.5	1,513.1	1,512.5	1,511.7	1,509.5	1,509.8	1,511.6	1,512.6	1,514.0	1,515.5	1,514.6	1,515.7	1,515.1	1,514.9	1,515.2	1,514.7	1,512.8	1,513.2
Clackamas	ACA 19-44	13,929.5	13,799.8	13,537.4	13,617.5	13,737.3	13,721.2	13,785.8	13,776.9	13,940.2	14,085.9	14,154.6	14,215.1	14,155.9	14,131.5	14,086.0	14,058.4	14,153.7	14,244.1	14,186.8	14,143.6	14,084.6	14,055.9	14,041.1	14,016.0	13,990.0	13,949.9	13,919.3	13,897.9	13,994.1	14,090.7	14,049.1	14,001.7	13,977.4	13,965.6	13,943.1	13,926.2	13,914.1	13,884.6	13,861.0	13,828.1	13,927.1	14,051.5	13,998.0	13,955.8	13,946.9	13,934.3	13,909.5	13,896.7
Clackamas	ACA 45-54	4,411.7	4,359.6	4,278.7	4,285.7	4,274.8	4,271.5	4,277.0	4,259.3	4,251.6	4,284.1	4,303.1	4,300.6	4,315.3	4,300.4	4,286.5	4,278.1	4,307.2	4,334.6	4,317.2	4,304.1	4,286.1	4,277.4	4,272.9	4,265.2	4,257.3	4,245.1	4,235.8	4,229.3	4,258.6	4,288.0	4,275.3	4,260.9	4,253.5	4,249.9	4,243.1	4,237.9	4,234.2	4,225.2	4,218.1	4,208.1	4,238.2	4,276.1	4,259.8	4,246.9	4,244.2	4,240.4	4,232.8	4,228.9
Clackamas	ACA 55-64	4,036.7	4,013.5	3,979.1	3,972.1	3,977.9	4,024.4	4,093.7	4,086.2	4,065.4	4,077.1	4,066.5	4,070.3	4,071.4	4,059.5	4,046.4	4,038.5	4,065.9	4,091.9	4,075.4	4,063.0	4,046.0	4,037.8	4,033.5	4,026.3	4,018.9	4,007.4	3,998.6	3,992.4	4,020.0	4,047.8	4,035.9	4,022.2	4,015.3	4,011.9	4,005.4	4,000.5	3,997.1	3,988.6	3,981.8	3,972.4	4,000.8	4,036.5	4,021.2	4,009.1	4,006.5	4,002.9	3,995.7	3,992.1
Clackamas	BCCP	12.0	11.0	8.4	9.0	9.8	9.4	10.0	10.0	11.0	10.9	11.4	12.0	12.0	12.2	12.2	12.2	12.2	12.2	12.2	12.2	12.3	12.3	12.3	12.2	12.3	12.2	12.1	12.1	12.1	12.0	12.0	12.0	12.1	12.1	12.1	12.0	12.0	12.0	12.0	12.0	12.0	12.0	11.9	11.9	12.0	12.0	12.0	11.9
Clatsop	TANF	567.5	573.5	570.2	593.1	608.8	590.2	574.7	570.4	573.0	590.1	602.2	605.1	618.9	619.5	621.3	624.2	626.4	628.9	631.4	632.4	634.7	636.4	637.3	636.9	637.5	638.4	638.2	639.1	639.0	640.4	641.4	641.7	642.9	644.0	644.2	645.3	646.3	647.1	647.9	649.1	649.2	650.8	651.3	651.4	652.9	654.1	654.4	655.6
Clatsop	PLMA	100.6	93.1	89.3	92.0	87.9	93.8	86.5	88.0	77.1	72.1	70.6	74.7	76.3	77.5	76.7	76.7	76.3	76.2	76.7	76.4	76.5	76.5	76.3	75.7	75.7	75.7	75.4	75.5	75.0	75.1	75.4	75.0	75.1	75.0	74.4	74.2	74.0	73.8	73.9	73.4	73.5	73.5	73.6	73.3	73.6	73.1	73.0
Clatsop	CHILD 00-01	239.8	239.5	234.1	230.5	227.0	223.1	212.2	207.5	203.2	205.5	202.5	198.6	202.2	207.3	206.9	206.6	206.4	206.0	205.9	205.3	204.8	204.5	204.1	203.5	203.3	203.4	203.5	203.5	203.3	203.4	203.5	203.1	203.0	202.8	202.3	202.1	202.0	202.1	202.4	202.4	202.3	202.6	202.5	202.1	202.2	202.1	201.6	201.5
Clatsop	CHILD 01-05	968.7	952.9	946.2	953.5	954.3	949.1	942.8	936.8	934.8	945.7	939.7	941.1	929.2	927.1	926.3	926.2	926.6	926.6	927.0	925.7	924.9	924.6	923.5	921.3	920.7	921.6	922.2	923.0	923.5	924.5	925.7	924.6	924.6	924.4	922.5	921.8	921.5	922.5	924.0	924.5	925.4	927.1	927.4	926.4	927.0	926.7	924.9	924.2
Clatsop	CHILD 06-18	2,144.7	2,128.3	2,131.1	2,185.4	2,202.7	2,175.2	2,163.9	2,151.0	2,192.6	2,221.9	2,197.2	2,217.5	2,213.9	2,212.1	2,212.1	2,213.9	2,217.6	2,220.5	2,222.6	2,222.4	2,222.9	2,224.3	2,222.9	2,218.4	2,217.2	2,220.1	2,222.5	2,225.5	2,229.1	2,232.9	2,236.5	2,235.4	2,236.4	2,237.1	2,233.5	2,232.1	2,231.5	2,234.5	2,238.7	2,241.2	2,245.3	2,250.3	2,252.0	2,250.7	2,252.5	2,252.7	2,248.7	2,247.2
Clatsop	DUAL-MEDS	767.9	770.5	770.8	775.6	770.0	776.7	776.1	772.8	772.5	777.2	777.0	782.7	782.9	789.2	790.4	792.1	793.1	793.9	795.5	796.6	797.5	799.1	800.0	801.4	802.9	804.2	805.3	806.8	807.6	808.3	809.5	810.4	811.8	813.1	814.0	815.2	816.4	817.5	818.6	819.9	820.6	821.4	822.4	823.0	824.5	825.6	826.5	827.5
Clatsop	ABAD & OAA	463.7	466.5	461.6	460.2	459.1	465.6	462.5	464.5	469.0	469.3	464.7	459.1	464.5	463.5	463.4	463.6	463.4	463.1	463.2	462.9	462.6	463.0	463.0	462.7	462.9	463.1	463.1	463.4	463.2	463.3	463.1	463.4	463.5	463.7	464.0	463.8	463.7	464.0	463.8	463.7	463.8	463.8	464.0	463.9	463.9
Clatsop	CAF	242.0	241.4	242.1	245.2	246.9	240.7	237.9	243.0	231.8	225.1	227.9	223.2	225.0	227.0	227.1	227.5	227.5	227.5	227.6	227.5	227.3	227.2	227.1	227.0	227.2	227.5	227.6	227.9	227.8	227.8	227.9	227.9	227.8	227.6	227.3	227.4	227.6	227.8	228.0	228.2	228.1	228.3	228.2	228.1	228.2	228.1	227.8	227.9
Clatsop	ACA 19-44	2,067.0	2,060.0	2,027.4	2,032.3	2,035.0	2,009.6	1,990.0	1,997.1	2,039.5	2,049.1	2,065.1	2,094.5	2,086.5	2,086.8	2,080.1	2,076.0	2,090.1	2,103.5	2,095.0	2,088.6	2,079.9	2,075.7	2,073.5	2,069.8	2,065.9	2,060.0	2,055.5	2,052.3	2,066.5	2,080.8	2,074.7	2,067.7	2,064.1	2,062.3	2,059.0	2,056.5	2,054.7	2,050.4	2,046.9	2,042.0	2,056.7	2,075.0	2,067.1	2,060.9	2,059.6	2,057.7	2,054.1	2,052.2
Clatsop	ACA 45-54	695.1	687.9	687.6	687.5	692.7	683.0	686.5	680.8	676.2	674.0	668.4	672.2	668.5	671.4	669.3	667.9	672.5	676.8	674.0	672.0	669.2	667.8	667.1	665.9	664.7	662.8	661.3	660.3	664.9	669.5	667.5	665.3	664.1	663.5	662.5	661.7	661.1	659.7	658.6	657.0	661.7	667.6	665.1	663.1	662.6	662.1	660.9	660.3
Clatsop	ACA 55-64	804.4	792.1	773.7	764.4	742.6	736.9	725.5	736.8	753.4	759.6	758.4	775.6	781.1	779.7	777.2	775.6	780.9	785.9	782.7	780.3	777.1	775.5	774.7	773.3	771.9	769.7	768.0	766.8	772.1	777.4	775.1	772.5	771.2	770.5	769.3	768.2	766.9	764.8	762.9	768.4	775.3	772.3

Lincoln	PLMA	117.2	114.8	109.5	112.4	105.5	104.1	108.9	96.4	89.8	89.7	83.9	77.4	86.3	88.2	87.2	87.3	86.8	86.7	87.3	87.0	87.1	87.1	86.8	86.1	86.1	86.2	85.8	85.9	85.3	85.4	85.8	85.4	85.4	85.3	84.6	84.5	84.4	84.2	84.0	84.0	83.5	83.7	83.7	83.4	83.7	83.7	83.2	83.1
Lincoln	CHILD 00-01	292.7	299.2	295.6	295.3	296.5	304.7	312.7	309.9	300.9	287.5	274.7	276.9	271.8	270.1	269.5	269.1	268.8	268.3	268.2	267.3	266.7	266.3	265.7	265.0	264.7	264.9	264.9	264.9	264.7	264.8	265.0	264.4	264.3	264.0	263.3	263.0	263.0	263.1	263.4	263.4	263.3	263.6	263.6	263.1	263.2	263.0	262.3	262.1
Lincoln	CHILD 01-05	1,223.5	1,202.3	1,219.9	1,262.7	1,260.4	1,251.5	1,249.2	1,251.5	1,238.2	1,255.6	1,252.9	1,228.9	1,241.5	1,228.0	1,226.5	1,226.0	1,226.1	1,225.5	1,225.8	1,223.5	1,222.1	1,221.3	1,219.6	1,216.5	1,215.6	1,216.8	1,217.4	1,218.2	1,218.5	1,219.5	1,220.9	1,219.2	1,219.1	1,218.6	1,215.9	1,214.9	1,214.6	1,215.7	1,217.6	1,218.1	1,218.8	1,220.9	1,221.2	1,219.5	1,220.3	1,219.8	1,217.2	1,216.4
Lincoln	CHILD 06-18	2,792.8	2,757.6	2,791.7	2,851.9	2,860.8	2,853.8	2,876.2	2,899.8	2,910.6	2,945.8	2,941.1	2,937.3	2,930.1	2,902.8	2,902.0	2,903.6	2,907.3	2,910.0	2,912.3	2,910.8	2,910.6	2,911.5	2,909.2	2,903.0	2,901.3	2,904.8	2,907.6	2,911.1	2,914.8	2,919.2	2,923.7	2,921.7	2,922.6	2,923.0	2,917.9	2,916.0	2,915.2	2,918.8	2,924.1	2,926.9	2,931.4	2,937.6	2,939.5	2,937.3	2,939.6	2,939.5	2,934.1	2,932.1
Lincoln	DUAL-MEDS	1,179.5	1,178.9	1,194.1	1,196.8	1,203.8	1,196.2	1,200.1	1,192.0	1,179.6	1,185.6	1,179.3	1,170.1	1,169.4	1,165.6	1,167.7	1,170.5	1,172.5	1,174.1	1,176.7	1,178.4	1,181.0	1,183.6	1,185.9	1,187.7	1,190.0	1,192.4	1,194.3	1,196.8	1,198.2	1,199.6	1,201.9	1,203.4	1,205.8	1,208.0	1,209.7	1,211.7	1,213.7	1,215.7	1,217.6	1,219.7	1,221.0	1,222.4	1,224.1	1,225.4	1,227.8	1,229.8	1,231.4	1,233.2
Lincoln	ABAD & OAA	708.9	713.1	705.1	691.9	684.8	681.5	675.8	683.6	674.2	675.1	672.3	670.5	667.8	657.0	656.9	657.3	657.1	656.6	656.9	656.4	656.5	656.6	656.6	656.3	656.7	656.9	657.0	657.4	657.2	657.0	657.3	657.0	657.2	657.4	657.2	657.3	657.7	657.9	658.2	658.6	658.4	658.3	658.5	658.2	658.6	658.6	658.7	658.8
Lincoln	CAF	263.3	259.5	256.6	255.5	254.7	252.8	255.3	255.9	256.0	260.4	253.8	254.0	252.6	257.3	257.4	257.9	257.9	257.9	258.0	257.9	257.7	257.6	257.4	257.3	257.6	257.9	258.0	258.4	258.2	258.3	258.4	258.3	258.2	258.1	257.7	257.7	258.0	258.2	258.4	258.7	258.5	258.8	258.6	258.6	258.6	258.6	258.2	258.3
Lincoln	ACA 19-44	2,594.4	2,589.3	2,567.0	2,618.0	2,686.2	2,687.0	2,665.3	2,693.6	2,723.7	2,751.6	2,777.2	2,778.0	2,787.5	2,766.5	2,757.6	2,752.2	2,770.9	2,788.6	2,777.3	2,768.9	2,757.3	2,751.7	2,748.8	2,743.9	2,738.8	2,731.0	2,725.0	2,720.8	2,739.6	2,758.5	2,750.4	2,741.1	2,736.4	2,734.0	2,729.6	2,726.3	2,724.0	2,718.2	2,713.6	2,707.1	2,726.5	2,750.9	2,740.4	2,732.1	2,730.4	2,727.9	2,723.1	2,720.6
Lincoln	ACA 45-54	1,059.4	1,033.6	1,005.0	1,017.1	1,030.2	1,018.0	994.2	986.4	996.6	992.3	988.4	974.4	976.0	981.7	978.5	976.6	983.3	989.5	985.5	982.6	978.5	976.5	975.4	973.7	971.9	969.1	967.0	965.5	972.2	978.9	976.0	972.7	971.0	970.2	968.6	967.4	966.6	964.6	962.9	960.6	967.5	976.2	972.4	969.5	968.9	968.0	966.3	965.4
Lincoln	ACA 55-64	1,211.2	1,201.5	1,199.3	1,191.0	1,184.5	1,189.8	1,196.1	1,202.1	1,212.1	1,227.4	1,240.1	1,227.4	1,232.8	1,235.2	1,231.2	1,228.8	1,237.2	1,245.1	1,240.1	1,236.3	1,231.1	1,228.6	1,227.3	1,225.1	1,222.9	1,219.4	1,216.7	1,214.8	1,223.2	1,231.7	1,228.0	1,223.9	1,221.8	1,220.7	1,218.8	1,217.3	1,216.2	1,213.6	1,211.6	1,208.7	1,217.4	1,228.2	1,223.6	1,219.9	1,219.1	1,218.0	1,215.8	1,214.7
Lincoln	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Linn	TANF	2,518.0	2,513.4	2,484.0	2,520.9	2,512.8	2,488.7	2,470.5	2,477.3	2,525.4	2,580.5	2,606.5	2,630.0	2,629.1	2,640.3	2,648.1	2,660.4	2,669.8	2,680.4	2,691.0	2,695.4	2,704.9	2,712.2	2,716.1	2,714.3	2,716.9	2,720.9	2,720.0	2,724.1	2,723.5	2,729.2	2,733.9	2,734.8	2,740.2	2,744.7	2,745.6	2,750.4	2,754.7	2,758.1	2,761.4	2,766.3	2,766.8	2,773.7	2,775.7	2,776.4	2,782.7	2,787.6	2,789.2	2,794.1
Linn	PLMA	318.5	283.2	276.6	280.7	272.5	259.5	269.7	257.5	259.4	262.3	278.2	274.8	272.2	269.2	266.4	266.4	264.9	264.7	266.5	265.5	265.9	265.8	265.0	263.0	262.9	263.1	261.9	262.3	260.5	260.8	261.9	260.6	260.8	260.4	258.3	257.9	257.6	257.0	256.5	256.6	254.9	255.4	255.6	254.6	255.6	255.6	253.9	253.7
Linn	CHILD 00-01	859.8	868.9	874.6	870.0	868.6	872.5	882.3	883.9	886.5	898.6	913.2	893.0	883.4	879.1	877.3	876.2	875.3	873.8	873.5	870.8	869.0	867.5	865.9	863.4	862.6	863.2	863.3	863.4	862.8	863.0	863.8	862.0	861.6	860.8	858.5	857.7	857.4	858.0	859.1	859.0	858.8	859.9	859.7	858.1	858.5	857.9	855.9	855.2
Linn	CHILD 01-05	3,672.7	3,580.2	3,633.4	3,696.4	3,755.0	3,730.3	3,713.6	3,742.4	3,731.6	3,736.7	3,684.9	3,694.3	3,712.3	3,648.5	3,644.4	3,643.3	3,644.0	3,642.9	3,643.8	3,637.6	3,633.9	3,631.7	3,626.9	3,617.9	3,615.3	3,618.9	3,620.8	3,623.4	3,624.7	3,628.0	3,632.4	3,627.5	3,627.4	3,626.1	3,618.2	3,615.5	3,614.4	3,617.8	3,623.6	3,625.2	3,627.8	3,634.1	3,635.1	3,630.5	3,632.7	3,631.6	3,623.9	3,621.3
Linn	CHILD 06-18	7,914.4	7,865.4	7,914.8	8,106.5	8,128.7	8,138.4	8,105.6	8,100.7	8,166.9	8,202.1	8,169.3	8,143.2	8,110.4	8,033.9	8,031.9	8,036.6	8,047.2	8,055.0	8,061.3	8,057.7	8,057.3	8,060.1	8,053.7	8,036.8	8,032.2	8,041.9	8,049.7	8,059.5	8,070.2	8,082.5	8,095.0	8,089.5	8,092.2	8,093.5	8,079.5	8,074.2	8,071.9	8,082.1	8,096.9	8,104.7	8,117.5	8,134.6	8,140.1	8,134.0	8,140.4	8,140.4	8,125.3	8,119.8
Linn	DUAL-MEDS	2,671.4	2,658.3	2,665.0	2,676.6	2,669.7	2,661.1	2,649.9	2,642.4	2,631.5	2,647.5	2,641.1	2,659.7	2,669.6	2,669.6	2,674.2	2,680.4	2,684.7	2,688.0	2,693.8	2,697.4	2,703.0	2,708.7	2,713.8	2,717.7	2,722.7	2,727.9	2,732.1	2,737.6	2,740.6	2,743.7	2,748.7	2,751.8	2,757.1	2,762.0	2,765.6	2,770.0	2,774.5	2,778.8	2,782.9	2,787.7	2,790.4	2,793.5	2,797.3	2,800.0	2,805.3	2,809.8	2,813.1	2,817.0
Linn	ABAD & OAA	2,029.7	2,034.9	2,052.0	2,054.5	2,065.1	2,078.3	2,089.0	2,109.3	2,120.5	2,124.6	2,126.6	2,102.1	2,097.7	2,094.2	2,093.8	2,094.8	2,093.9	2,092.4	2,093.0	2,091.4	2,091.3	2,091.6	2,091.5	2,090.4	2,091.3	2,092.0	2,092.1	2,093.4	2,092.5	2,091.8	2,092.6	2,091.5	2,091.9	2,092.4	2,091.8	2,092.0	2,093.1	2,093.5	2,094.2	2,095.6	2,094.8	2,094.6	2,094.8	2,094.1	2,095.0	2,095.6	2,095.1	2,095.4
Linn	CAF	666.8	654.3	659.0	665.1	670.7	671.6	669.2	682.1	682.9	682.2	679.9	681.0	673.7	676.8	677.1	678.3	678.4	678.4	678.7	678.4	677.9	677.6	677.1	676.8	677.6	678.4	678.7	679.6	679.2	679.4	679.6	679.4	679.2	678.8	677.8	677.9	678.8	679.2	679.8	680.5	680.1	680.6	680.3	680.2	680.3	680.2	679.3	679.5
Linn	ACA 19-44	6,507.3	6,501.4	6,462.3	6,556.7	6,661.5	6,664.4	6,594.4	6,613.6	6,763.6	6,849.4	6,868.6	6,887.8	6,902.3	6,883.7	6,861.5	6,848.1	6,894.5	6,938.5	6,910.6	6,889.6	6,860.9	6,846.9	6,839.7	6,827.4	6,814.8	6,795.3	6,780.4	6,769.9	6,816.8	6,863.9	6,843.6	6,820.5	6,808.7	6,802.9	6,792.0	6,783.7	6,777.8	6,763.4	6,751.9	6,735.9	6,784.1	6,844.8	6,818.7	6,798.1	6,793.8	6,787.7	6,775.6	6,769.4
Linn	ACA 45-54	2,092.8	2,082.9	2,056.2	2,072.7	2,064.7	2,066.5	2,057.4	2,035.5	2,071.0	2,090.9	2,098.7	2,105.3	2,110.8	2,094.9	2,088.2	2,084.1	2,098.2	2,111.6	2,103.1	2,096.7	2,087.9	2,083.7	2,081.5	2,077.8	2,073.9	2,068.0	2,063.5	2,060.3	2,074.5	2,088.9	2,082.7	2,075.7	2,072.1	2,070.3	2,067.0	2,064.5	2,062.7	2,058.3	2,054.8	2,049.9	2,064.6	2,083.0	2,075.1	2,068.9	2,067.5	2,065.7	2,062.0	2,060.1
Linn	ACA 55-64	1,929.7	1,892.5	1,874.8	1,886.7	1,878.6	1,882.3	1,889.4	1,884.0	1,916.5	1,934.1	1,960.0	1,948.0	1,966.8	1,966.3	1,959.9	1,956.1	1,969.4	1,981.9	1,973.9	1,968.0	1,959.7	1,955.7	1,953.7	1,950.2	1,946.6	1,941.0	1,936.7	1,933.8	1,947.1	1,960.6	1,954.8	1,948.2	1,944.8	1,943.2	1,940.1	1,937.7	1,936.0	1,931.9	1,928.6	1,924.1	1,937.8	1,955.1	1,947.7	1,941.8	1,940.6	1,938.8	1,935.4	1,933.6
Linn	BCCP	4.0	4.6	5.0	5.5	4.0	3.0	3.0	3.0	3.0	1.0	1.0	1.0	1.0	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
Malheur	TANF	761.4	757.3	756.4	761.9	775.3	786.6	799.3	787.7	815.0	834.5	837.0	827.9	822.5	838.4	840.8	844.8	847.7	851.1	854.5	855.8	858.9	861.2	862.4	861.9	862.7	864.0	863.7	865.0	864.8	866.6	868.1	868.4	870.1	871.5	871.8	873.3	874.7	875.8	876.8	878.4	878.5	880.7	881.4	881.6	883.6	885.1	885.6	887.2
Malheur	PLMA	114.0	110.5	105.8	104.7	86.8	78.7	76.2	76.5	80.0	85.2	87.2	88.6	85.6	89.0	88.1	88.1	87.6	87.5	88.1	87.8	87.9	87.9	87.6	87.0	86.9	87.0	86.6	86.7	86.1	86.2	86.6	86.2	86.2	86.1	85.4	85.3	85.2	85.0	84.8	84.8	84.3	84.5	84.5	84.2	84.5	84.5	84.0	83.9
Malheur	CHILD 00-01	348.6	360.9	358.5	363.2	370.1	358.0	351.5	339.3	330.5	317.4	315.5	318.1	319.4	312.0	311.4	310.9	310.6	310.0	309.9	308.9	308.2	307.6	307.0	306.1	305.9	306.1	306.1	306.1	305.8	305.9	306.1	305.5	305.3	305.0	304.2	303.9	303.8	304.0	304.4	304.3	304.2	304.6	304.5	303.9	304.1	303.8	303.1	302.9
Malheur	CHILD 01-05	1,361.2	1,342.0	1,330.5	1,354.7	1,360.8	1,362.3	1,388.2	1,387.1	1,407.7	1,427.2	1,426.3	1,392.8	1,362.4	1,380.3	1,378.3	1,377.4	1,377.0	1,375.9	1,376.0	1,372.9	1,371.0	1,369.7	1,367.6	1,364.0	1,362.9	1,364.1	1,364.6	1,365.3	1,365.3	1,366.2	1,367.7	1,365.5	1,365.2	1,364.5	1,361.2	1,360.1	1,359.7	1,360.9	1,362.9	1,363.2	1,363.7	1,365.9	1,366.0	1,364.0	1,364.8	1,364.2	1,361.2	1,360.2
Malheur	CHILD 06-18	2,947.1	2,908.0	2,951.0	3,011.2	3,001.7	3,010.8	3,047.5	3,050.2	3,087.7	3,128.2	3,142.1	3,168.5	3,147.1	3,147.5	3,145.7	3,146.6	3,149.5	3,151.2	3,153.1	3,150.3	3,149.1	3,149.2	3,146.1	3,139.1	3,137.1	3,140.7	3,143.2	3,146.5	3,149.6	3,153.8	3,158.3	3,155.4	3,156.1	3,156.0	3,150.1	3,147.9	3,147.0	3,150.6	3,156.1	3,158.6	3,162.7	3,168.9	3,170.6	3,167.7	3,170.0	3,169.6	3,163.5	3,161.3
Malheur	DUAL-MEDS	814.9	815.6	824.7	823.6	833.4	833.4	841.0	840.7	844.0	853.8	862.2	868.9	859.2	857.5	858.9	860.9	862.2	863.2	865.0	866.0	867.8	869.5	871.1	872.3	873.8	875.4	876.7	878.4	879.3	880.3	881.8	882.8	884.4	885.9	887.0	888.4	889.8	891.1	892.4	893.9	894.7	895.6	896.8	897.6	899.3	900.6	901.7	902.9
Malheur	ABAD & OAA	534.1	540.1	539.6	537.0	535.5	543.9	548.3	539.3	545.5	555.6	557.6	551.1	542.1	546.5	546.4	546.7	546.5	546.2	546.4	546.0	546.0	546.1	546.1	545.9	546.2	546.4	546.4	546.8	546.6	546.4	546.7	546.4	546.6	546.7	546.6	546.7	547.0	547.1	547.4	547.7	547.6	547.5	547.6	547.4	547.7	547.9	547.8	547.9
Malheur	CAF	213.5	227.0	235.7	230.5	238.4	233.3	228.4	240.8	231.8	241.0	245.0	245.8	241.0	245.4	245.5	246.0	246.0	246.0	246.1	246.0	245.8	245.7	245.5	245.4	245.7	246.0	246.1	246.4	246.3	246.4	246.5	246.4	246.3	246.2	245.8	245.8	246.1	246.3	246.5	246.8	246.6	246.8	246.7	246.7	246.7	246.6	246.3	246.4
Malheur	ACA 19-44	1,763.3	1,686.9	1,676.1	1,681.8	1,727.0	1,730.3	1,743.6	1,766.9	1,810.3	1,862.2	1,838.1	1,856.2	1,863.5	1,854.5	1,848.5	1,844.9	1,857.4	1,869.3	1,861.7	1,856.1	1,848.3	1,844.6	1,842.6	1,839.3	1,835.9	1,830.7	1,826.6	1,823.8	1,836.4	1,849.1	1,843.7	1,837.5	1,834.3	1,832.7	1,829.8	1,827.5	1,826.0	1,822.1	1,819.0	1,814.7	1,827.7	1,844.0	1,837.0	1,831.4	1,830.3	1,828.6	1,825.4	1,823.7
Malheur	ACA 45-54	553.6	550.5	556.5	555.7	561.9	575.9	579.5	564.0	572.1	575.0	576.3	581.2	592.9	604.5	602.6	601.4	605.5	609.4	606.9	605.1	602.5	601.3	600.7	599.6	598.5	596.8	595.5	594.6	598.7	602.8	601.0	599.0	598.0	597.5	596.5	595.8	595.2	594.0	593.0	591.6	595.8	601.1	598.8	597.0	596.7	596.1	595.1	594.5
Malheur	ACA 55-64	495.1	493.9	495.8	506.6	502.9	494.5	504.8	510.5	514.6	523.7	515.1	528.6	522.3	532.0	530.3	529.2	532.8	536.2	534.1	532.5	530.2	529.2	528.6	527.7	526.7	525.2	524.0	523.2	526.8	530.5	528.9	527.1	526.2	525.8	524.9	524.3	523.8	522.7	521.8	520.6	524.3	529.0	527.0	525.4	525.0	524.6	523.6	523.2
Malheur	BCCP	1.0	1.0	1.0	1.0	1.0	1.9	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Marion	TANF	5,802.2	5,790.4	5,750.3	5,769.6	5,827.9	5,820.6	5,812.8	5,803.3	5,877.7	6,017.7	6,053.0	6,100.4	6,155.6	6,230.4	6,248.8	6,278.0	6,300.1	6,325.2	6,350.3	6,360.4	6,383.0	6,400.2	6,409.3	6,405.2	6,411.4	6,420.8	6,418.7	6,428.2	6,426.8	6,440.4	6,451.3	6,453.5	6,466.2	6,476.8	6,479.1	6,490.3	6,500.4	6,508.5	6,516.2	6,527.9	6,528.9	6,545.4	6,550.0	6,551.6	6,566.6	6,578.1	6,581.9	6,593.5
Marion	PLMA	915.1	869.5	826.6	832.3	798.5	751.4	768.6	709.7	694.3	674.9	652.1	645.5	660.0	682.9	675.7	675.8	672.0	671.5	676.2	673.6	674.6	674.4	672.2	667.3	667.0	667.5	664.4	665.6	660.8	661.6	664.5	661.2	661.7	660.6	655.4	654.3	653.6	651.9	650.8	651.0	646.7	648.1	648.4	645.9	648.5	648.4	644.2	643.5
Marion	CHILD 00-01	2,812.1	2,846.5	2,818.2	2,809.8	2,814.1	2,816.1	2,814.3	2,802.8	2,772.1	2,732.3	2,750.0	2,707.5	2,684.9	2,664.5	2,659.0	2,655.6	2,652.7	2,648.1	2,647.1	2,638.9	2,633.3	2,628.8	2,623.7	2,616.1	2,613.8	2,615.7	2,615.8	2,616.1	2,614.1	2,614.8	2,616.9	2,611.4	2,610.2	2,607.7	2,600.7	2,598.4	2,597.5	2,599.1	2,602.5	2,602.2	2,601.4	2,604.8	2,604.3	2,599.4	2,600.5	2,598.7	2,592.5	2,590.5
Marion	CHILD 01-05	11,790.0	11,645.7	11,751.3	11,912.5	11,987.3	11,930.8	11,871.5	11,827.4	11,738.2	11,748.7	11,644.1	11,631.2	11,523.9	11,428.6	11,416.0	11,412.8	11,415.2	11,411.8	11,414.7	11,395.5	11,384.0	11,377.2	11,362.3	11,334.1	11,326.1	11,337.1	11,343.4	11,351.4	11,355.6	11,366.2	11,380.0	11,364.8	11,364.5	11,360.5	11,335.8	11,327.2	11,323.8	11,334.6	11,352.8	11,357.9	11,366.2	11,386.0	11,389.0	11,374.6	11,381.8	11,378.1	11,354.2	11,346.1
Marion	CHILD 06-18	26,862.3	26,642.9	26,779.0	27,175.4	27,275.2	27,124.7	27,018.6	27,071.5	27,118.8	27,243.6	27,133.9	27,049.8	26,960.4	26,802.0	26,798.4	26,817.0	26,856.4	26,886.8	26,909.8	26,901.9	26,904.2	26,916.7	26,897.2	26,842.0	26,827.0	26,860.3	26,887.6	26,922.4	26,961.2	27,004.4	27,047.3	27,031.5	27,041.5	27,047.6	27,002.5	26,985.2	26,977.4	27,012.5	27,062.8	27,090.6	27,136.4	27,195.0	27,214.6	27,196.0	27,218.1	27,219.0	27,169.5	27,151.2
Marion	DUAL-MEDS	6,252.7	6,265.1	6,264.3	6,266.8	6,261.4	6,280.9	6,245.2	6,230.3	6,232.4	6,244.9	6,264.5	6,284.8	6,327.0	6,324.6	6,335.9	6,351.4	6,362.1	6,370.7	6,385.0	6,394.1	6,408.0	6,422.1	6,434.9	6,444.7	6,457.0	6,469.9	6,480.4	6,493.8	6,501.4	6,509.3	6,521.6	6,529.5	6,542.7	6,554.7	6,563.8	6,574.6	6,585.7	6,596.2	6,606.5	6,618.0	6,624.9	6,632.6	6,642.0	6,648.9	6,661.9	6,673.0	6,681.4	6,691.2
Marion	ABAD & OAA	4,226.1	4,247.2	4,235.7	4,234.7	4,242.2	4,242.3	4,256.3	4,272.8	4,264.8	4,245.7	4,250.2	4,239.0	4,218.7	4,211.8	4,211.4	4,213.8	4,212.3	4,209.6	4,211.2	4,208.4	4,208.5	4,209.4	4,209.6	4,207.8	4,209.9	4,211.5	4,212.0	4,214.9	4,213.3	4,212.1	4,214.0	4,212.2	4,213.3	4,214.6	4,213.7	4,214.5	4,216.8	4,217.8	4,219.9	4,222.6	4,221.2	4,220.9	4,221.7	4,220.4	4,222.5	4,223.9	4,223.3	4,224.2
Marion	CAF	1,471.3	1,469.2	1,489.6	1,491.1	1,492.8	1,477.0	1,469.0	1,468.1	1,448.5	1,446.6	1,445.5	1,451.1	1,418.3	1,423.5	1,424.1	1,426.7	1,426.9	1,426.8	1,427.6	1,426.9	1,425.7	1,425.2	1,424.1	1,423.5	1,425.1	1,426.9	1,427.5	1,429.4	1,428.5	1,428.9	1,429.4	1,429.0	1,428.5	1,427.7	1,425.6	1,425.9	1,427.6	1,428.6	1,429.9	1,431.2	1,430.4	1,431.5	1,430.9	1,430.7	1,431.0	1,430.6	1,428.7	1,429.2
Marion	ACA 19-44	16,457.0	16,440.2	16,272.7	16,435.0	16,584.9	16,579.8	16,461.3	16,515.1	16,557.8	16,661.1	16,662.5	16,602.6	16,425.1	16,263.9	16,211.5	16,179.7	16,289.5	16,393.4	16,327.5	16,277.9	16,209.9	16,176.9	16,159.8	16,130.9	16,101.0	16,054.9	16,019.7	15,995.1	16,105.7	16,217.0	16,169.1	16,114.6	16,086.6	16,072.9	16,047.1	16,027.6	16,013.7	15,979.7	15,952.6	15,914.8	16,028.6	16,171.8	16,110.3	16,061.7	16,051.4	16,036.9	16,008.4	15,993.7
Marion	ACA 45-54	4,922.8	4,900.4	4,853.7	4,876.9	4,931.8	4,886.9	4,853.6	4,858.5	4,839.5	4,884.3	4,879.7	4,801.9	4,792.7	4,763.1	4,747.7	4,738.4	4,770.6	4,801.0	4,781.7	4,767.2	4,747.3	4,737.6	4,732.6	4,724.1	4,715.4	4,701.9	4,691.6	4,684.3	4,716.7	4,749.3	4,735.3	4,719.3	4,711.1	4,707.1	4,699.6	4,693.9	4,689.8	4,679.8	4,671.9	4,660.8	4,694.2	4,736.1	4,718.1	4,703.9	4,700.8	4,696.6	4,688.2	4,683.9
Marion	ACA 55-64	4,298.4	4,254.8	4,224.5	4,219.9	4,195.1	4,202.7	4,225.1	4,213.7	4,234.8	4,254.6	4,286.6	4,290.0	4,321.8	4,343.2	4,329.2	4,320.8	4,350.1	4,377.8	4,360.2	4,347.0	4,328.8	4,320.0	4,315.4	4,307.7	4,299.7	4,287.4	4,278.0	4,271.4	4,301.0	4,330.7	4,317.9	4,303.4	4,295.9	4,292.2	4,285.3	4,280.1	4,276.4	4,267.3	4,260.1	4,250.0	4,280.4	4,318.6	4,302.2	4,289.2	4,286.5	4,282.6	4,275.0	4,271.1
Marion	BCCP	15.9	16.0	14.9	15.0	15.0	15.0	15.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	13.9	13.9	14.0	14.1	14.1	14.1	14.0	13.9	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.8	13.7	13.8	13.8	13.8	13.7	13.7	13.8	13.8	13.8	13.8	13.7
Morrow	TANF	204.7	193.2	192.1	204.7	204.1	199.6	202.9	214.8	220.7	223.7	229.8	220.6	219.2	225.4	226.1	227.1	227.9	228.8	229.8	230.1	230.9	231.6	231.9	231.7	232.0	232.3	232.2	232.6	232.5	233.0	233.4	233.5	233.9	234.3	234.4	234.8	235.2	235.5	235.8	236.2	236.2	236.8	237.0	237.0	237.6	238.0	238.1	238.6
Morrow	PLMA	27.7	26.0	27.8	28.5	26.6	26.0	26.0	24.2	23.8	23.0	20.3	24.0	22.3	20.0	19.8	19.8	19.7	19.7	19.8	19.7	19.8	19.8	19.7	19.5	19.5	19.6	19.5	19.5	19.4	19.4	19.5	19.4	19.4	19.3	19.2	19.2	19.1	19.1	19.1	19.1	18.9	19.0	19.0	18.9	19.0	19.0	18.9	18.8
Morrow	CHILD 00-01	111.0	115.3	118.0	114.3	113.3	111.8	115.7	108.1	101.5	105.0	102.7	109.0	113.9	115.8	115.6	115.4	115.3	115.1	115.0	114.7	114.4	114.2	114.0	113.7	113.6	113.6	113.6	113.7	113.6	113.6	113.7	113.4	113.4	113.3	113.0	112.9	112.8	112.9	113.0	113.0	113.0	113.1	113.1	112.9	112.9	112.8	112.6	112.5
Morrow	CHILD 01-05	401.2	378.2	401.2	428.9	426.2	420.5	420.2	434.9	428.4	440.4	433.9	428.7	426.8	415.7	415.3	415.1	415.2	415.1	415.2	414.5	414.1	413.9	413.3	412.3	412.0	412.4	412.7	413.0	413.1	413.5	414.0	413.5	413.5	413.3	412.4	412.1	412.0	412.4	413.0	413.2	413.5	414.3	414.4	413.9	414.1	414.0	413.1	412.8
Morrow	CHILD 06-18	954.1	918.3	920.8	943.9	935.9	920.2	937.3	961.7	966.3	991.4	999.1	985.6	990.5	980.2	980.0	980.6	981.9	982.8	983.6	983.1	983.1	983.4	982.7	980.6	980.0	981.2	982.2	983.4	984.7	986.2	987.7	987.0	987.4	987.5	985.8	985.2	984.9	986.1	987.9	988.9	990.5	992.6	993.2	992.5	993.3	993.3	991.4	990.7
Morrow	DUAL-MEDS	165.7	161.1	164.5	162.3	164.6	162.2	157.0	154.4	159.3	162.0	163.0	161.7	160.1	158.6	158.9	159.3	159.5	159.7	160.0	160.2	160.6	160.9	161.2	161.4	161.7	162.0	162.3	162.6	162.8	162.9	163.2	163.4	163.7	164.0	164.2	164.5	164.7	165.0	165.2	165.5	165.6	165.8	166.0	166.2	166.5	166.8	167.0	167.2
Morrow	ABAD & OAA	137.5	140.2	143.6	141.5	141.4	141.5	141.0	142.5	145.3	142.5	141.8	141.7	140.3	138.1	138.1	138.2	138.1	138.0	138.1	138.0	138.0	138.1	138.1	138.0	138.1	138.1	138.2	138.3	138.2	138.2	138.2	138.2	138.2	138.3	138.2	138.3	138.4	138.4	138.5	138.6	138.5	138.5	138.5	138.5	138.6	138.6	138.6	138.6
Morrow	CAF	41.1	37.7	38.1	37.5	41.6	45.0	44.3	44.6	45.3	46.0	48.4	51.0	48.1	42.6	42.6	42.7	42.7	42.7	42.7	42.7	42.7	42.6	42.6	42.6	42.6	42.7	42.7	42.8	42.7	42.7	42.8	42.7	42.7	42.7	42.6	42.7	42.7	42.7	42.8	42.8	42.8	42.8	42.8	42.8	42.8	42.8	42.7	42.8
Morrow	ACA 19-44	390.9	366.3	376.7	382.2	383.9	396.4	400.7	408.8	413.2	425.9	424.4	424.4	426.5	419.6	418.3	417.4	420.3	423.0	421.3	420.0	418.2	417.4	416.9	416.2	415.4	414.2	413.3	412.7	415.5	418.4	417.2	415.8	415.0	414.7	414.0	413.5	413.2	412.3	411.6	410.6	413.5	417.2	415.6	414.4	414.1	413.8	413.0	412.6
Morrow	ACA 45-54	130.4	129.0	120.9	119.0	126.5	123.9	126.2	123.1	118.2	124.5	127.4	127.9	131.9	135.9	135.4	135.2	136.1	137.0	136.4	136.0	135.4	135.1	135.0	134.8	134.5	134.1	133.8	133.6	134.5	135.5	135.1	134.6	134.4	134.3	134.1	133.9	133.8	133.5	133.3	133.0	133.9	135.1	134.6	134.2	134.1	134.0	133.7	133.6
Morrow	ACA 55-64	157.3	151.9	142.3	142.6	143.6	154.0	158.3	153.6	156.5	160.4	164.5	160.1	158.5	160.0	159.5	159.2	160.3	161.3	160.6	160.1	159.5	159.1	159.0	158.7	158.4	157.9	157.6	157.4	158.4	159.5	159.1	158.5	158.3	158.1	157.9	157.7	157.5	157.2	156.9	156.6	157.7	159.1	158.5	158.0	157.9	157.8	157.5	157.3
Morrow	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Multnomah	TANF	11,376.7	11,249.7	11,045.6	11,096.0	11,103.9	10,989.2	10,839.7	10,680.0	10,765.8	10,981.6	11,049.7	11,094.4	11,119.2	11,207.2	11,240.3	11,292.8	11,332.5	11,377.7	11,422.8	11,441.1	11,481.6	11,512.6	11,529.1	11,521.7	11,532.7	11,549.6	11,545.9	11,562.9	11,560.5	11,584.9	11,604.5	11,608.4	11,631.3	11,650.5	11,654.5	11,674.7	11,692.8	11,707.5	11,721.4	11,742.4	11,744.2	11,773.8	11,782.1	11,785.0	11,811.9	11,832.6	11,839.4	11,860.3
Multnomah	PLMA	1,609.0	1,516.4	1,499.6	1,571.8	1,507.5	1,481.2	1,514.7	1,460.9	1,411.3	1,362.1	1,371.6	1,374.3	1,368.4	1,363.3	1,349.1	1,349.2	1,341.6	1,340.7	1,350.0	1,344.7	1,346.8	1,346.4	1,342.0	1,332.1	1,331.6	1,332.7	1,326.3	1,328.8	1,319.3	1,320.8	1,326.6	1,320.0	1,321.0	1,318.9	1,308.5	1,306.3	1,304.8	1,301.6	1,299.2	1,299.7	1,291.0	1,293.8	1,294.5	1,289.5	1,294.6	1,294.4	1,286.1	1,284.8
Multnomah	CHILD 00-01	4,313.3	4,339.8	4,261.2	4,208.5	4,151.8	4,112.4	4,071.5	4,045.3	4,047.2	4,001.6	3,991.1	3,967.4	3,930.0	3,936.5	3,928.5	3,923.6	3,919.7	3,913.0	3,911.7	3,899.8	3,891.7	3,885.2	3,877.9	3,866.6	3,863.3	3,866.1	3,866.4	3,866.9	3,864.2	3,865.3	3,868.5	3,860.5	3,858.8	3,855.2	3,844.9	3,841.5	3,840.3	3,842.6	3,847.8	3,847.3	3,846.4	3,851.5	3,850.7	3,843.6	3,845.3	3,842.7	3,833.5	3,830.6
Multnomah	CHILD 01-05	18,139.7	17,761.7	17,704.1	17,879.2	17,998.8	17,912.4	17,835.3	17,720.2	17,468.6	17,455.0	17,290.5	17,083.9	16,975.3	16,857.6	16,838.2	16,832.5	16,834.9	16,828.6	16,832.3	16,802.7	16,784.8	16,773.8	16,751.2	16,709.3	16,697.3	16,713.4	16,722.2	16,733.5	16,738.7	16,753.7	16,773.8	16,750.7	16,749.9	16,743.4	16,706.4	16,693.7	16,688.6	16,704.3	16,730.8	16,737.9	16,749.1	16,778.0	16,782.0	16,760.2	16,770.6	16,764.9	16,729.4	16,717.4
Multnomah	CHILD 06-18	39,663.5	39,305.6	39,168.7	39,784.8	39,923.3	39,681.6	39,599.1	39,442.1	39,427.8	39,596.6	39,596.0	39,425.0	39,057.9	38,941.0	38,934.0	38,959.2	39,013.9	39,055.4	39,087.7	39,073.6	39,074.8	39,091.0	39,061.5	38,980.6	38,958.5	39,006.4	39,045.2	39,094.5	39,148.9	39,210.4	39,271.9	39,247.5	39,261.4	39,269.1	39,202.6	39,177.3	39,165.9	39,216.3	39,288.9	39,328.0	39,392.7	39,477.1	39,504.6	39,476.5	39,508.2	39,508.9	39,436.5	39,409.8
Multnomah	DUAL-MEDS	16,089.0	16,123.1	16,111.6	16,124.4	16,120.7	16,113.3	16,100.8	16,127.0	16,149.4	16,146.3	16,181.2	16,195.7	16,248.8	16,280.1	16,311.4	16,353.3	16,383.2	16,407.6	16,446.7	16,472.5	16,510.7	16,549.3	16,584.3	16,611.9	16,645.2	16,680.3	16,708.9	16,745.1	16,766.4	16,788.4	16,821.7	16,844.1	16,880.0	16,912.8	16,938.1	16,967.7	16,997.5	17,026.1	17,053.9	17,084.9	17,104.3	17,125.6	17,151.3	17,170.6	17,205.9	17,235.9	17,259.2	17,285.8
Multnomah	ABAD & OAA	11,179.8	11,221.7	11,225.3	11,269.6	11,328.5	11,378.2	11,354.4	11,292.3	11,254.6	11,172.5	11,172.9	11,130.5	11,125.3	11,082.3	11,082.5	11,089.9	11,087.2	11,081.3	11,086.7	11,080.5	11,082.1	11,085.7	11,087.4	11,084.0	11,090.2	11,095.5	11,097.7	11,106.2	11,102.9	11,100.8	11,106.7	11,102.9	11,106.8	11,111.1	11,110.0	11,112.8	11,119.7	11,123.2	11,129.2	11,137.1	11,134.4	11,134.3	11,137.2	11,134.6	11,141.0	11,145.6	11,144.9	11,148.0
Multnomah	CAF	2,621.1	2,607.2	2,583.1	2,574.1	2,573.4	2,593.9	2,593.0	2,564.1	2,555.4	2,499.1	2,502.8	2,498.0	2,499.7	2,478.2	2,479.4	2,483.7	2,484.1	2,484.0	2,485.3	2,484.1	2,482.2	2,481.2	2,479.4	2,478.2	2,481.1	2,484.2	2,485.2	2,488.5	2,487.0	2,487.6	2,488.6	2,487.9	2,486.9	2,485.6	2,481.9	2,482.4	2,485.4	2,487.1	2,489.3	2,491.7	2,490.3	2,492.2	2,491.1	2,490.8	2,491.3	2,490.5	2,487.4	2,488.1
Multnomah	ACA 19-44	45,669.1	45,225.1	44,230.1	44,342.2	44,577.1	44,622.4	44,653.8	44,527.2	45,036.0	45,358.7	45,519.8	45,411.3	45,238.5	45,294.5	45,148.7	45,060.1	45,365.7	45,655.3	45,471.7	45,333.5	45,144.1	45,052.1	45,004.6	44,924.2	44,840.9	44,712.5	44,614.5	44,545.9	44,854.0	45,163.9	45,030.6	44,878.6	44,800.7	44,762.7	44,690.8	44,636.4	44,597.7	44,503.1	44,427.5	44,322.2	44,639.4	45,038.2	44,866.7	44,731.4	44,702.7	44,662.5	44,583.0	44,542.1
Multnomah	ACA 45-54	12,607.1	12,454.6	12,213.5	12,243.8	12,293.5	12,213.5	12,212.5	12,087.1	12,187.0	12,230.8	12,291.7	12,282.3	12,221.7	12,166.5	12,127.3	12,103.6	12,185.7	12,263.4	12,214.1	12,177.0	12,126.1	12,101.4	12,088.7	12,067.1	12,044.7	12,010.2	11,983.9	11,965.4	12,048.2	12,131.4	12,095.6	12,054.8	12,033.9	12,023.7	12,004.4	11,989.8	11,979.4	11,953.9	11,933.6	11,905.4	11,990.5	12,097.7	12,051.6	12,015.3	12,007.6	11,996.8	11,975.4	11,964.4
Multnomah	ACA 55-64	10,398.9	10,339.0	10,308.8	10,323.5	10,287.5	10,306.7	10,336.2	10,254.6	10,392.2	10,413.8	10,452.1	10,444.3	10,483.0	10,457.9	10,424.3	10,403.8	10,474.4	10,541.2	10,498.8	10,466.9	10,423.2	10,402.0	10,391.0	10,372.5	10,353.2	10,323.6	10,300.9	10,285.1	10,356.2	10,427.8	10,397.0	10,361.9	10,343.9	10,335.1	10,318.6	10,306.0	10,297.1	10,275.2	10,257.8	10,233.4	10,306.7	10,398.8	10,359.2	10,327.9	10,321.3	10,312.0	10,293.7	10,284.2
Multnomah	BCCP	25.9	26.6	23.7	24.0	23.8	18.5	18.3	19.1	18.1	19.0	20.2	21.6	19.1	20.6	20.6	20.6	20.5	20.5	20.6	20.7	20.7	20.7	20.6	20.5	20.4	20.3	20.4	20.4	20.4	20.3	20.3	20.4	20.4	20.4	20.4	20.3	20.3	20.2	20.3	20.3	20.3	20.1	20.1	20.3	20.3	20.3	20.3	20.1
Polk	TANF	1,327.3	1,282.5	1,272.6	1,314.4	1,335.9	1,324.2	1,320.0	1,322.6	1,359.0	1,386.9	1,398.3	1,424.6	1,433.6	1,443.1	1,447.4	1,454.1	1,459.2	1,465.1	1,470.9	1,473.2	1,478.4	1,482.4	1,484.5	1,483.6	1,485.0	1,487.2	1,486.7	1,488.9	1,488.6	1,491.7	1,494.3	1,494.8	1,497.7	1,500.2	1,500.7	1,503.3	1,505.6	1,507.5	1,509.3	1,512.0	1,512.2	1,516.1	1,517.1	1,517.5	1,521.0	1,523.6	1,524.5	1,527.2
Polk	PLMA	156.9	144.3	136.0	125.0	130.1	123.5	140.0	136.8	127.3	121.5	117.1	112.7	117.5	105.5	104.4	104.4	103.8	103.8	104.5	104.1	104.2	104.2	103.9	103.1	103.1	103.1	102.7	102.8	102.1	102.2	102.7	102.2	102.2	102.1	101.3	101.1	101.0	100.7	100.6	100.6	99.9	100.1	100.2	99.8	100.2	100.2	99.5	99.4
Polk	CHILD 00-01	469.9	449.1	450.5	455.7	468.6	466.2	464.4	452.6	454.1	456.2	433.0	426.8	429.3	448.9	447.9	447.4	446.9	446.1	445.9	444.5	443.6	442.9	442.0	440.7	440.3	440.6	440.7	440.7	440.4	440.5	440.9	439.9	439.7	439.3	438.1	437.7	437.6	437.9	438.4	438.4	438.2	438.8	438.7	437.9	438.1	437.8	436.7	436.4
Polk	CHILD 01-05	2,034.6	2,021.9	2,010.5	2,051.9	2,063.8	2,047.1	2,046.4	2,022.0	2,003.9	1,992.8	1,983.7	1,974.7	1,958.6	1,967.7	1,965.6	1,965.0	1,965.3	1,964.7	1,965.2	1,961.8	1,959.8	1,958.6	1,956.0	1,951.2	1,949.8	1,951.7	1,952.8	1,954.1	1,954.8	1,956.6	1,959.0	1,956.3	1,956.3	1,955.6	1,951.3	1,949.8	1,949.2	1,951.1	1,954.2	1,955.1	1,956.5	1,959.9	1,960.4	1,957.9	1,959.1	1,958.5	1,954.3	1,952.9
Polk	CHILD 06-18	4,636.5	4,560.5	4,539.8	4,640.2	4,650.8	4,632.5	4,630.2	4,665.6	4,716.4	4,737.6	4,694.5	4,672.2	4,630.1	4,588.5	4,587.9	4,591.0	4,597.7	4,602.8	4,606.7	4,605.3	4,605.6	4,607.6	4,604.3	4,594.9	4,592.3	4,598.0	4,602.6	4,608.6	4,615.2	4,622.5	4,629.8	4,627.1	4,628.8	4,629.8	4,622.0	4,619.1	4,617.7	4,623.7	4,632.3	4,637.1	4,644.8	4,654.9	4,658.2	4,655.0	4,658.8	4,658.9	4,650.4	4,647.3
Polk	DUAL-MEDS	1,353.3	1,354.2	1,353.5	1,355.9	1,351.7	1,348.7	1,340.8	1,338.1	1,352.7	1,360.6	1,375.2	1,387.1	1,386.4	1,396.3	1,398.5	1,401.7	1,403.8	1,405.4	1,408.3	1,410.0	1,412.8	1,415.6	1,418.2	1,420.1	1,422.6	1,425.2	1,427.3	1,430.1	1,431.5	1,433.0	1,435.6	1,437.1	1,439.7	1,442.2	1,444.0	1,446.1	1,448.4	1,450.5	1,452.6	1,455.0	1,456.4	1,457.9	1,459.8	1,461.1	1,463.8	1,466.0	1,467.7	1,469.6
Polk	ABAD & OAA	883.8	882.0	887.6	907.8	914.4	905.7	912.5	914.6	914.1	912.4	917.9	919.7	913.2	906.5	906.5	907.0	906.8	906.3	906.7	906.1	906.2	906.5	906.6	906.3	906.8	907.2	907.3	908.0	907.7	907.5	907.9	907.6	907.9	908.2	908.1	908.3	908.9	909.1	909.6	910.2	910.0	909.9	910.1	909.9	910.4	910.8	910.7	910.9
Polk	CAF	381.5	371.3	382.2	387.7	391.1	396.6	402.6	400.7	398.9	403.6	403.6	403.2	403.0	399.1	399.3	400.0	400.1	400.0	400.2	400.1	399.7	399.6	399.3	399.1	399.6	400.1	400.2	400.8	400.5	400.6	400.8	400.7	400.5	400.3	399.7	399.8	400.3	400.5	400.9	401.3	401.0	401.4	401.2	401.1	401.2	401.1	400.6	400.7
Polk	ACA 19-44	3,455.2	3,480.4	3,436.2	3,463.4	3,481.3	3,508.4	3,487.0	3,483.2	3,521.0	3,535.6	3,546.6	3,523.7	3,495.6	3,467.0	3,455.8	3,449.1	3,472.5	3,494.6	3,480.6	3,470.0	3,455.5	3,448.5	3,444.8	3,438.7	3,432.3	3,422.5	3,414.9	3,409.7	3,433.3	3,457.0	3,446.8	3,435.2	3,429.2	3,426.3	3,420.8	3,416.6	3,413.7	3,406.4	3,400.6	3,392.6	3,416.9	3,447.4	3,434.3	3,423.9	3,421.7	3,418.6	3,412.5	3,409.4
Polk	ACA 45-54	948.0	927.8	923.3	919.2	933.6	939.3	927.6	925.8	921.6	921.3	915.0	914.5	914.9	904.1	901.2	899.5	905.6	911.3	907.7	904.9	901.1	899.3	898.3	896.7	895.1	892.5	890.6	889.2	895.3	901.5	898.9	895.8	894.3	893.5	892.1	891.0	890.2	888.3	886.8	884.7	891.1	899.0	895.6	892.9	892.3	891.5	889.9	889.1
Polk	ACA 55-64	879.8	870.3	886.9	885.4	868.6	876.6	888.7	907.1	911.5	911.9	903.7	907.2	914.0	917.8	914.9	913.1	919.3	925.2	921.4	918.6	914.8	912.9	912.0	910.3	908.6	906.0	904.1	902.7	908.9	915.2	912.5	909.4	907.8	907.1	905.6	904.5	903.7	901.8	900.3	898.1	904.6	912.6	909.2	906.4	905.8	905.0	903.4	902.6
Polk	BCCP	2.0	2.9	4.0	4.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0	1.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Sherman	TANF	23.3	24.3	23.4	21.9	22.0	19.7	20.5	22.0	21.0	22.0	17.3	16.7	15.0	18.5	18.5	18.6	18.7	18.7	18.8	18.8	18.9	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.0	19.1	19.1	19.1	19.1	19.2	19.2	19.2	19.3	19.3	19.3	19.3	19.3	19.4	19.4	19.4	19.4	19.5	19.5	19.5
Sherman	PLMA	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.9	1.7	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
Sherman	CHILD 00-01	9.5	9.0	7.0	7.0	6.0	6.0	6.0	6.0	6.4	7.0	6.0	3.2	4.1	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.1	7.1	7.1	7.1	7.1	7.1	7.2	7.2	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Sherman	CHILD 01-05	28.3	29.1	25.9	26.4	23.2	22.5	23.3	22.9	24.0	25.0	26.4	25.7	26.7	29.4	29.3	29.3	29.3	29.2	29.2	29.2	29.1	29.1	29.0	28.9	28.9	28.9	28.9	28.9	28.9	28.9	29.0	28.9	28.9	28.9	28.8	28.8	28.8	28.8	28.8	28.8	28.8	28.9	28.9	28.8	28.8	28.8	28.7	28.7
Sherman	CHILD 06-18	92.4	88.4	83.5	83.3	84.3	83.0	84.9	84.8	86.2	85.5	82.3	76.5	75.9	72.5	72.4	72.5	72.6	72.7	72.7	72.7	72.7	72.7	72.7	72.5	72.5	72.6	72.6	72.7	72.8	72.9	73.0	73.0	73.0	73.0	72.9	72.9	72.8	72.9	73.1	73.1	73.3	73.4	73.5	73.4	73.5	73.5	73.3	73.3
Sherman	DUAL-MEDS	22.6	23.4	23.4	23.0	22.0	22.7	23.5	25.1	26.4	27.5	26.0	28.7	31.3	34.0	34.1	34.1	34.2	34.2	34.3	34.4	34.4	34.5	34.6	34.6	34.7	34.8	34.8	34.9	34.9	35.0	35.0	35.1	35.1	35.2	35.3	35.3	35.4	35.4	35.5	35.5	35.6	35.6	35.7	35.7	35.8	35.8	35.9	35.9
Sherman	ABAD & OAA	25.9	24.6	24.7	25.0	25.0	24.9	25.5	26.6	27.0	28.0	27.8	26.5	25.0	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7	24.7
Sherman	CAF	23.9	20.0	20.0	20.0	20.0	20.0	18.7	20.8	21.9	22.7	24.0	23.0	22.9	21.0	21.0	21.0	21.1	21.0	21.1	21.1	21.0	21.0	21.0	21.0	21.0	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.0	21.0	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1	21.1
Sherman	ACA 19-44	86.3	88.5	81.5	84.1	87.7	87.3	90.1	87.4	88.2	87.3	90.1	85.8	82.5	80.1	79.9	79.7	80.3	80.8	80.4	80.2	79.9	79.7	79.6	79.5	79.3	79.1	78.9	78.8	79.3	79.9	79.7	79.4	79.3	79.2	79.1	79.0	78.9	78.7	78.6	78.4	79.0	79.7	79.4	79.1	79.1	79.0	78.9	78.8
Sherman	ACA 45-54	24.9	23.1	25.0	26.1	27.2	28.0	28.5	29.7	31.3	29.0	29.9	27.0	26.7	25.0	24.9	24.9	25.0	25.2	25.1	25.0	24.9	24.9	24.8	24.8	24.7	24.7	24.6	24.6	24.8	24.9	24.9	24.8	24.7	24.7	24.7	24.6	24.6	24.6	24.5	24.5	24.6	24.9	24.8	24.7	24.7	24.7	24.6	24.6
Sherman	ACA 55-64	32.0	29.4	30.0	28.3	27.2	25.9	26.0	22.0	22.9	24.1	26.1	29.0	28.8	29.3	29.2	29.2	29.4	29.6	29.4	29.3	29.2	29.2	29.1	29.1	29.0	28.9	28.9	28.8	29.0	29.2	29.2	29.1	29.0	29.0	28.9	28.9	28.8	28.8	28.8	28.7	28.9	29.2	29.0	29.0	28.9	28.9	28.9	28.8
Sherman	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Tillamook	TANF	379.6	380.5	380.8	386.1	394.9	396.1	398.3	392.5	403.5	408.6	413.1	424.9	438.0	447.8	449.2	451.3	452.8	454.7	456.5	457.2	458.8	460.0	460.7	460.4	460.8	461.5	461.4	462.1	462.0	462.9	463.7	463.9	464.8	465.6	465.7	466.5	467.2	467.8	468.4	469.2	469.3	470.5	470.8	470.9	472.0	472.8	473.1	473.9
Tillamook	PLMA	63.3	61.1	62.5	65.5	58.6	56.4	56.6	52.8	55.6	53.1	48.7	46.1	44.8	42.4	41.9	41.9	41.7	41.7	42.0	41.8	41.9	41.9	41.7	41.4	41.4	41.4	41.2	41.3	41.0	41.1	41.2	41.0	41.1	41.0	40.7	40.6	40.6	40.5	40.4	40.4	40.1	40.2	40.2	40.1	40.3	40.2	40.0	39.9
Tillamook	CHILD 00-01	140.8	134.3	132.3	128.0	130.7	130.7	131.6	129.6	140.1	144.9	141.0	146.3	156.9	161.1	160.8	160.6	160.4	160.2	160.1	159.6	159.3	159.0	158.7	158.3	158.1	158.2	158.3	158.3	158.2	158.2	158.3	158.0	157.9	157.8	157.4	157.2	157.2	157.3	157.5	157.5	157.4	157.6	157.6	157.3	157.4	157.3	156.9	156.8
Tillamook	CHILD 01-05	653.0	642.2	631.5	648.6	661.8	667.3	669.9	661.6	650.8	651.1	655.9	656.5	658.7	643.0	642.2	642.0	642.0	641.8	641.9	640.7	640.0	639.6	638.7	637.1	636.6	637.2	637.6	638.0	638.1	638.7	639.5	638.6	638.5	638.3	636.8	636.3	636.2	636.7	637.7	638.0	638.4	639.5	639.6	638.8	639.2	639.0	637.6	637.1
Tillamook	CHILD 06-18	1,534.8	1,505.7	1,495.7	1,516.2	1,551.4	1,549.7	1,544.6	1,558.8	1,588.7	1,570.5	1,558.4	1,582.5	1,606.7	1,617.5	1,617.1	1,618.0	1,620.1	1,621.6	1,622.9	1,622.1	1,622.0	1,622.6	1,621.3	1,617.9	1,616.9	1,618.9	1,620.4	1,622.4	1,624.5	1,627.0	1,629.5	1,628.4	1,628.9	1,629.1	1,626.3	1,625.2	1,624.8	1,626.8	1,629.8	1,631.3	1,633.9	1,637.3	1,638.4	1,637.2	1,638.5	1,638.4	1,635.4	1,634.3
Tillamook	DUAL-MEDS	532.1	526.1	520.1	518.1	526.8	523.0	518.7	533.3	544.5	545.1	535.9	534.4	534.1	536.0	536.7	537.9	538.6	539.1	540.2	540.7	541.7	542.7	543.6	544.2	545.1	546.1	546.8	547.8	548.3	548.8	549.7	550.2	551.2	552.0	552.7	553.4	554.2	555.0	555.8	556.6	557.1	557.6	558.3	558.7	559.7	560.5	561.0	561.7
Tillamook	ABAD & OAA	311.4	309.4	312.7	316.5	316.1	314.3	316.1	314.7	316.1	316.5	316.9	311.1	312.2	312.1	312.1	312.2	312.1	311.9	312.0	311.8	311.8	311.8	311.8	311.7	311.9	312.0	312.0	312.2	312.1	312.0	312.1	312.0	312.0	312.1	312.1	312.1	312.3	312.3	312.5	312.7	312.6	312.5	312.6	312.5	312.6	312.7	312.7	312.7
Tillamook	CAF	104.3	103.6	105.2	101.7	103.0	104.3	107.6	104.3	102.8	102.7	99.9	97.0	95.9	98.7	98.8	98.9	98.9	98.9	99.0	98.9	98.8	98.8	98.8	98.7	98.8	99.0	99.0	99.1	99.1	99.1	99.1	99.1	99.1	99.0	98.9	98.9	99.0	99.1	99.2	99.3	99.2	99.3	99.2	99.2	99.2	99.2	99.1	99.1
Tillamook	ACA 19-44	1,213.5	1,206.6	1,195.8	1,210.1	1,233.2	1,224.1	1,223.1	1,221.1	1,258.5	1,262.1	1,283.1	1,265.8	1,263.2	1,265.8	1,261.7	1,259.3	1,267.8	1,275.9	1,270.8	1,266.9	1,261.6	1,259.0	1,257.7	1,255.5	1,253.1	1,249.5	1,246.8	1,244.9	1,253.5	1,262.2	1,258.4	1,254.2	1,252.0	1,250.9	1,248.9	1,247.4	1,246.3	1,243.7	1,241.6	1,238.6	1,247.5	1,258.6	1,253.9	1,250.1	1,249.3	1,248.1	1,245.9	1,244.8
Tillamook	ACA 45-54	491.5	480.8	485.3	481.9	488.1	480.7	478.2	470.3	472.5	491.0	490.6	491.4	502.0	498.5	496.8	495.9	499.2	502.4	500.4	498.9	496.8	495.8	495.3	494.4	493.5	492.0	491.0	490.2	493.6	497.0	495.5	493.9	493.0	492.6	491.8	491.2	490.8	489.7	488.9	487.8	491.2	495.6	493.7	492.3	491.9	491.5	490.6	490.2
Tillamook	ACA 55-64	564.7	555.6	550.4	552.7	552.1	554.5	553.3	556.1	567.9	564.0	574.5	585.2	593.2	586.5	584.7	583.5	587.5	591.2	588.8	587.1	584.6	583.4	582.8	581.8	580.7	579.0	577.7	576.9	580.8	584.9	583.1	581.2	580.2	579.7	578.7	578.0	577.5	576.3	575.3	574.0	578.1	583.2	581.0	579.3	578.9	578.4	577.3	576.8
Tillamook	BCCP	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Umatilla	TANF	1,401.7	1,352.1	1,366.0	1,392.7	1,416.2	1,418.5	1,396.5	1,385.3	1,419.3	1,440.0	1,454.3	1,474.3	1,497.6	1,521.8	1,526.3	1,533.5	1,538.9	1,545.0	1,551.1	1,553.6	1,559.1	1,563.3	1,565.5	1,564.5	1,566.0	1,568.3	1,567.8	1,570.1	1,569.8	1,573.1	1,575.8	1,576.3	1,579.4	1,582.0	1,582.6	1,585.3	1,587.8	1,589.8	1,591.7	1,594.5	1,594.8	1,598.8	1,599.9	1,600.3	1,604.0	1,606.8	1,607.7	1,610.5
Umatilla	PLMA	193.4	182.1	179.4	202.9	183.6	187.8	184.1	176.9	175.8	169.1	166.0	162.8	157.3	159.2	157.5	157.5	156.6	156.5	157.6	157.0	157.2	157.2	156.7	155.5	155.5	155.6	154.8	155.1	154.0	154.2	154.9	154.1	154.2	154.0	152.8	152.5	152.3	152.0	151.7	151.7	150.7	151.1	151.1	150.5	151.1	151.1	150.2	150.0
Umatilla	CHILD 00-01	633.5	634.7	630.2	645.3	646.1	633.9	636.5	640.8	645.8	639.9	623.1	608.5	617.5	624.4	623.0	622.2	621.6	620.4	620.2	618.3	616.9	615.9	614.7	612.9	612.4	612.8	612.8	612.9	612.4	612.5	613.0	611.7	611.5	610.9	609.2	608.7	608.5	608.8	609.6	609.5	609.4	610.1	610.0	608.9	609.1	608.7	607.2	606.8
Umatilla	CHILD 01-05	2,604.9	2,495.9	2,536.5	2,579.6	2,609.2	2,628.3	2,598.3	2,613.5	2,604.8	2,606.4	2,598.2	2,587.6	2,570.9	2,557.9	2,554.9	2,554.0	2,554.3	2,553.2	2,553.7	2,549.1	2,546.3	2,544.6	2,541.1	2,534.7	2,532.9	2,535.3	2,536.6	2,538.3	2,539.0	2,541.2	2,544.2	2,540.7	2,540.5	2,539.5	2,533.9	2,531.9	2,531.2	2,533.5	2,537.5	2,538.5	2,540.2	2,544.5	2,545.1	2,541.8	2,543.3	2,542.4	2,537.0	2,535.2
Umatilla	CHILD 06-18	5,725.5	5,644.9	5,617.5	5,717.1	5,773.9	5,720.9	5,678.6	5,748.4	5,716.8	5,769.2	5,754.2	5,756.7	5,689.2	5,644.8	5,643.2	5,646.2	5,653.4	5,658.5	5,662.9	5,660.0	5,659.5	5,661.2	5,656.5	5,644.6	5,641.3	5,648.0	5,653.4	5,660.2	5,667.4	5,675.9	5,684.6	5,680.6	5,682.3	5,683.1	5,673.2	5,669.4	5,667.8	5,674.9	5,685.2	5,690.5	5,699.3	5,711.2	5,714.9	5,710.5	5,715.0	5,714.9	5,704.2	5,700.3
Umatilla	DUAL-MEDS	1,398.0	1,398.1	1,396.3	1,377.5	1,367.4	1,351.4	1,349.2	1,354.0	1,345.0	1,362.4	1,369.9	1,376.0	1,381.5	1,386.7	1,389.3	1,392.7	1,395.2	1,397.1	1,400.4	1,402.5	1,405.6	1,408.8	1,411.7	1,413.9	1,416.7	1,419.6	1,422.0	1,425.0	1,426.7	1,428.5	1,431.3	1,433.1	1,436.1	1,438.8	1,440.8	1,443.3	1,445.8	1,448.1	1,450.4	1,453.0	1,454.6	1,456.3	1,458.5	1,460.0	1,463.0	1,465.4	1,467.4	1,469.6
Umatilla	ABAD & OAA	874.4	878.8	882.3	890.1	889.3	897.8	893.8	887.2	887.2	875.1	865.0	860.2	853.3	857.9	857.8	858.3	857.9	857.4	857.7	857.1	857.0	857.2	857.2	856.8	857.2	857.5	857.6	858.2	857.8	857.6	857.9	857.6	857.7	858.0	857.8	857.9	858.4	858.6	859.0	859.5	859.2	859.1	859.3	859.0	859.4	859.7	859.5	859.7
Umatilla	CAF	333.8	339.5	346.2	345.8	351.8	356.2	351.8	355.9	363.9	358.9	360.9	362.6	357.7	364.8	365.0	365.7	365.7	365.7	365.9	365.7	365.4	365.3	365.0	364.8	365.3	365.7	365.9	366.4	366.1	366.2	366.4	366.3	366.1	365.9	365.4	365.5	365.9	366.2	366.5	366.8	366.6	366.9	366.7	366.7	366.8	366.7	366.2	366.3
Umatilla	ACA 19-44	3,241.2	3,117.0	3,026.2	3,040.6	3,056.0	3,048.4	3,035.5	3,080.4	3,131.8	3,174.0	3,185.6	3,192.6	3,168.8	3,202.6	3,192.3	3,186.1	3,207.7	3,228.2	3,215.2	3,205.4	3,192.0	3,185.5	3,182.2	3,176.5	3,170.6	3,161.5	3,154.6	3,149.7	3,171.5	3,193.4	3,184.0	3,173.2	3,167.7	3,165.0	3,160.0	3,156.1	3,153.4	3,146.7	3,141.3	3,133.9	3,156.3	3,184.5	3,172.4	3,162.8	3,160.8	3,158.0	3,152.3	3,149.4
Umatilla	ACA 45-54	1,082.7	1,045.3	1,013.7	1,031.6	1,040.5	1,040.5	1,035.5	1,023.3	1,036.4	1,031.7	1,023.3	1,035.3	1,021.0	1,031.4	1,028.1	1,026.1	1,033.0	1,039.6	1,035.4	1,032.3	1,028.0	1,025.9	1,024.8	1,023.0	1,021.1	1,018.1	1,015.9	1,014.3	1,021.4	1,028.4	1,025.4	1,021.9	1,020.1	1,019.3	1,017.6	1,016.4	1,015.5	1,013.4	1,011.6	1,009.2	1,016.5	1,025.6	1,021.6	1,018.6	1,017.9	1,017.0	1,015.2	1,014.3
Umatilla	ACA 55-64	952.1	932.5	907.8	910.6	915.1	921.0	924.3	952.2	965.5	981.0	979.4	971.8	967.6	975.7	972.6	970.7	977.3	983.5	979.6	976.6	972.5	970.5	969.5	967.8	966.0	963.2	961.1	959.6	966.3	972.9	970.1	966.8	965.1	964.3	962.7	961.6	960.7	958.7	957.1	954.8	961.6	970.2	966.5	963.6	963.0	962.1	960.4	959.5
Umatilla	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Union	TANF	506.1	509.0	504.8	510.9	519.2	513.4	516.5	499.9	505.3	518.4	516.5	512.8	508.5	526.1	527.6	530.1	531.9	534.1	536.2	537.0	538.9	540.4	541.2	540.8	541.3	542.1	542.0	542.8	542.6	543.8	544.7	544.9	546.0	546.9	547.1	548.0	548.9	549.5	550.2	551.2	551.3	552.7	553.1	553.2	554.4	555.4	555.7	556.7
Union	PLMA	56.9	56.7	60.5	64.7	48.7	48.3	44.3	40.3	37.7	39.4	42.5	39.6	44.1	57.3	56.7	56.7	56.4	56.3	56.7	56.5	56.6	56.6	56.4	56.0	56.0	56.0	55.7	55.8	55.4	55.5	55.7	55.5	55.5	55.4	55.0	54.9	54.8	54.7	54.6	54.6	54.3	54.4	54.4	54.2	54.4	54.4	54.0	54.0
Union	CHILD 00-01	181.4	187.1	191.4	194.1	185.3	193.1	184.8	187.8	185.1	188.8	180.0	171.3	159.0	152.8	152.5	152.3	152.2	152.0	151.9	151.5	151.2	151.0	150.7	150.2	150.1	150.2	150.3	150.3	150.2	150.2	150.4	150.1	150.0	149.9	149.5	149.4	149.3	149.4	149.6	149.6	149.6	149.8	149.8	149.5	149.6	149.5	149.1	149.0
Union	CHILD 01-05	793.0	768.4	777.9	788.9	795.8	783.4	791.4	783.2	764.7	758.6	761.6	743.2	752.1	760.2	759.2	758.9	758.9	758.5	758.6	757.2	756.3	755.8	754.7	752.8	752.2	752.9	753.3	753.8	753.9	754.6	755.4	754.3	754.3	753.9	752.2	751.7	751.4	752.1	753.3	753.6	754.0	755.3	755.4	754.4	754.9	754.6	753.0	752.4
Union	CHILD 06-18	1,703.5	1,674.7	1,684.9	1,731.3	1,761.0	1,744.8	1,754.1	1,719.0	1,744.2	1,764.3	1,758.5	1,745.4	1,737.3	1,716.3	1,715.7	1,716.6	1,718.6	1,720.0	1,721.3	1,720.2	1,720.0	1,720.4	1,718.9	1,715.2	1,714.2	1,716.2	1,717.8	1,719.8	1,721.9	1,724.4	1,727.0	1,725.7	1,726.2	1,726.3	1,723.3	1,722.1	1,721.6	1,723.7	1,726.8	1,728.4	1,731.0	1,734.6	1,735.6	1,734.2	1,735.6	1,735.5	1,732.2	1,731.0
Union	DUAL-MEDS	480.9	483.9	480.1	480.8	495.2	497.7	493.7	493.3	505.2	513.4	504.7	509.0	501.9	509.6	510.5	511.6	512.4	513.0	514.1	514.7	515.7	516.8	517.7	518.4	519.3	520.3	521.1	522.1	522.6	523.2	524.1	524.7	525.6	526.5	527.2	528.0	528.8	529.6	530.4	531.2	531.7	532.3	533.0	533.5	534.5	535.3	535.9	536.6
Union	ABAD & OAA	352.8	351.1	358.0	354.5	357.0	360.3	360.2	351.3	350.4	353.2	352.3	357.4	355.5	362.2	362.1	362.3	362.2	361.9	362.0	361.8	361.8	361.8	361.8	361.6	361.8	361.9	362.0	362.2	362.0	361.9	362.1	361.9	362.0	362.1	362.0	362.0	362.2	362.3	362.4	362.7	362.5	362.5	362.5	362.4	362.6	362.7	362.6	362.7
Union	CAF	128.7	122.8	122.8	123.3	126.0	130.2	129.6	131.5	136.4	135.8	138.6	140.7	143.2	142.5	142.6	142.8	142.8	142.8	142.9	142.8	142.7	142.7	142.6	142.5	142.7	142.8	142.9	143.1	143.0	143.0	143.1	143.0	143.0	142.9	142.7	142.7	142.9	143.0	143.1	143.3	143.2	143.3	143.2	143.2	143.2	143.2	143.0	143.1
Union	ACA 19-44	1,383.3	1,321.1	1,342.0	1,336.8	1,351.6	1,358.1	1,356.0	1,360.8	1,383.0	1,385.9	1,397.7	1,395.1	1,383.9	1,358.2	1,353.9	1,351.2	1,360.4	1,369.0	1,363.5	1,359.4	1,353.7	1,351.0	1,349.5	1,347.1	1,344.6	1,340.8	1,337.8	1,335.8	1,345.0	1,354.3	1,350.3	1,345.8	1,343.4	1,342.3	1,340.1	1,338.5	1,337.3	1,334.5	1,332.2	1,329.1	1,338.6	1,350.5	1,345.4	1,341.3	1,340.5	1,339.3	1,336.9	1,335.7
Union	ACA 45-54	388.7	383.2	391.3	388.0	377.7	380.5	379.4	383.8	391.6	393.4	394.3	390.1	384.8	372.1	370.9	370.2	372.7	375.1	373.6	372.4	370.9	370.1	369.7	369.1	368.4	367.3	366.5	366.0	368.5	371.1	370.0	368.7	368.1	367.8	367.2	366.7	366.4	365.6	365.0	364.1	366.7	370.0	368.6	367.5	367.3	366.9	366.3	365.9
Union	ACA 55-64	354.1	351.5	336.3	328.8	319.3	321.9	325.6	332.7	335.0	332.8	333.0	337.1	340.3	341.6	340.5	339.9	342.2	344.4	343.0	341.9	340.5	339.8	339.5	338.9	338.2	337.3	336.5	336.0	338.3	340.7	339.7	338.5	337.9	337.6	337.1	336.7	336.4	335.7	335.1	334.3	336.7	339.7	338.4	337.4	337.2	336.9	336.3	336.0
Union	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Wallowa	TANF	125.8	128.2	126.8	136.4	132.8	129.1	124.8	124.5	124.4	125.8	115.8	119.8	118.8	117.8	118.1	118.7	119.1	119.6	120.0	120.2	120.7	121.0	121.2	121.1	121.2	121.4	121.3	121.5	121.5	121.7	121.9	122.0	122.2	122.4	122.5	122.7	122.9	123.0	123.2	123.4	123.4	123.7	123.8	123.8	124.1	124.3	124.4	124.6
Wallowa	PLMA	11.2	6.0	5.9	7.5	6.0	5.0	4.1	5.7	10.2	9.0	9.0	9.2	10.8	11.0	10.9	10.9	10.8	10.8	10.9	10.9	10.9	10.9	10.8	10.7	10.7	10.8	10.7	10.7	10.6	10.7	10.7	10.7	10.7	10.6	10.6	10.5	10.5	10.5	10.5	10.5	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4
Wallowa	CHILD 00-01	38.5	43.4	45.2	45.4	44.6	42.1	39.2	40.6	43.6	38.9	34.4	35.3	36.0	33.4	33.3	33.3	33.3	33.2	33.2	33.1	33.1	33.1	33.0	32.9	32.9	32.9	32.9	32.9	32.9	32.9	33.0	32.9	32.9	32.9	32.8	32.8	32.7	32.8	32.8	32.8	32.8	32.9	32.9	32.8	32.8	32.8	32.7	32.7
Wallowa	CHILD 01-05	175.3	170.5	171.3	182.4	184.8	183.6	176.7	174.4	174.6	179.2	184.0	185.8	184.7	186.4	186.3	186.3	186.4	186.4	186.5	186.3	186.2	186.2	186.0	185.6	185.4	185.6	185.8	185.9	186.1	186.3	186.6	186.6	186.4	186.4	186.0	185.9	185.8	186.0	186.3	186.5	186.7	187.0	187.1	186.9	187.0	187.0	186.6	186.5
Wallowa	CHILD 06-18	449.3	445.0	442.7	456.1	459.5	459.4	445.3	448.5	456.8	461.6	454.4	458.4	452.4	458.3	458.4	458.9	459.7	460.5	461.0	461.1	461.3	461.6	461.4	460.5	460.3	460.9	461.4	462.1	462.9	463.8	464.6	464.4	464.7	464.9	464.2	463.9	463.7	464.4	465.3	465.9	466.8	467.9	468.3	468.1	468.5	468.5	467.7	467.4
Wallowa	DUAL-MEDS	183.8	186.5	187.0	186.2	187.7	185.6	182.3	178.3	177.8	177.4	178.8	180.5	179.4	178.2	178.4	178.8	179.1	179.3	179.6	179.8	180.2	180.5	180.8	181.0	181.3	181.7	181.9	182.3	182.4	182.6	182.9	183.1	183.4	183.7	183.9	184.2	184.5	184.7	185.0	185.3	185.5	185.6	185.9	186.0	186.3	186.6	186.8	187.1
Wallowa	ABAD & OAA	70.6	70.7	69.5	71.0	68.6	71.1	73.6	72.0	71.5	73.7	73.0	73.3	71.6	69.5	69.5	69.6	69.6	69.5	69.6	69.5	69.5	69.5	69.5	69.5	69.5	69.6	69.6	69.6	69.6	69.6	69.6	69.6	69.6	69.6	69.6	69.6	69.7	69.7	69.7	69.8	69.8	69.8	69.8	69.7	69.8	69.8	69.8	69.8
Wallowa	CAF	18.4	19.6	19.8	16.1	15.6	13.2	14.5	14.4	15.0	15.5	14.5	13.0	15.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.2	16.3	16.2	16.2	16.2	16.2	16.2	16.2
Wallowa	ACA 19-44	343.8	333.5	335.7	341.5	346.3	354.4	353.3	361.1	366.4	377.9	380.7	375.8	375.0	380.5	379.2	378.5	381.1	383.5	381.9	380.8	379.2	378.4	378.0	377.3	376.6	375.6	374.7	374.2	376.8	379.4	378.2	377.0	376.3	376.0	375.4	374.9	374.6	373.8	373.2	372.3	374.9	378.3	376.9	375.7	375.5	375.1	374.5	374.1
Wallowa	ACA 45-54	130.1	129.7	127.0	132.0	128.0	120.3	127.7	129.0	129.4	134.0	129.3	124.8	128.0	124.3	123.9	123.6	124.5	125.2	124.7	124.4	123.8	123.6	123.5	123.2	123.0	122.7	122.4	122.2	123.0	123.9	123.5	123.1	122.9	122.8	122.6	122.5	122.3	122.1	121.9	121.6	122.5	123.6	123.1	122.7	122.6	122.5	122.3	122.2
Wallowa	ACA 55-64	172.3	167.7	163.9	161.6	165.2	166.9	169.0	166.8	172.6	175.1	175.9	172.8	174.6	171.4	170.8	170.5	171.7	172.8	172.1	171.5	170.8	170.5	170.3	170.0	169.7	169.2	168.8	168.6	169.7	170.9	170.4	169.8	169.5	169.4	169.1	168.9	168.8	168.4	168.1	167.7	168.9	170.4	169.8	169.3	169.1	169.0	168.7	168.5
Wallowa	BCCP	1.0	1.0	1.9	2.0	2.0	1.2	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Wasco	TANF	407.3	398.6	393.3	395.9	412.3	409.0	410.2	415.1	419.7	433.9	435.4	454.2	455.3	465.1	466.4	468.6	470.3	472.1	474.0	474.8	476.5	477.7	478.4	478.0	478.6	479.3	479.1	479.8	479.7	480.7	481.6	481.7	482.7	483.5	483.6	484.5	485.2	485.8	486.4	487.3	487.3	488.6	488.9	489.0	490.2	491.0	491.3	492.2
Wasco	PLMA	82.6	78.1	83.3	85.9	80.3	71.0	77.6	80.2	78.2	74.3	66.5	62.3	65.4	62.9	62.3	62.3	61.9	61.9	62.3	62.1	62.2	62.2	62.0	61.5	61.5	61.5	61.2	61.3	60.9	61.0	61.2	60.9	61.0	60.9	60.4	60.3	60.2	60.1	60.0	60.0	59.6	59.7	59.8	59.5	59.8	59.8	59.4	59.3
Wasco	CHILD 00-01	221.9	215.7	215.3	212.1	208.5	209.6	209.5	209.8	212.0	198.3	195.4	192.7	191.9	198.2	197.8	197.5	197.3	197.0	196.9	196.3	195.9	195.5	195.2	194.6	194.4	194.6	194.6	194.6	194.4	194.5	194.7	194.2	194.2	194.0	193.4	193.3	193.2	193.3	193.6	193.6	193.5	193.8	193.7	193.4	193.4	193.3	192.8	192.7
Wasco	CHILD 01-05	874.2	859.5	860.2	870.4	891.3	897.9	882.2	886.6	882.5	879.3	887.0	876.6	856.0	859.9	859.2	859.1	859.6	859.6	859.9	858.8	858.1	857.8	856.8	854.8	854.2	855.1	855.6	856.4	856.9	857.8	858.9	857.9	858.0	857.8	856.1	855.4	855.2	856.1	857.5	858.0	858.8	860.4	860.7	859.7	860.3	860.1	858.4	857.8
Wasco	CHILD 06-18	1,870.5	1,827.0	1,847.7	1,879.3	1,904.8	1,896.7	1,875.8	1,904.5	1,911.5	1,916.9	1,916.5	1,923.2	1,913.2	1,907.0	1,907.4	1,909.3	1,912.8	1,915.9	1,917.9	1,918.2	1,919.0	1,920.5	1,919.5	1,915.8	1,914.8	1,917.3	1,919.6	1,922.4	1,925.8	1,929.3	1,932.6	1,931.9	1,932.9	1,933.7	1,930.7	1,929.6	1,929.0	1,931.7	1,935.5	1,937.8	1,941.7	1,946.1	1,947.8	1,946.8	1,948.5	1,948.8	1,945.4	1,944.1
Wasco	DUAL-MEDS	612.5	598.1	598.0	592.0	591.9	586.1	584.3	595.9	607.8	603.2	602.0	598.5	588.9	598.8	600.0	601.5	602.5	603.4	604.8	605.7	607.1	608.5	609.7	610.7	611.9	613.2	614.2	615.5	616.2	617.0	618.2	619.0	620.3	621.5	622.4	623.5	624.5	625.6	626.6	627.7	628.4	629.1	630.1	630.7	632.0	633.1	633.9	634.9
Wasco	ABAD & OAA	352.2	353.6	363.0	369.1	377.4	383.2	376.2	375.6	376.8	377.5	382.3	379.6	375.7	371.4	371.4	371.6	371.4	371.2	371.3	371.1	371.1	371.1	371.2	371.0	371.2	371.3	371.3	371.6	371.4	371.3	371.5	371.3	371.4	371.5	371.4	371.5	371.7	371.8	372.0	372.2	372.1	372.0	372.1	372.0	372.2	372.3	372.2	372.3
Wasco	CAF	179.1	180.4	186.3	187.1	185.2	183.4	185.9	180.8	180.8	180.8	176.1	177.3	179.8	178.1	178.2	178.5	178.5	178.5	178.6	178.5	178.4	178.3	178.2	178.1	178.3	178.5	178.6	178.8	178.7	178.7	178.8	178.7	178.7	178.6	178.3	178.4	178.6	178.7	178.9	179.0	178.9	179.1	179.0	179.0	179.0	179.0	178.7	178.8
Wasco	ACA 19-44	1,459.3	1,407.4	1,369.2	1,369.2	1,382.4	1,400.0	1,392.3	1,417.4	1,436.5	1,438.4	1,437.5	1,437.3	1,420.5	1,412.1	1,407.6	1,404.8	1,414.4	1,423.4	1,417.7	1,413.3	1,407.4	1,404.6	1,403.1	1,400.6	1,398.0	1,394.0	1,390.9	1,388.8	1,398.4	1,408.1	1,403.9	1,399.2	1,396.7	1,395.5	1,393.3	1,391.6	1,390.4	1,387.5	1,385.1	1,381.8	1,391.7	1,404.1	1,398.8	1,394.6	1,393.7	1,392.4	1,389.9	1,388.7
Wasco	ACA 45-54	466.2	454.3	444.0	426.4	420.6	408.2	415.8	416.6	426.3	430.1	438.7	432.4	438.7	433.6	432.2	431.4	434.3	437.1	435.3	434.0	432.2	431.3	430.9	430.1	429.3	428.1	427.1	426.5	429.4	432.4	431.1	429.7	428.9	428.6	427.9	427.3	427.0	426.1	425.3	424.3	427.4	431.2	429.5	428.3	428.0	427.6	426.8	426.4
Wasco	ACA 55-64	477.7	477.5	470.4	474.6	471.3	462.9	464.7	463.3	454.1	438.8	434.1	433.5	435.4	432.7	431.3	430.5	433.4	436.2	434.4	433.1	431.3	430.4	429.9	429.2	428.4	427.1	426.2	425.6	428.5	431.5	430.2	428.7	428.0	427.6	426.9	426.4	426.1	425.1	424.4	423.4	426.5	430.3	428.6	427.3	427.1	426.7	425.9	425.5
Wasco	BCCP	2.0	1.0	1.0	1.7	2.0	2.0	2.5	3.4	4.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9
Washington	TANF	5,707.9	5,677.0	5,579.2	5,643.5	5,646.8	5,604.5	5,585.5	5,557.3	5,615.3	5,719.6	5,802.3	5,844.2	5,836.5	5,914.8	5,932.3	5,960.0	5,980.9	6,004.8	6,028.6	6,038.2	6,059.6	6,076.0	6,084.7	6,080.8	6,086.6	6,095.5	6,093.5	6,102.5	6,101.3	6,114.1	6,124.5	6,126.6	6,138.6	6,148.7	6,150.9	6,161.5	6,171.1	6,178.8	6,186.2	6,197.2	6,198.2	6,213.8	6,218.2	6,219.7	6,233.9	6,244.9	6,248.5	6,259.5
Washington	PLMA	872.3	805.1	815.4	822.9	797.4	804.5	818.7	796.8	788.3	758.3	765.6	741.8	744.7	729.4	721.7	721.8	717.8	717.3	722.3	719.4	720.5	720.3	718.0	712.7	712.4	713.0	709.6	710.9	705.8	706.6	709.7	706.2	706.8	705.6	700.0	698.9	698.1	696.3	695.1	695.3	690.7	692.2	692.6	689.9	692.6	692.5	688.1	687.3
Washington	CHILD 00-01	2,585.1	2,570.4	2,581.6	2,557.5	2,517.6	2,497.4	2,468.1	2,471.7	2,486.8	2,455.1	2,458.9	2,421.7	2,416.4	2,378.0	2,373.2	2,370.3	2,367.9	2,363.9	2,363.2	2,356.0	2,351.1	2,347.3	2,342.9	2,336.1	2,334.1	2,335.8	2,336.0	2,336.3	2,334.7	2,335.4	2,337.4	2,332.5	2,331.5	2,329.4	2,323.1	2,321.1	2,320.4	2,321.8	2,324.9	2,324.7	2,324.1	2,327.2	2,326.8	2,322.5	2,323.6	2,322.0	2,316.5	2,314.7
Washington	CHILD 01-05	11,421.3	11,213.0	11,182.3	11,348.4	11,421.8	11,391.2	11,349.5	11,298.5	11,242.5	11,309.7	11,282.0	11,197.1	11,085.6	11,013.1	11,003.3	11,002.6	11,008.0	11,008.2	11,012.5	10,997.4	10,989.0	10,985.0	10,972.0	10,945.9	10,938.5	10,949.8	10,957.0	10,966.2	10,972.9	10,984.8	10,999.1	10,986.2	10,986.9	10,984.5	10,961.8	10,953.8	10,950.5	10,961.9	10,980.1	10,986.5	10,996.8	11,017.0	11,021.1	11,008.6	11,016.0	11,013.3	10,990.9	10,983.1
Washington	CHILD 06-18	26,698.1	26,450.8	26,405.3	26,767.3	26,922.2	26,882.2	26,900.6	26,962.4	26,940.5	26,995.1	26,916.7	26,848.1	26,678.7	26,527.5	26,532.7	26,560.0	26,610.3	26,653.3	26,681.6	26,686.3	26,698.3	26,720.4	26,706.2	26,655.3	26,641.7	26,677.1	26,708.5	26,748.2	26,796.5	26,845.4	26,891.3	26,882.3	26,895.9	26,907.2	26,866.8	26,850.7	26,843.0	26,881.1	26,933.5	26,966.2	27,020.5	27,082.6	27,106.2	27,092.9	27,116.5	27,120.6	27,073.8	27,056.0
Washington	DUAL-MEDS	6,618.0	6,628.5	6,612.0	6,648.3	6,641.9	6,622.8	6,647.6	6,635.9	6,677.9	6,676.3	6,694.8	6,730.8	6,743.9	6,755.3	6,768.9	6,786.9	6,800.0	6,810.8	6,827.6	6,839.0	6,855.5	6,872.2	6,887.4	6,899.5	6,913.8	6,928.9	6,941.2	6,956.7	6,966.1	6,975.7	6,990.0	6,999.9	7,015.4	7,029.5	7,040.5	7,053.3	7,066.0	7,078.4	7,090.3	7,103.5	7,112.0	7,121.3	7,132.4	7,140.8	7,156.0	7,168.9	7,179.0	7,190.5
Washington	ABAD & OAA	3,419.5	3,445.8	3,463.8	3,480.2	3,481.2	3,474.6	3,495.3	3,488.8	3,508.8	3,505.4	3,504.0	3,491.0	3,468.0	3,459.2	3,459.2	3,461.5	3,460.7	3,458.9	3,460.5	3,458.6	3,459.1	3,460.3	3,460.8	3,459.7	3,461.7	3,463.4	3,464.0	3,466.7	3,465.7	3,465.0	3,466.9	3,465.7	3,466.9	3,468.3	3,467.9	3,468.8	3,471.0	3,472.1	3,473.9	3,476.4	3,475.6	3,475.5	3,476.4	3,475.6	3,477.6	3,479.1	3,478.9	3,479.8
Washington	CAF	1,419.3	1,408.2	1,416.5	1,433.3	1,450.3	1,440.8	1,450.1	1,428.6	1,424.1	1,404.6	1,408.4	1,439.8	1,439.9	1,435.3	1,436.0	1,438.5	1,438.7	1,438.6	1,439.4	1,438.7	1,437.6	1,437.0	1,436.0	1,435.3	1,436.9	1,438.8	1,439.3	1,441.2	1,440.4	1,440.7	1,441.3	1,440.9	1,440.3	1,439.5	1,437.4	1,437.7	1,439.5	1,440.5	1,441.7	1,443.1	1,442.3	1,443.4	1,442.8	1,442.6	1,442.8	1,442.4	1,440.6	1,441.0
Washington	ACA 19-44	19,013.7	18,822.4	18,500.2	18,610.8	18,630.4	18,680.5	18,807.4	18,826.8	18,903.1	18,981.2	18,948.3	18,929.1	18,852.6	18,850.4	18,789.7	18,752.9	18,880.1	19,000.6	18,924.2	18,866.6	18,787.8	18,749.6	18,729.8	18,696.3	18,661.7	18,608.2	18,567.4	18,538.9	18,667.1	18,796.1	18,740.6	18,677.4	18,644.9	18,629.1	18,599.2	18,576.6	18,560.4	18,521.1	18,489.6	18,445.8	18,577.8	18,743.7	18,672.4	18,616.1	18,604.1	18,587.4	18,554.3	18,537.3
Washington	ACA 45-54	5,093.4	5,009.6	4,880.2	4,903.1	4,880.3	4,853.8	4,897.6	4,901.2	4,924.3	4,943.8	4,946.4	4,950.8	4,900.0	4,880.9	4,865.2	4,855.6	4,888.5	4,919.8	4,900.0	4,885.1	4,864.7	4,854.8	4,849.6	4,841.0	4,832.0	4,818.2	4,807.6	4,800.2	4,833.4	4,866.8	4,852.4	4,836.1	4,827.7	4,823.6	4,815.8	4,810.0	4,805.8	4,795.6	4,787.4	4,776.1	4,810.3	4,853.3	4,834.8	4,820.2	4,817.1	4,812.8	4,804.2	4,799.8
Washington	ACA 55-64	4,857.8	4,829.2	4,778.9	4,788.6	4,809.7	4,814.0	4,866.5	4,845.0	4,853.6	4,834.6	4,854.0	4,855.8	4,876.4	4,899.3	4,883.6	4,874.0	4,907.0	4,938.4	4,918.5	4,903.5	4,883.1	4,873.1	4,868.0	4,859.3	4,850.3	4,836.4	4,825.8	4,818.3	4,851.7	4,885.2	4,870.8	4,854.3	4,845.9	4,841.8	4,834.0	4,828.1	4,824.0	4,813.7	4,805.5	4,794.2	4,828.5	4,871.6	4,853.1	4,838.4	4,835.3	4,831.0	4,822.4	4,817.9
Washington	BCCP	16.0	15.0	11.1	11.0	11.0	12.7	11.2	11.0	10.0	11.6	14.1	15.3	16.7	17.0	17.0	17.0	16.9	16.9	17.0	17.1	17.1	17.1	17.0	16.9	16.8	16.7	16.8	16.8	16.8	16.7	16.7	16.8	16.8	16.8	16.8	16.7	16.7	16.6	16.7	16.7	16.7	16.6	16.6	16.7	16.7	16.7	16.7	16.6
Wheeler	TANF	24.3	24.8	24.7	23.5	23.3	20.2	21.0	20.5	21.6	17.6	20.8	21.0	20.5	18.0	18.1	18.1	18.2	18.3	18.3	18.4	18.4	18.5	18.5	18.5	18.5	18.5	18.5	18.6	18.6	18.6	18.6	18.6	18.7	18.7	18.7	18.8	18.8	18.8	18.8	18.9	18.9	18.9	18.9	18.9	19.0	19.0	19.0	19.0
Wheeler	PLMA	2.0	2.1	3.6	5.0	4.0	4.0	4.0	5.0	3.0	3.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9
Wheeler	CHILD 00-01	7.3	6.1	7.9	8.7	5.0	5.5	7.7	9.2	8.0	8.0	7.0	6.7	7.0	8.2	8.1	8.1	8.1	8.1	8.1	8.1	8.1	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	8.0	7.9	7.9	7.9	8.0	8.0	8.0	8.0	8.0	7.9	8.0	7.9	7.9	7.9
Wheeler	CHILD 01-05	29.3	29.6	31.5	32.7	35.6	36.4	36.1	38.6	43.2	43.0	43.0	41.9	41.3	40.6	40.6	40.5	40.5	40.5	40.5	40.4	40.3	40.3	40.2	40.1	40.1	40.1	40.1	40.1	40.1	40.1	40.2	40.1	40.1	40.1	40.0	40.0	39.9	40.0	40.0	40.0	40.1	40.1	40.1	40.1	40.1	40.1	40.0	39.9
Wheeler	CHILD 06-18	57.2	58.2	56.2	52.4	49.5	51.6	52.3	49.3	52.3	51.0	53.4	49.0	50.6	50.8	50.8	50.8	50.9	50.9	50.9	50.8	50.8	50.8	50.8	50.6	50.6	50.7	50.7	50.7	50.8	50.9	50.9	50.9	50.9	50.9	50.8	50.7	50.7	50.8	50.9	50.9	51.0	51.1	51.1	51.0	51.1	51.1	51.0	50.9
Wheeler	DUAL-MEDS	31.5	32.4	33.0	32.7	32.6	33.0	34.7	35.4	33.8	33.0	33.5	34.1	32.7	31.0	31.1	31.2	31.3	31.4	31.5	31.5	31.6	31.8	31.8	31.9	32.0	32.1	32.2	32.3	32.3	32.4	32.5	32.6	32.7	32.7	32.8	32.9	33.0	33.0	33.1	33.2	33.2	33.3	33.4	33.4	33.5	33.6	33.7	33.7
Wheeler	ABAD & OAA	16.3	16.6	17.0	17.7	17.0	16.0	16.0	16.6	16.0	16.0	16.0	16.0	14.3	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0
Wheeler	CAF	5.0	5.0	4.6	4.0	4.0	4.0	3.0	3.0	4.0	4.7	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0
Wheeler	ACA 19-44	44.9	47.0	56.4	60.3	62.6	63.5	63.7	60.5	63.6	66.9	67.4	66.8	65.5	62.6	62.4	62.3	62.7	63.1	62.9	62.7	62.4	62.3	62.2	62.1	62.0	61.8	61.7	61.6	62.0	62.4	62.2	62.0	61.9	61.9	61.8	61.7	61.6	61.5	61.4	61.3	61.7	62.3	62.0	61.8	61.8	61.7	61.6	61.6
Wheeler	ACA 45-54	33.2	34.0	32.9	34.5	32.0	29.8	31.4	32.0	29.3	30.6	29.0	29.7	29.2	27.4	27.3	27.2	27.4	27.6	27.5	27.4	27.3	27.2	27.2	27.2	27.1	27.0	27.0	26.9	27.1	27.3	27.2	27.1	27.1	27.1	27.0	27.0	27.0	26.9	26.9	26.8	27.0	27.2	27.1	27.0	27.0	27.0	27.0	26.9
Wheeler	ACA 55-64	41.0	41.0	39.1	39.6	38.9	40.8	41.6	44.0	44.2	46.0	46.2	49.0	49.0	48.4	48.2	48.1	48.5	48.8	48.6	48.4	48.2	48.1	48.1	48.0	47.9	47.8	47.7	47.6	47.9	48.2	48.1	47.9	47.9	47.8	47.7	47.7	47.6	47.5	47.5	47.3	47.7	48.1	47.9	47.8	47.8	47.7	47.6	47.6
Wheeler	BCCP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Yamhill	TANF	1,585.0	1,577.1	1,546.4	1,567.7	1,565.7	1,552.1	1,529.9	1,510.2	1,540.7	1,589.8	1,585.3	1,577.7	1,588.3	1,615.1	1,619.9	1,627.5	1,633.2	1,639.7	1,646.2	1,648.8	1,654.7	1,659.1	1,661.5	1,660.4	1,662.0	1,664.5	1,663.9	1,666.4	1,666.0	1,669.6	1,672.4	1,672.9	1,676.2	1,679.0	1,679.6	1,682.5	1,685.1	1,687.2	1,689.2	1,692.3	1,692.5	1,696.8	1,698.0	1,698.4	1,702.3	1,705.3	1,706.2	1,709.2
Yamhill	PLMA	238.9	217.4	214.1	222.6	210.5	209.5	206.0	199.4	192.5	180.0	179.0	173.3	167.9	175.8	174.0	174.0	173.0	172.9	174.1	173.4	173.7	173.6	173.1	171.8	171.7	171.9	171.0	171.4	170.1	170.3	171.1	170.2	170.4	170.1	168.7	168.5	168.3	167.8	167.5	167.6	166.5	166.8	166.9	166.3	167.0	166.9	165.9	165.7
Yamhill	CHILD 00-01	572.5	578.8	574.7	577.1	561.3	575.2	605.6	606.6	603.4	588.3	585.2	580.4	596.6	605.3	604.1	603.4	602.8	601.8	601.6	599.8	598.6	597.6	596.5	594.8	594.3	594.7	594.8	594.9	594.5	594.6	595.2	593.9	593.7	593.1	591.6	591.0	590.9	591.2	592.0	592.0	591.9	592.6	592.5	591.5	591.7	591.3	589.9	589.5
Yamhill	CHILD 01-05	2,625.7	2,585.3	2,603.0	2,606.0	2,635.7	2,639.1	2,600.2	2,628.6	2,589.5	2,614.6	2,598.2	2,594.2	2,564.8	2,557.2	2,555.0	2,555.0	2,556.3	2,556.5	2,557.6	2,554.2	2,552.4	2,551.6	2,548.6	2,542.6	2,540.9	2,543.6	2,545.3	2,547.5	2,549.2	2,552.0	2,555.3	2,552.4	2,552.6	2,552.1	2,546.9	2,545.1	2,544.3	2,547.0	2,551.2	2,552.8	2,555.3	2,560.0	2,561.0	2,558.2	2,559.9	2,559.3	2,554.1	2,552.3
Yamhill	CHILD 06-18	6,362.7	6,337.3	6,337.1	6,463.5	6,422.9	6,377.8	6,396.4	6,404.8	6,441.0	6,427.2	6,432.0	6,369.2	6,307.6	6,294.1	6,294.2	6,299.5	6,309.9	6,318.4	6,324.4	6,323.9	6,325.4	6,329.4	6,325.3	6,312.7	6,309.4	6,317.4	6,324.3	6,333.0	6,343.2	6,353.9	6,364.4	6,361.4	6,364.1	6,366.1	6,355.9	6,352.0	6,350.1	6,358.7	6,370.8	6,377.9	6,389.6	6,403.8	6,408.8	6,405.0	6,410.3	6,410.9	6,399.5	6,395.2
Yamhill	DUAL-MEDS	1,757.6	1,754.8	1,735.4	1,727.8	1,736.1	1,739.4	1,719.1	1,714.1	1,723.4	1,732.2	1,757.8	1,757.3	1,772.4	1,760.8	1,764.0	1,768.3	1,771.3	1,773.7	1,777.8	1,780.3	1,784.2	1,788.2	1,791.7	1,794.5	1,798.0	1,801.6	1,804.5	1,808.3	1,810.4	1,812.6	1,816.1	1,818.3	1,822.0	1,825.4	1,827.9	1,831.0	1,834.1	1,837.0	1,839.9	1,843.1	1,845.1	1,847.2	1,849.9	1,851.8	1,855.4	1,858.5	1,860.9	1,863.6
Yamhill	ABAD & OAA	947.6	953.7	944.2	952.1	954.6	956.6	963.7	959.6	960.8	963.5	962.3	958.1	959.9	961.9	961.8	962.4	962.1	961.6	962.0	961.4	961.5	961.8	961.9	961.5	962.0	962.4	962.6	963.3	962.9	962.7	963.2	962.8	963.1	963.5	963.3	963.5	964.1	964.4	964.8	965.5	965.2	965.2	965.4	965.1	965.7	966.0	965.9	966.2
Yamhill	CAF	423.2	426.7	419.8	406.4	403.3	399.4	390.3	388.3	394.0	395.3	388.3	392.0	393.5	397.1	397.3	398.0	398.0	398.0	398.2	398.0	397.7	397.6	397.3	397.1	397.6	398.1	398.2	398.7	398.5	398.6	398.8	398.7	398.5	398.3	397.7	397.8	398.3	398.5	398.9	399.3	399.0	399.3	399.2	399.1	399.2	399.1	398.6	398.7
Yamhill	ACA 19-44	4,391.2	4,346.3	4,283.1	4,308.4	4,359.4	4,323.4	4,287.2	4,302.6	4,359.5	4,399.3	4,431.1	4,408.4	4,371.5	4,368.9	4,354.8	4,346.3	4,375.7	4,403.7	4,386.0	4,372.6	4,354.4	4,345.5	4,340.9	4,333.2	4,325.1	4,312.7	4,303.3	4,296.7	4,326.4	4,356.3	4,343.4	4,328.8	4,321.2	4,317.6	4,310.6	4,305.4	4,301.7	4,292.5	4,285.2	4,275.1	4,305.7	4,344.1	4,327.6	4,314.6	4,311.8	4,307.9	4,300.2	4,296.3
Yamhill	ACA 45-54	1,328.7	1,304.1	1,295.0	1,322.4	1,324.6	1,319.1	1,306.5	1,291.9	1,295.3	1,302.8	1,307.7	1,332.6	1,326.7	1,314.3	1,310.0	1,307.5	1,316.3	1,324.7	1,319.4	1,315.4	1,309.9	1,307.2	1,305.8	1,303.5	1,301.1	1,297.4	1,294.5	1,292.5	1,301.5	1,310.5	1,306.6	1,302.2	1,299.9	1,298.8	1,296.7	1,295.2	1,294.0	1,291.3	1,289.1	1,286.0	1,295.2	1,306.8	1,301.8	1,297.9	1,297.1	1,295.9	1,293.6	1,292.4
Yamhill	ACA 55-64	1,300.5	1,275.7	1,259.0	1,260.2	1,256.0	1,254.6	1,258.3	1,251.4	1,258.4	1,245.8	1,247.1	1,245.2	1,250.7	1,247.9	1,243.9	1,241.5	1,249.9	1,257.9	1,252.8	1,249.0	1,243.8	1,241.3	1,239.9	1,237.7	1,235.4	1,231.9	1,229.2	1,227.3	1,235.8	1,244.3	1,240.7	1,236.5	1,234.3	1,233.3	1,231.3	1,229.8	1,228.7	1,226.1	1,224.0	1,221.1	1,229.9	1,240.9	1,236.1	1,232.4	1,231.6	1,230.5	1,228.3	1,227.2
Yamhill	BCCP	4.0	4.0	4.0	4.0	4.0	3.7	4.5	5.0	4.0	4.0	4.0	4.0	4.0	4.8	4.8	4.8	4.8	4.8	4.8	4.9	4.9	4.9	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.7	4.8	4.8	4.8	4.7	4.7	4.8	4.8	4.8	4.8	4.7

Estimated CCO Dental Enrollment by County and Rate Group

Month ->

		Actuals													Forecast																	
County	Rate Group	201707	201708	201709	201710	201711	201712	201801	201802	201803	201804	201805	201806	201807	201808	201809	201810	201811	201812	201901	201902	201903	201904	201905	201906	201907	201908	201909	201910	201911	201912	202001	202002	202003	202004	202005	202006	202007	202008	202009	202010	202011	202012	202101	202102	202103	202104	202105	202106
Baker	TANF	356.8	351.5	354.5	352.4	336.6	333.8	325.1	332.0	330.9	346.3	345.4	343.8	348.7	353.3	354.3	356.0	357.2	358.6	360.1	360.6	361.9	362.9	363.4	363.2	363.5	364.1	363.9	364.5	364.4	365.2	365.8	365.9	366.6	367.2	367.4	368.0	368.6	369.0	369.5	370.1	370.2	371.1	371.4	371.5	372.3	373.0	373.2	373.8
Baker	PLMA	38.5	39.0	35.2	47.0	48.2	45.9	44.3	38.7	34.0	31.5	32.2	31.1	33.6	32.6	32.3	32.3	32.1	32.3	32.2	32.2	32.2	32.2	32.1	31.9	31.9	31.9	31.7	31.8	31.6	31.6	31.7	31.6	31.6	31.6	31.3	31.2	31.2	31.1	31.1	31.1	30.9	31.0	31.0	30.8	31.0	30.8	30.7
Baker	CHILD 00-01	114.0	112.5	112.0	112.3	110.6	114.8	111.7	109.6	110.4	112.1	113.1	114.9	112.4	117.4	117.1	117.0	116.8	116.6	116.6	116.2	116.0	115.8	115.6	115.2	115.1	115.2	115.2	115.2	115.2	115.3	115.0	115.0	114.9	114.6	114.5	114.4	114.5	114.7	114.6	114.6	114.8	114.7	114.5	114.6	114.5	114.2	114.1
Baker	CHILD 01-05	479.4	482.4	484.1	478.4	478.4	466.5	468.4	477.5	476.6	475.7	475.3	468.5	461.7	444.2	443.6	443.4	443.3	443.0	443.1	442.1	441.6	441.2	440.5	439.4	439.0	439.4	439.6	439.9	439.9	440.2	440.7	440.0	440.0	439.7	438.7	438.4	438.2	438.6	439.3	439.4	439.6	440.3	440.4	439.8	440.0	439.8	438.6
Baker	CHILD 06-18	988.9	988.9	983.4	1,001.0	1,009.9	999.9	1,007.0	1,025.4	1,053.5	1,065.3	1,061.5	1,068.8	1,051.4	1,046.4	1,045.8	1,046.1	1,047.0	1,047.6	1,048.2	1,047.3	1,046.9	1,046.9	1,045.9	1,043.6	1,042.9	1,044.1	1,044.9	1,046.0	1,047.1	1,048.5	1,050.0	1,049.0	1,049.2	1,049.2	1,047.2	1,046.5	1,046.2	1,047.4	1,049.2	1,050.1	1,051.4	1,053.5	1,054.0	1,053.1	1,053.8	1,053.7	1,051.7	1,050.9
Baker	DUAL-MEDS	356.7	352.5	351.3	344.1	340.2	340.8	335.4	336.3	340.6	337.4	339.0	341.3	342.0	347.1	347.6	348.4	348.8	349.2	349.9	350.2	350.9	351.5	352.1	352.5	353.1	353.7	354.2	354.8	355.2	355.5	356.1	356.4	357.0	357.6	358.0	358.5	359.0	359.5	360.0	360.6	360.9	361.2	361.7	361.9	362.6	363.1	363.5	363.9
Baker	ABAD & OAA	219.2	217.3	218.9	221.3	226.5	228.5	227.1	229.6	229.9	232.2	231.0	230.9	225.9	225.8	225.8	225.7	225.7	225.6	225.6	225.6	225.5	225.6	225.6	225.5	225.6	225.7	225.7	225.8	225.7	225.8	225.7	225.8	225.9	225.9	226.0	226.2	226.1	226.1	226.1	226.0	226.1	226.2	226.2	226.2	226.2	226.2
Baker	CAF	71.5	73.0	72.8	72.2	72.9	73.1	72.8	75.7	74.6	76.0	78.5	80.5	78.0	76.9	77.0	77.1	77.1	77.2	77.1	77.1	77.0	77.0	76.9	77.0	77.1	77.2	77.3	77.2	77.2	77.2	77.3	77.2	77.1	77.1	77.2	77.2	77.3	77.4	77.3	77.4	77.3	77.3	77.3	77.4	77.3	77.3	77.2	77.2
Baker	ACA 19-44	803.7	792.5	798.4	790.9	804.7	810.0	804.8	816.6	821.3	832.4	849.6	854.8	831.1	826.7	824.0	822.4	828.0	833.3	829.9	827.4	823.9	822.3	821.4	819.9	818.4	816.1	814.3	813.0	818.6	824.3	821.9	819.1	817.7	817.0	815.7	814.7	814.0	812.2	810.9	808.9	814.7	822.0	818.9	816.4	815.9	815.1	813.7	812.9
Baker	ACA 45-54	306.9	310.7	307.0	309.6	313.9	307.6	291.7	295.3	295.1	296.9	300.4	298.6	299.0	300.9	299.9	299.3	301.4	303.3	302.1	301.2	299.9	299.3	299.0	298.4	297.9	297.0	296.4	295.9	298.0	300.0	299.1	298.1	297.6	296.5	296.3	295.6	295.1	294.4	296.6	299.2	298.1	297.2	297.0	296.7	296.2	295.9
Baker	ACA 55-64	316.5	301.4	302.9	302.1	300.1	302.0	305.5	300.0	301.8	302.6	304.6	309.5	305.6	312.0	311.0	310.4	312.5	314.5	313.3	312.3	311.0	310.4	310.0	309.5	308.9	308.0	307.3	306.9	309.0	311.1	310.2	309.2	308.6	308.4	307.9	307.5	307.2	306.6	306.1	305.3	307.5	310.3	309.1	308.2	308.0	307.7	307.1	306.8
Baker	BCCP	1.0	1.0	1.0	1.0	1.1	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Benton	TANF	786.3	798.6	786.5	771.3	748.0	741.1	750.6	739.8	766.4	796.7	798.0	814.5	813.5	831.9	834.3	838.2	841.2	844.5	847.9	849.2	852.2	854.5	855.8	855.2	856.0	857.3	857.0	858.3	858.1	859.9	861.4	861.7	863.3	864.8	865.1	866.6	867.9	869.0	870.0	871.6	871.7	873.9	874.5	874.8	876.8	878.3	878.8	880.3
Benton	PLMA	93.2	92.2	101.6	94.5	88.4	86.0	82.5	85.0	88.3	79.0	77.4	72.9	80.0	73.2	72.5	72.5	72.1	72.0	72.5	72.2	72.3	72.3	72.1	71.6	71.5	71.6	71.2	71.4	70.9	70.9	71.1	70.8	70.8	70.3	70.2	70.1	69.9	69.8	69.8	69.3	69.5	69.5	69.3	69.5	69.5	69.1	69.0
Benton	CHILD 00-01	338.5	334.0	325.9	323.1	304.3	297.2	279.7	269.6	269.2	263.6	255.5	263.3	263.3	254.9	254.4	254.0	253.8	253.3	253.2	252.4	251.9	251.5	251.0	250.2	250.0	250.2	250.2	250.2	250.0	250.1	250.3	249.8	249.7	249.4	248.7	248.5	248.4	248.6	248.9	248.9	248.8	249.1	249.1	248.6	248.7	248.5	247.9	247.8
Benton	CHILD 01-05	1,319.1	1,293.3	1,319.0	1,326.3	1,316.7	1,305.9	1,324.0	1,321.6	1,312.2	1,337.1	1,349.9	1,352.0	1,346.3	1,328.0	1,326.7	1,326.4	1,326.8	1,326.6	1,327.0	1,325.0	1,323.8	1,323.1	1,321.5	1,318.2	1,317.3	1,318.6	1,319.4	1,320.4	1,321.1	1,322.4	1,324.0	1,322.4	1,322.4	1,322.0	1,319.2	1,318.2	1,317.8	1,319.1	1,321.2	1,321.9	1,323.0	1,325.3	1,325.8	1,324.2	1,325.0	1,324.6	1,321.9	1,320.9
Benton	CHILD 06-18	2,917.6	2,896.3	2,877.5	2,903.6	2,921.8	2,895.1	2,889.5	2,884.1	2,920.5	2,976.7	2,967.2	2,949.6	2,936.9	2,949.2	2,948.9	2,950.9	2,955.3	2,958.7	2,961.3	2,960.4	2,960.7	2,962.1	2,960.0	2,953.9	2,952.3	2,956.0	2,959.0	2,962.8	2,967.1	2,971.9	2,976.6	2,974.9	2,976.0	2,976.7	2,971.8	2,969.9	2,969.0	2,972.9	2,978.4	2,981.5	2,986.6	2,993.1	2,995.2	2,993.2	2,995.6	2,995.7	2,990.3	2,988.3
Benton	DUAL-MEDS	857.2	866.4	863.4	854.9	861.7	867.0	868.4	869.3	875.3	875.0	886.1	893.7	899.0	900.7	902.0	903.8	905.0	905.8	907.5	908.4	910.0	911.7	913.1	914.2	915.6	917.2	918.4	920.0	920.8	921.7	923.1	924.0	925.5	926.9	927.9	929.2	930.6	931.8	933.0	934.5	935.2	936.1	937.2	937.9	939.5	940.8	941.7	942.9
Benton	ABAD & OAA	542.1	544.1	539.4	537.6	539.8	543.9	540.9	544.7	547.2	544.3	541.6	544.7	544.3	548.9	548.8	549.0	548.8	548.4	548.6	548.2	548.1	548.2	548.2	547.9	548.1	548.3	548.3	548.3	548.7	548.4	548.2	548.5	548.2	548.3	548.4	548.3	548.6	548.7	548.9	549.3	549.0	549.0	549.0	548.8	549.1	549.2	549.1	549.2
Benton	CAF	209.6	210.5	213.7	214.1	218.1	219.0	217.4	221.4	227.5	221.8	225.3	217.7	218.4	224.9	225.0	225.4	225.5	225.5	225.6	225.5	225.3	225.2	225.0	224.9	225.2	225.5	225.6	225.9	225.7	225.8	225.9	225.8	225.7	225.6	225.3	225.3	225.6	225.7	225.9	226.2	226.0	226.2	226.1	226.1	226.1	226.1	225.8	225.8
Benton	ACA 19-44	3,613.7	3,592.7	3,500.2	3,562.9	3,624.1	3,581.8	3,640.2	3,740.9	3,795.2	3,829.7	3,866.0	3,849.3	3,819.1	3,788.1	3,775.9	3,768.5	3,794.1	3,818.3	3,802.9	3,791.4	3,775.6	3,767.9	3,763.9	3,757.2	3,750.2	3,739.5	3,731.3	3,727.2	3,766.1	3,753.4	3,746.8	3,743.7	3,737.6	3,733.1	3,729.9	3,721.9	3,715.6	3,706.8	3,733.3	3,766.7	3,752.4	3,741.0	3,738.6	3,735.3	3,728.6	3,725.2
Benton	ACA 45-54	727.6	724.0	721.8	717.2	716.8	718.3	713.3	725.4	743.7	749.0	754.9	762.3	764.5	774.5	772.0	770.5	775.7	780.7	777.5	775.2	771.9	770.3	769.5	768.2	766.7	764.5	762.9	761.7	767.0	772.3	770.0	767.4	766.0	765.4	764.2	763.2	762.6	761.0	759.7	757.9	763.3	770.1	767.2	764.9	764.4	763.7	762.3	761.6
Benton	ACA 55-64	809.1	797.5	795.3	787.8	784.1	792.9	806.7	816.9	827.4	839.5	824.9	821.6	817.6	816.5	813.9	812.3	817.8	823.0	819.7	817.2	813.8	812.1	811.3	809.8	808.3	806.0	804.3	803.0	808.6	814.2	811.8	809.0	807.6	806.9	805.6	804.7	804.0	802.2	800.9	799.0	804.7	811.9	808.8	806.4	805.8	805.1	803.7	803.0
Benton	BCCP	2.0	2.0	2.0	2.0	2.4	2.0	2.0	1.1	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Clackamas	TANF	4,715.2	4,687.8	4,677.6	4,697.5	4,729.9	4,709.5	4,652.6	4,609.4	4,683.9	4,810.0	4,818.8	4,837.7	4,836.2	4,877.8	4,892.2	4,915.1	4,932.4	4,952.1	4,971.7	4,979.6	4,997.3	5,010.7	5,017.9	5,014.7	5,019.5	5,026.9	5,025.2	5,032.7	5,031.6	5,042.2	5,050.8	5,052.5	5,062.4	5,070.8	5,072.5	5,081.3	5,089.2	5,095.6	5,101.6	5,110.8	5,111.5	5,124.4	5,128.1	5,129.3	5,141.0	5,150.0	5,153.0	5,162.1
Clackamas	PLMA	655.9	606.0	598.8	614.2	580.5	567.3	585.6	572.0	553.0	542.0	525.2	506.0	481.1	471.8	466.9	466.9	464.3	463.9	467.2	465.4	466.1	465.9	464.4	461.0	460.8	461.2	459.0	459.8	456.5	457.1	459.1	456.8	457.2	456.4	452.8	452.0	451.5	450.4	449.6	449.8	446.8	447.7	448.0	446.2	448.0	447.9	445.1	444.6
Clackamas	CHILD 00-01	1,692.5	1,660.9	1,653.8	1,624.1	1,631.0	1,632.6	1,638.7	1,615.1	1,622.9	1,616.2	1,603.3	1,577.8	1,554.1	1,540.8	1,537.7	1,535.9	1,534.4	1,531.9	1,531.5	1,526.9	1,523.8	1,521.4	1,518.6	1,514.2	1,512.9	1,514.0	1,514.2	1,514.4	1,513.5	1,513.9	1,515.2	1,512.1	1,511.5	1,510.2	1,506.2	1,504.8	1,504.4	1,505.3	1,507.4	1,507.2	1,506.9	1,509.0	1,508.7	1,506.0	1,506.7	1,505.7	1,502.1	1,501.0
Clackamas	CHILD 01-05	6,996.7	6,885.5	6,913.0	7,000.5	7,083.8	7,039.4	7,004.1	6,994.8	6,902.6	6,961.1	6,923.1	6,916.7	6,845.6	6,872.6	6,866.6	6,866.2	6,869.7	6,870.0	6,872.7	6,863.4	6,858.2	6,855.9	6,847.8	6,831.5	6,826.9	6,834.0	6,838.5	6,844.3	6,848.6	6,856.1	6,865.0	6,857.1	6,857.5	6,856.0	6,841.9	6,836.9	6,834.9	6,842.0	6,853.4	6,857.4	6,864.0	6,876.6	6,879.2	6,871.4	6,876.1	6,874.5	6,860.5	6,855.6
Clackamas	CHILD 06-18	16,429.3	16,205.7	16,157.3	16,373.4	16,411.0	16,286.0	16,251.9	16,225.5	16,280.1	16,379.5	16,319.8	16,322.7	16,210.1	16,066.3	16,068.1	16,083.3	16,112.0	16,136.1	16,152.4	16,153.3	16,159.1	16,171.0	16,161.7	16,130.3	16,121.9	16,142.9	16,161.2	16,184.5	16,212.2	16,240.9	16,268.2	16,261.8	16,269.4	16,275.5	16,250.4	16,240.4	16,235.8	16,258.4	16,289.7	16,308.7	16,340.2	16,377.2	16,390.9	16,382.0	16,396.1	16,398.1	16,369.4	16,358.6
Clackamas	DUAL-MEDS	5,237.0	5,265.6	5,222.0	5,229.5	5,222.6	5,185.8	5,188.7	5,198.0	5,234.2	5,244.2	5,287.7	5,316.2	5,324.3	5,332.6	5,342.2	5,355.2	5,364.2	5,371.5	5,383.6	5,386.4	5,390.4	5,393.1	5,403.0	5,414.9	5,425.7	5,434.0	5,444.4	5,455.3	5,464.1	5,475.4	5,481.8	5,488.4	5,498.8	5,505.5	5,516.6	5,526.8	5,534.5	5,543.6	5,553.0	5,561.8	5,570.5	5,580.2	5,586.0	5,592.6	5,600.5	5,606.3	5,617.3	5,626.6	5,633.7	5,641.9
Clackamas	ABAD & OAA	2,944.0	2,947.9	2,984.6	3,004.6	3,004.7	2,997.3	3,004.5	2,992.4	2,990.0	2,997.2	2,982.5	2,961.4	2,949.2	2,934.9	2,934.8	2,936.5	2,935.6	2,933.9	2,935.1	2,933.3	2,933.5	2,934.3	2,934.6	2,933.5	2,935.0	2,936.3	2,936.7	2,938.8	2,937.8	2,937.1	2,941.1	2,941.9	2,943.4	2,945.4	2,944.6	2,944.4	2,945.0	2,944.2	2,945.8	2,946.9	2,946.6	2,947.2
Clackamas	CAF	1,442.6	1,452.2	1,468.0	1,473.9	1,476.4	1,486.6	1,491.2	1,478.0	1,485.3	1,491.6	1,475.2	1,470.9	1,482.3	1,486.1	1,486.8	1,489.4	1,489.7	1,489.6	1,490.4	1,489.7	1,488.5	1,487.9	1,486.8	1,486.1	1,487.8	1,489.7	1,490.3	1,492.3	1,491.4	1,491.8	1,492.3	1,491.9	1,491.3	1,490.5	1,488.4	1,488.6	1,490.5	1,491.5	1,492.8	1,494.2	1,493.4	1,494.5	1,493.9	1,493.7	1,493.9	1,493.5	1,491.6	1,492.1
Clackamas	ACA 19-44	13,914.3	13,788.2	13,527.6	13,603.7	13,725.0	13,712.6	13,777.0	13,761.5	13,924.2	14,074.2	14,138.5	14,204.8	14,146.0	14,119.5	14,074.0	14,046.4	14,141.7	14,231.9	14,174.7	14,131.6	14,072.6	14,043.9	14,029.1	14,004.0	13,978.1	13,938.0	13,907.5	13,886.1	13,982.1	14,078.7	14,037.2	13,989.8	13,965.5	13,953.7	13,931.3	13,914.3	13,902.2	13,872.7	13,849.2	13,816.4	13,915.2	14,039.6	13,986.1	13,943.9	13,935.0	13,922.4	13,897.7	13,884.9
Clackamas	ACA 45-54	4,409.7	4,356.6	4,276.6	4,283.4	4,272.7	4,269.1	4,272.2	4,255.2	4,250.2	4,281.6	4,300.6	4,298.5	4,313.5	4,299.2	4,285.4	4,277.0	4,306.0	4,333.5	4,316.0	4,302.9	4,285.0	4,276.2	4,271.7	4,264.1	4,256.2	4,244.0	4,234.7	4,228.2	4,257.4	4,286.8	4,274.2	4,259.8	4,252.4	4,248.7	4,241.9	4,236.8	4,233.1	4,224.1	4,216.9	4,206.9	4,237.0	4,274.9	4,258.6	4,245.8	4,243.1	4,239.2	4,231.7	4,227.8
Clackamas	ACA 55-64	4,034.8	4,011.6	3,977.1	3,970.3	3,976.8	4,021.9	4,091.2	4,084.1	4,061.1	4,074.5	4,064.8	4,069.1	4,070.7	4,057.6	4,044.5	4,036.6	4,064.0	4,089.9	4,073.5	4,061.1	4,044.1	4,035.9	4,031.6	4,024.4	4,016.9	4,005.4	3,996.7	3,990.5	4,018.1	4,045.9	4,033.9	4,020.3	4,013.3	4,009.9	4,003.5	3,998.6	3,995.2	3,986.7	3,979.9	3,970.5	3,998.0	4,034.6	4,019.3	4,007.1	4,004.6	4,001.0	3,993.8	3,990.2
Clackamas	BCCP	12.0	11.0	8.4	9.0	9.8	9.4	10.0	10.0	11.0	10.9	11.4	12.0	12.0	12.2	12.2	12.2	12.2	12.2	12.2	12.2	12.3	12.3	12.3	12.2	12.1	12.1	12.1	12.1	12.0	12.0	12.0	12.0	12.1	12.1	12.1	12.0	12.0	12.0	12.0	12.0	12.0	12.0	11.9	12.0	12.0	12.0	12.0	11.9
Clatsop	TANF	567.5	573.3	568.7	591.8	607.9	589.5	574.7	570.3	572.4	589.6	601.5	604.1	618.6	618.5	620.4	623.3	625.5	628.0	630.4	631.5	633.7	635.4	636.3	635.9	636.5	637.4	637.2	638.2	638.0	639.4	640.5	640.7	642.0	643.0	643.2	644.3	645.3	646.2	646.9	648.1	648.2	649.8	650.3	650.4	651.9	653.1	653.4	654.6
Clatsop	PLMA	100.6	93.1	89.3	92.0	87.3	93.5	86.5	88.0	77.1	72.1	70.6	74.7	76.3	77.1	76.3	76.3	75.9	75.8	76.3	76.0	76.2	76.1	75.9	75.3	75.3	75.4	75.0	75.1	74.6	74.7	74.6	74.0	73.9	73.8	73.6	73.5	73.5	73.0	73.2	73.2	72.9	73.2	72.7	72.7
Clatsop	CHILD 00-01	239.8	239.5	233.6	230.5	227.0	223.1	212.2	206.9	202.8	205.5	202.5	198.6	202.2	207.3	206.9	206.6	206.4	206.0	205.9	205.3	204.8	204.5	204.1	203.5	203.3	203.4	203.5	203.5	203.3	203.4	203.5	203.1	203.0	202.8	202.3	202.1	202.0	202.1	202.4	202.4	202.3	202.6	202.5	202.1	202.2	202.1	201.6	201.5
Clatsop	CHILD 01-05	968.5	952.9	945.6	953.3	954.3	949.1	942.8	936.6	933.6	945.6	938.9	941.1	929.2	927.1	926.3	926.2	926.6	926.6	927.0	925.7	924.9	924.6	923.5	921.3	920.7	921.6	922.2	923.0	923.5	924.5	925.7	924.6	924.6	924.4	922.5	921.8	921.5	922.5	924.0	924.5	925.4	927.1	927.4	926.4	927.0	926.7	924.9	924.2
Clatsop	CHILD 06-18	2,144.0	2,128.3	2,131.1	2,184.7	2,201.7	2,172.4	2,162.4	2,149.8	2,191.3	2,219.9	2,195.5	2,217.1	2,213.9	2,209.5	2,209.6	2,211.4	2,215.0	2,218.0	2,220.1	2,219.8	2,220.4	2,221.7	2,220.3	2,215.9	2,214.7	2,217.5	2,219.9	2,223.0	2,226.5	2,230.3	2,233.9	2,232.8	2,233.8	2,234.5	2,230.9	2,229.5	2,228.9	2,231.9	2,236.1	2,238.6	2,242.7	2,247.6	2,249.4	2,248.0	2,249.9	2,250.1	2,246.1	2,244.6
Clatsop	DUAL-MEDS	767.9	767.5	770.8	775.6	770.0	776.7	775.9	772.4	772.2	777.2	777.0	779.2	782.8	788.8	790.0	791.7	792.7	793.5	795.1	795.9	797.4	798.9	800.2	801.3	802.5	803.9	805.0	806.4	807.2	807.9	809.3	810.0	811.4	812.7	813.6	814.8	816.0	817.1	818.2	819.5	820.2	821.0	822.0	822.7	824.1	825.3	826.1	827.1
Clatsop	ABAD & OAA	463.7	466.5	460.9	459.9	458.8	465.6	462.5	464.5	469.0	469.3	464.7	459.1	464.5	463.1	463.0	463.3	463.1	462.7	462.9	462.5	462.5	462.6	462.6	462.3	462.5	462.7	462.7	463.0	462.8	462.7	462.8	462.6	462.7	462.8	463.0	463.1	463.3	463.6	463.4	463.3	463.4	463.6	463.5	463.6
Clatsop	CAF	242.0	241.4	242.1	245.2	246.9	240.7	237.9	243.0	231.8	225.1	227.9	223.2	225.0	227.0	227.1	227.5	227.5	227.6	227.5	227.3	227.2	227.1	227.0	227.2	227.5	227.6	227.9	227.8	227.6	227.8	227.9	227.9	227.8	227.6	227.8	228.0	228.2	228.1	228.3	228.2	228.1	228.2	228.1	227.8	227.9
Clatsop	ACA 19-44	2,065.9	2,058.5	2,026.6	2,030.5	2,033.5	2,006.3	1,988.7	1,995.8	2,036.5	2,047.2	2,064.0	2,093.6	2,085.5	2,086.2	2,079.5	2,075.4	2,089.5	2,102.8	2,094.4	2,088.0	2,079.3	2,075.0	2,072.8	2,069.1	2,065.3	2,059.4	2,054.9	2,051.7	2,065.9	2,080.2	2,074.0	2,067.0	2,063.4	2,061.7	2,058.4	2,055.9	2,054.1	2,049.7	2,046.3	2,041.4	2,056.0	2,074.4	2,066.5	2,060.3	2,058.9	2,057.1	2,053.4	2,051.5
Clatsop	ACA 45-54	695.1	687.9	687.6	685.5	691.5	683.0	686.5	680.8	676.0	672.5	667.5	671.9	668.3	669.7	667.6	666.2	670.8	675.0	672.3	670.3	667.5	666.1	665.4	664.2	663.0	661.1	659.7	658.6	663.2	667.8	665.8	663.6	662.4	661.8	660.8	660.0	659.4	658.0	656.9	655.3	660.0	665.9	663.4	661.4	661.0	660.4	659.2	658.6
Clatsop	ACA 55-64	804.1	791.5	773.4	764.4	742.6	736.9	725.5	736.6	752.7	758.4	758.2	773.8	780.3	779.7	777.2	775.6	780.9	785.9	782.7	780.3	777.1	775.5	774.7	773.3	771.9	769.7	768.0	766.8	772.1	777.4	775.1	772.5	771.2	770.5	769.3	768.3	767.7	766.1	764.8	762.9	768.4	775.3	772.3	770.0	769.5	768.8	767.4	766.7
Clatsop



Calendar Year 2020 Maternity Case Rate Forecasts

Historical Counts and Projected by Enrollment Forecast and Delivery Utilization Rate

County	Procurement Rating Region	Historical Case Rates (July 2017 - June 2018)	Estimated Case Rates by Enrollment Forecast
Baker	Service Area 1	88	69
Benton	Service Area 8	162	166
Clackamas	Service Area 7	1,078	992
Clatsop	Service Area 6	160	149
Columbia	Service Area 6	167	159
Coos	Service Area 9	322	293
Crook	Service Area 2	136	123
Curry	Service Area 9	103	92
Deschutes	Service Area 2	696	727
Douglas	Service Area 4	533	478
Gilliam	Service Area 1	7	4
Grant	Service Area 1	24	23
Harney	Service Area 1	30	31
Hood River	Service Area 3	92	73
Jackson	Service Area 4	1,052	1,024
Jefferson	Service Area 2	95	108
Josephine	Service Area 4	518	511
Klamath	Service Area 4	369	318
Lake	Service Area 1	24	32
Lane	Service Area 8	1,461	1,532
Lincoln	Service Area 8	183	187
Linn	Service Area 8	577	533
Malheur	Service Area 1	223	176
Marion	Service Area 5	1,667	1,342
Morrow	Service Area 1	56	40
Multnomah	Service Area 7	2,695	2,696
Polk	Service Area 5	282	252
Sherman	Service Area 3	0	3
Tillamook	Service Area 6	97	91
Umatilla	Service Area 1	398	315
Union	Service Area 1	117	113
Wallowa	Service Area 1	24	24
Wasco	Service Area 3	132	116
Washington	Service Area 7	1,433	1,394
Wheeler	Service Area 1	6	4
Yamhill	Service Area 5	363	347

Attachment 12 — Cost and Financial Questionnaire

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.

A.1. Does Applicant have internal measures of clinical value and efficiency that will inform delivery of services to Members?

If so, please describe.

UHA's Utilization Management Committee (UMC) has developed several reports that define claims, member utilization and overall costs for discrete service lines, specialties, and facilities. They track the growth of these activities over a 3-year timeline to ascertain potential over- and under-utilization by trending patterns. UHA's Chief Medical Officer is the chair of the UMC that meets monthly to discuss the standard reports described above along with specific analysis of areas of increased costs or utilization. Hypotheses generated are evaluated with drill-down analysis. These trends also provide potential network adequacy gaps. Our goals include keeping overall cost of care trending below 3.4% annually to support OHA's 1115 waiver.

[redacted] In recent years, UHA has paid close attention to the percent of premium spent on behavioral health, primary care, and specialty care. We are striving to increase the first, enhance the second, and ensure that the last is appropriate and conforms with the guidelines of the Prioritized List as outlined by the HERC. We believe this approach emphasizes wellness and prevention over "sick care".

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?

UHA's UMC is appointed and charged with the obligation to manage the medical costs of the CCO through appropriate application of the Prioritized List and Oregon Administrative Rules (OAR) for claims management. The UMC routinely monitors and identifies UHA costs and utilization trends to make informed interventions as necessary. The UMC may apply a prior authorization requirements to monitor the safety, efficacy, and appropriateness of services or supplies. It may also recommend other strategies, such as additional care coordination to potentially reduce costs and improve patient outcomes. The UMC also provides constructive feedback in operationalizing utilization management strategies, collaboration for optimizing medically appropriate care, and advocating for education.

UHA proactively monitors for **unnecessary spending** through its Claims Analyst, third-party

administrator (TPA), and BI vendor. Both the TPA and UHA Claims Analyst are able to monitor claim submissions to prevent payment of claims that either contain errors or lack certain information for the claims to be properly processed. UHA's BI vendor enables UHA to analyze claims data and to produce data mining reports to examine utilization and billing outliners. These audits help identify sources of inefficiencies and waste that can be modified and areas that can be improved.

One critical key to improving quality and outcomes while managing costs is our approach to working with providers. UHA is actively working with our contracted providers to increase transparency on less costly alternatives for care. For example, UHA publishes prices in our formulary so providers can see the costs. Board meetings are public, which encourages member feedback. This transparency helps control costs and reduce inefficiencies and wasteful spending. Having third party claims, concurrent and retrospective reviews, audits and consistent PA processes creates an accountability among providers. Providers know we examine billing and coding value of procedures. This approach both encourages the use of more cost-effective options, but also increases provider satisfaction. UHA's Clinical Advisory Panel provides input into where our efforts are best deployed in terms of high quality, cost-effective care.

Within this context, UHA uses the following **proactive systems and processes** to target waste and enhance efficiencies:

- [redacted]
- [redacted].
- UHA has established policies and procedures for the review of prior authorizations, including the requirements for adverse benefit determinations (ABD), at UHA and by subcontractors. Staff receive training on these requirements to ensure compliance and parity, and UHA uses IRR analysis to ensure that utilization management criteria are applied consistently.
- UHA examines areas of potential waste using UmpquaOneChart, which is a community electronic health record (EHR) to identify improper payments and connects providers across the community.
- UHA's pharmacy director reviews prescription claim information to identify high costs or high utilization drugs being prescribed for our members, in order to research possible alternative medications that are as clinically effective but lower costs. UHA's Pharmacy Benefits Manager (PBM) subcontractor routinely audits pharmacies and provides UHA with a variety of reporting tools to detect and prevent FWA.
- Reviews of appeal and grievance data can suggest issues that could be addressed through provider or member education, or referring members to case management for additional individualized assistance.

- [redacted]
- Waste and abuse are included in UHA's Compliance Plan, which applies to all internal personnel as well as external personnel (i.e. individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities, and their workforce).
- Additionally, UHA has adopted a Choosing Wisely initiative to encourage providers to avoid unnecessary medical tests, treatments and procedures. The Choosing Wisely initiative has a variety of resources to assist providers including a mobile app, print materials, and signage. The resources are educational for providers and members with recommendations rooted in evidence-based practices. This program encourages treatment with more efficiency and less waste.

UHA's BI software environment has enabled staff to arrive at several population insights. For example, an extensive study was done to test for any outcome disparities in state-reported metrics for our assigned population based on race, ethnicity, and gender.

Lastly, the organization has invested substantially in its Third Party Recovery (TPR) Department. The TPR department is responsible for taking all reasonable actions to pursue recovery of Third Party Liability (TPL) for covered services. The TPR department uses multiple resources to help identify members with TPL: Providers and Facilities, Attorneys, Members, Insurance Companies, Weekly/Monthly Audit Reports, Claims Department, Medical Review Personnel, Unsolicited Refunds, Oregon Health Authority, and Law Enforcement.

A.3. Does the Applicant have a strategy to use Health-Related Services to reduce avoidable health care services utilization and cost?

UHA does have a strategy for Health-Related Services (HRS) to reduce avoidable health care services utilization and costs. Historically, the organization has made substantial investments into programs that ultimately reduce unnecessary and avoidable expenses while ensuring optimal members outcomes. Currently, the organization offers the following HRS aimed at reducing avoidable health care costs:

- Care Coordination Programs

  UHA invests a significant amount of staffing and resources to reduce unnecessary and avoidable health care through its Care Coordination program. The Care Coordination programs are designed to address barriers to ensure quality outcomes. Specifically, the Care Coordination programs tackle the following domains:

  - New Day Program

    UHA's New Day Program assists pregnant women struggling with substance abuse, as well as other challenges. From August 2017 through the end of February 2019, 101 patients have enrolled in the program. This has thus far resulted in 66 healthy births (including two sets of twins), with 60 babies going home with mom

after being released from the hospital. The success of the program's healthy births has reduced the need for neonatal intensive care unit stays.

Currently members are transitioned off the program at six weeks postpartum. Based on member feedback, Umpqua Health is implementing New Beginnings, a program to identify and support children ages 0–5 at high risk. This continuum of care will ensure members are stable during a very critical period of early childhood development. The New Day Program is also planning to add a traditional health worker and peer support groups.

- Intensive Case Management Program

  UHA has implemented a three-tier system for members. The first tier consists of members that require intensive care management coordination services (ICC), who are members with overutilization of services (such as ED visits), chronic conditions, co-morbidities, and social determinants of health issues, such as homelessness. These members have a case manager assigned to them and are discussed regularly in Interdisciplinary Team (IDT) meetings with a detailed assessment and care plan.

- Behavioral Health Case Management Program

  UHA is currently in the process of hiring a Behavioral Health Manager, additional Behavioral Health Care Coordinators, and a Traditional Health Worker (THW), who will ultimately be responsible for the utilization and coordination of Behavioral Health services. The strategy behind this integration is to have an understanding of members' needs and establish higher collaboration and coordination with members and the providers.

- Chronic Disease Case Management Program

  The Chronic Disease Case Management program is comprised of well-trained, highly experienced, certified personnel each of which may have a number of particular strengths in understanding and assisting members with unique Case Management needs. All of the team members may be involved in assisting members with a wide array of chronic conditions, but particularly those with specialty strengths in diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, infectious diseases, and palliative care. Case management staff evaluate, plan, implement, and coordinate services according to the members' health care and psychosocial needs in close collaboration with the member's medical and community partners.

- Transitional Care Program

  In 2018, UHA launched its Transitional Care Program to address avoidable hospital readmissions. The program adopted a validated model to curb inpatient growth by reducing wasted services and avoidable readmission. The three-prong approach includes the Eric Coleman *Care Transition Interventions* (CTI) of coaching model, care coordination with UHA and Mercy Medical Center's nurse case managers and discharge planners, and access to provider services. Because most of the work is done through coaching and care coordination, the HRS investment into the program helps make it

sustainable, while reducing readmissions.

- Diabetes Education

  Beginning in late 2018, UHA trained its Care Coordinator on facilitation of the Diabetes Education and Empowerment Program (DEEP). This six-week program is offered to any UHA members and their families with diabetes to educate and empower them to manage their disease. The idea behind the program is that with education and empowerment members will be self-reliant in managing their diabetes to reduce future complications. HRS funds are used to pay for the DEEP training.

- Quit 4 Life

  UHA offers a proven and effective tobacco cessation program to its members. The Quit 4 Life program uses evidence-based strategies to curb member's tobacco addiction. Knowing that tobacco uses is a key contributor to future health issues, early intervention and treatment is so important in reducing future health concerns. HRS funds are utilize to support the cost to deliver the program to UHA members.

A.4. What is the Applicant's strategy for spending on Health-Related Services to create efficiency and improved quality in service delivery?

For HRS items related to improved quality in services, UHA has invested in programs and systems that provides our provider community actionable data to improve quality. Specifically, the organization intends to make the following HRS investments to improve quality:

- EMR Subsidy: UHA will continue to support contracted providers by offering an EHR subsidy and aid with the adoption and implementation strategies of a certified EHR.
- The inteligenz System, Provider Portal: UHA's PCPCH provider network has access to HIT through our BI software's provider portal to monitor the real-time status of the current year CCO metrics on a provider level, or at the community level. The tool allows PCP providers to view member level CCO metric gap information that enables providers to strategically close metric gaps. The report identifies new members that may be assigned to providers and any metrics they may qualify for. Providers can skillfully schedule patients and close multiple metric gaps during a single visit.
- Milliman Software: Risk stratification software uses individual member's MARA (Milliman Advanced Risk Adjusters) concurrent and prospective scores. UHA uses this software to measure its quality across multiple national benchmark standards.

In addition to HIT and community initiatives, UHA engages individual members to address a variety of needs that improve health outcomes and the quality of services. Providers are encouraged to submit requests for individual members for qualifying Flexible Services which are reviewed by case management to ensure appropriateness, efficiency, and the value of the request. Flexible Services have also historically been used to improve access to health care through transportation benefits, or items specific to members' needs to improve their health quality, such the following:

- Home and living environment items or improvements not otherwise covered by 1915

Home and Community Based Services authorities

- Non-Durable Medical Equipment (DME) items to improve mobility, access, hygiene, or other improvements to address a particular health condition such as an air conditioner, athletic shoes, or other special clothing;
- Transportation not covered under State Plan benefits; and
- Housing support.

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?

Through collaborative efforts, Health-Related Services (HRS) are applied to areas demonstrating the greatest needs of the community. For SDOH investments the organization uses two approaches to meet these ideas:

1. CCO Directed Investments
2. Community Advisory Committee (CAC) CHP Program

CCO Directed Investments

Strategic Investments: Annually, the CCO looks to identify areas where it needs to invest in items on more programmatic and system level to address SDOH-HE items. Specifically, the organization has made the following investments on a program level to reduce SDOH-HE:

- Bay Cities Flexible Transportation

  UHA recognized that rural areas such as Douglas County often have limited public transportation and there are many factors that prevent members from have reliable private transportation. This insufficiency can lead to barriers accessing care, which may furthermore lead to a decline in physical, behavioral, and oral health. Transportation has historically been an issue for members getting to and from appointments, picking up prescription medications, consistent with standard non-emergent medical transportation (NEMT) coverage. UHA works with Bay Cities for NEMT and has also contracted with them for expanded service to support members to meet additional transportation needs.

- Temporary Phones

  UHA provides cell phones to members discharged from the hospital and Emergency room or in a defined program (New Day) to ensure communication for follow-up care, thus avoiding readmission or deterioration of status. (We strive to replace these interim phones with more permanent ones through federal programs.)

- Transitional Care Program

  The transitional care program supports members through discharge planning and follow up. The program includes home visits when appropriate which is an effective way to address the needs of homebound members and evaluate social determinants of health.

- Traditional Health Workers

  THWs assess social determinants of health and address barriers. They assist the member in peer-delivered support by collaborating with providers and using community resources

to provide the member with needed services. They work with care managers to improve outcomes, and address barriers to the integration of care by collaborating with behavioral, physical, and oral health providers. They ensure patients receive the right care at the right time and in the right place.

Evaluation: Annually, UHA goes through a strategic initiatives process with its leadership team and Board of Directors to identify opportunities to improve outcomes, improve quality, and reduce SDOH-HE barriers. During these planning sessions, the organization identifies key programs in which to invest to meet the demands of the community, its members, and the ever evolving regulatory environment. These investments tend to be more focused on the "big picture," investments, or areas where UHA recognizes that a significant need exists, but that the community has limited resources to support those needs. For example, in 2017 UHA recognized that it was experiencing barriers with members being seen timely post hospitalization. The feedback the organization received was the lack of timely follow up was a multi-faceted problem including provider availability, proper discharge planning, member barriers, and care coordination. To improve on access, UHA opened in 2018 its Transitional Care program to support members who have barriers for timely follow up visits. UHA also empowers the case management team to identify and eliminate barriers to optimal health outcomes. For example, gym memberships or transportation to an AA meeting are targeted so the funds are spent effectively. UHA feels that we can give the case management team these tools to interact with the member to resolve barriers.

CAC CHP Program

The Community Health Improvement Plan (CHP) development enables UHA's CAC to identify the community needs and fund the community benefit initiative portion of the HRS. The CHP Program application identifies who is eligible to apply, how to apply for funding, and the process by which the funds are awarded by the CAC. The CHP is currently focused on access to care, addictions, mental health, parents and children, and healthy lifestyles.

Strategic Investments: The CHP has used HRS to fund numerous community wide programs addressing SDOH to improve health outcomes and alleviate health disparities and promote health equity. The following programs are examples of funded programs to improve community or public health:

- Mobile Food Market: A Mobile Food Market (MFM) travels to community sites in designated food deserts (Glendale, Sutherlin, and southeast Roseburg). The MFM is stocked with local produce when available.
- Kick Start Douglas County: In 2017, more than 3,200 people participated in the 15 unique activities offered throughout the summer.
    - 90% of participants believe the program helped to add physical activity to their lives.
    - 88% indicated that they'd seen health improvements because of the program.
    - 82% of participants said they would continue healthy activities beyond the program.
- Play2Learn & Growth Mindset Series: This series offers parenting education opportunities in which the parents can interact with their children while learning about how play encourages learning. This class series is offered in conjunction with a workshop for parents to explore the concept of growth mindset. In 2017, the 18 participants reported a 14% increase in

overall kindergarten readiness factors. These factors include feeling confident in knowing how to best promote their child's reading at home, feeling prepared to help their child enter kindergarten, and feeling that their child understands and can follow the rules. Two-thirds of Growth Mindset workshop participants said the workshop was very helpful and that they will use the materials and resources a lot.

- Partner Sports Camp: This summer camp pairs volunteer students with campers who are identified as having intellectual/developmental disabilities, physical disabilities, and mental health needs.
- Cooking with Double Up Bucks: Funds are used to double the Double Up Bucks food benefits for low socio-economic status families who shop at the Southside Community Farmers' Market, and to provide cooking classes at the market.
- Clubhouse: This project established a Clubhouse in Douglas County, which is a place for individuals living with mental illness to find opportunities for friendship, employment, housing, education, and more.

Housing supports related to social determinants of health helped with temporary housing or shelter, utilities, or critical repairs:

- Case Management: Case managers averaged 21 visits a month in 2018. Half of all people referred were homeless at the time of referral. Of those, Optimal Health Management was able to secure housing for 50% of the people.
- Tiny Home Village: Funding helped establish a community of tiny homes in Roseburg. Valiant Seed plans to build 13 homes. The site plans also include an engagement center, complete with classrooms, laundry capabilities, and more.

CHP Programs also assisted with food or other social resources, such as supplemental food, referral to job training, or social services, for example:

- Friendly Kitchen/Meals on Wheels of Roseburg: Funds are used to provide seniors and adults with disabilities a hot, nutritious meal once a day, Monday through Friday.
- Full Tummies, Healthy Kids: CHP funding enabled 1,164 children to receive additional food and diapers when accessing services at FISH Food Pantry. Before this project, children were receiving 36 ounces of infant food, along with a container of single grain cereal and a can of infant formula. With this funding, infants received as much as 58 ounces of infant food, as well as the cereal and formula. In addition to food, parents and caregivers of infants were given twice as many diapers and wipes as they had received before CHP funding.

These programs and many others support improvements in health equity, access, and address social determinants of health.

Evaluation: The CHP application requires that projects have *specific, measurable outcomes*, and a defined outcome criteria. The outcome criteria may be different for every project, but should include a specific way to measure the level of performance or achievement that occurred because of the activity or services the organization provided.

- Interim reports are required for project-related investments, including pre- and post-test metrics of success. Final reports from each project are analyzed through CHP progress reports each year.

- UHA uses EHR data to analyze utilization on a regular basis. Claims data can measure the utilization and costs to compare before and after interventions.
- The prevalence and changes in complaints also enables UHA to measure the effectiveness of HRS. Categories for grievances include issues related to access to care, non-emergent medical transportation, provider bias, cultural barriers/sensitivity, language/translation, and member rights.

UHA carefully targets its programs to ensure that costs incurred in HRS are really going to meet the greatest need. Moving forward, all programs and projects that receive funding through UHA's community benefit initiative funding stream must align with the five key focus areas identified in UHA's most recent CHP. Community partners analyzed data found in UHA's Community Health Assessment (CHA) to determine strategies for the CHP. In 2017, UHA's CAC partnered with Umpqua Community Health Center (an area FQHC) and United Community Action Network, a local social service provider, and began working on an updated assessment. They followed a similar creation process as the 2013 CHA, including community surveys, focus groups for targeted populations, and secondary quantitative data collection. CAC members had a strong voice in the review process and provided feedback to help UHA complete a final version. Now that the CHA is updated, the CAC has begun updating the Community Health Improvement Plan. This work will help UHA understand the community health findings and plan the best ways to address the needs identified. The updated CHP will be complete by June 30, 2019. UHA plans to continue to engage in collaborative efforts with community partners, including projects that focus on SDOH and other social complexities.

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).

B.1. Does Applicant currently measure, track, or evaluate quality or value of Hospital services provided to its enrollees?

If so, please describe.

UHA monitors the quality of hospital services to its members. In particular, UHA works closely with its sole community hospital, Mercy Medical Center (MMC), to avoid unnecessary hospitalizations and emergency room visits with a focus on decreasing 30-day readmissions. MMC and UHA share data on the OHP population hospitalized locally. MMC has granted (read only) access to hospital EHR and patient wards for UHA case managers to initiate optimal discharge planning and follow-up needs and education on discharge. Medication reconciliation by hospital pharmacy staff and a UHA Transitional Care Team is an important feature. UHA and MMC work with local PCP clinics to schedule follow-up office visits within 7 days of discharge, which in a recent study of a Medicaid population has been shown to reduce hospital readmission.

UHA provides concurrent review of hospitalizations outside of Douglas County and conducts more focused reviews of MMC hospitalizations, which comprise ~90% of admissions. Our Case

Management programs allow for a cross sectional review of both ambulatory and hospital care, which then informs more focused review. For example, UHA has found that focused review of all 1-day length of stay provides accountability to the prospective payment system; applying InterQual criteria allows for an evidence-based evaluation of use of Observation and Inpatient status in the hospital to ensure cost efficient expenditure of resources. We also monitor admissions for hospital acquired conditions and 30-day readmissions and apply the OARs for determination of payment.

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.

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?

UHA has historically and intends to continue to distribute Quality Pool earnings to non-clinical providers, such as SDOH-HE partners as approved and funded through our Community Advisory Council programs. [redacted]. Moving forward, UHA will evaluate this level of incentive to determine its impact and as needed, adjust to optimize outcomes.

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.

Quality Pool earnings have historically been distributed by UHA amongst our clinical providers that include Primary Care Providers, Dental Care Organizations, Mental Health Agencies, and Substance Use Disorder providers which represent upwards of [redacted] total Quality Pool earnings. The remaining 10% would be distributed as detailed above in Section C.1 and A.5. The HRS that receive funding through UHA's community benefit initiative funding stream must align with community priorities and be approved through the rigorous process described in Section A above.

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?

UHA annually distributes [redacted] of the Quality Pool earnings to outside organizations based on the categories detailed above in Section C.2

C.4. How will the Applicant decide and govern its spending of the Quality Pool earnings?

UHA has a board-approved budget that includes an incentive pool for the CCO Quality Pool. Once the incentive pool for distribution has been established for each budget year the amount in such fund shall be allocated pro rata across all applicable metrics. The amount allocated to each

metric shall be divided among the providers who meet that particular measure. The funding and payment of the program is contingent on UHA receiving 100% of the Quality Pool from OHA. In the event that UHA does not receive 100% of the program, UHA may reduce the amount of the funds to be distributed. In 2019, primary care, mental health, SUD, and dental care providers are eligible for the pool.

C.5. When will Applicant invest its Quality Pool earnings, compared with when these earning are received?

Traditionally, and through the Quality Pool program definitions and details, UHA invests its quality pool earnings within 60 days of funding receipt from OHA.

C.6. Does the Applicant have sufficient cash resources to be able to manage a withhold of a portion of its Capitation Payments?

UHA has sufficient cash reserves to manage a withhold of a portion of its Capitation Payments and does not foresee a cash shortage. UHA closely monitors required cash outflows each month to ensure appropriate timing of payments to maximize cash balances, while remaining fully compliant with payment terms. UHA can receive contributions from its Parent, Umpqua Health, LLC if additional cash is required.

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.

D.1. Please describe the Pharmacy Benefit Managers (PBMs) arrangements Applicant will use for its CCO Members.

UHA has an agreement with MedImpact for Pharmacy Benefit Management (PBM) services. We feel it is important to maintain local control as much as possible. We manage much of pharmacy program internally, including formulary management, utilization management and customer service. We primarily use MedImpact for pharmacy network contracting and claim adjudication. Through MedImpact, our contracted network pharmacies are electronically linked for real-time claims adjudication. MedImpact 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.

D.2. Does Applicant currently have a "no-spread" arrangement with its PBM?

Yes. Our current pharmacy pricing is [redacted] This provides a performance incentive for MedImpact to negotiate lower pharmacy rates. MedImpact has agreed to remove P4P from our contract for the CCO 2.0 amendment, if requested.

D.3. Does the Applicant obtain 3rd party market checks or audits of its PBM arrangement to ensure competitive pricing?

Yes, we currently obtain third party market checks of our PBM arrangement to ensure competitiveness of the financial guarantees, rates, and fees. The current contract allows for one

market check twenty-four months into the four-year contract that compares aggregate pricing based on claims processing fees (administration fee), network discounts, and any products/services we have elected. However, MedImpact has committed to annual market checks starting in 2020. If the market check results in a finding that current market conditions can yield a pre-determined percentage of savings of gross plan costs (defined as eligible charges plus base administrative fees), then we will negotiate in good faith and execute a revision to the existing pricing terms. Market checks shall review the pricing both in aggregate and by each price point (discounts, dispensing fees, and administrative fees) independently. Additionally, MedImpact has agreed that an independent auditor can review and audit contracts or relevant portions of contracts with manufacturers and data specific to the administration of participating program's pharmacy program for compliance with the pass-through terms of this RFP.

D.4. Does the Applicant plan to use the Oregon Prescription Drug Program to meet the PBM transparency requirements?

Currently, we do not plan to use the Oregon Prescription Drug Program (OPDP) to meet the PBM transparency requirements. According to the analysis of a third-party consultant, our current contract has better rates than the OPDP offer. If the OPDP rates were to change and have demonstrable cost-savings, then we would consider joining OPDP at that time.

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 well as the coverage and Prior Authorization criteria for all pharmaceutical products.

E.1. Does Applicant currently publish its PDL?

UHA has designed an evidence-based Preferred Drug List (PDL) and associated Utilization Management (UM) criteria to ensure our members have access to safe and effective drugs at the best value. Our preferred drug list is publicly posted on our website, which is accessible to members, prescribers, pharmacies and the OHA.

E.2. Does Applicant currently publish its pharmacy coverage and Prior Authorization criteria concurrently with or in advance of changes made?

We are actively working towards publishing UHA's pharmacy coverage and prior authorization (PA) criteria in its entirety for our public website, and these documents will be ready by 2020 to post on our website. They will be posted concurrently or in advance of negative changes. Additionally, we notify members and providers in advance of any negative changes impacting them. We wholeheartedly support efforts to allow easy access to these materials publicly and will comply with providing both the PDL and associated PA criteria in other formats or through other distribution channels as specified by the Oregon Health Authority (OHA).

E.3. To what extent is Applicant's PDL aligned with OHA's fee-for-service PDL?

In order to assess, with complete accuracy, the degree of alignment with OHA's fee-for-service (FFS) PDL, we would need OHA to provide us with an electronic version of the FFS PDL at a national drug code (NDC) level. However, based on the information provided a preliminary

analysis estimated our PDL is 71 percent aligned with the FFS PDL. In 2018, the Oregon Health Authority (OHA) contracted with Myers and Stauffer, an accounting firm, to perform an evaluation of PDL alignment. In their report, Myers and Stauffer stated that a large portion of CCO utilization and spend is already aligned with the FFS PDL. Nine percent of the CCO claims and 26 percent of the CCO spend were for FFS non-preferred drugs under the FFS PDL.

After considering safety and efficacy, we prefer agents based on our lowest net costs. We follow Oregon Administrative Rule 410-120-1200 stating that the Division "shall make no payment for any expense incurred for any of the following services or items that are similar or identical to services or items that will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same". Due to the proprietary and confidential nature of federal rebates, CCOs do not have access to drug-specific rebate information and are not able to determine which drugs are the lowest net cost for the OHA. Thus, we generally do not make PDL decisions based on federal rebates. Supplemental rebates are usually minimal and generally do not drive differences in our PDL compared to the FFS PDL.

E.4. Does the Applicant plan to fully align its PDL with the fee-for-service PDL?

UHA has been an active and vocal participant in PDL alignment discussions to date, and would prefer to maintain control of its own PDL. The alignment process will likely be complicated and could result in unintended consequences. We are eager to assist the OHA during this process with our pharmacy data analytics and operations experience. We will continue to advocate for a thorough and complete data analysis to determine the best strategy for alignment and to avoid unintended consequences such as increased pharmaceutical costs or member disruption. Alignment will likely result in increased gross costs to UHA, thus aligned drug classes will need to be excluded from the 3.4 percent growth calculation. We expect that prior to moving forward with alignment, the OHA will follow Myer and Stauffer recommendations to evaluate the impact to CCO capitation rates and consider use of an Administrative Services Organization (ASO) model of aligned classes where the OHA pays administrative fees to the CCOs for claims processing-related activities and reimburses the CCO directly for aligned therapeutic class pharmacy expenditures. UHA also strongly believes that prior to moving forward with any changes, a multi-faceted strategy is needed to alert members and prescribers of any formulary and prior authorization changes resulting from alignment, and to minimize potentially harmful therapy disruption. We are eager to participate in this process and collaborate with the OHA and CCOs.

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.

F.1. Does Applicant or any Affiliate of Applicant currently report on National Association of Insurance Commissioners (NAIC) health insurance forms?

If so, please describe the reporting company or companies and its relationship with Applicant.

UHA currently does not report on a NAIC forms. One of UHA's affiliates, ATRIO Health Plans, does report on NAIC insurance forms.

F.2. Does the Applicant currently participate and file financial statements with the NAIC?

UHA does not currently file financial statements with the NAIC.

F.3. Has Applicant prepared a financial statement which includes a RBC calculation?

If so, please submit.

UHA has prepared a financial statement that includes RBC calculation. It is included in submitted financials.

F.4. Does the Applicant currently have experience reporting in SAP either directly or through any Affiliate of Applicant?

Umpqua Health Alliance has no direct experience reporting in SAP, however, we own a minority share of stock in an affiliate that does report under SAP annually.

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.

Yes, an exemption will be required.

(a) Currently, Umpqua Health Alliance does not have an insurance license through the NAIC. The application must be filed and awarded. Umpqua would need to obtain a reporting software specific to Statutory Accounting Principles, staff training, and identify and contract with experts in Statutory Accounting and work with external auditors for a transition to SAP from GAAP.

(b) Umpqua plans to submit for licensure from NAIC in early 2020 and build into the 2020 Budget an IT & capital projects plan to procurement the required software. Additionally, we would need to work with our CPA firm to identify training necessary and potential contractors to help transition to SAP reporting guidelines.

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 Documentation

We have included the following requested documents:

- Completed Pro Forma Workbook Templates (NAIC Form 13H)
- Completed NAIC Biographical Affidavit (NAIC Form 11)

- Completed UCAA Supplemental Financial Analysis Workbook Template
- Three years of Audited Financial Reports – (2016-2018)

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.

G.1. What strategies will the Applicant employ to achieve a sustainable expenditure growth year over year?

UHA's overall budget process aims to achieve a sustainable expenditure growth each year. We use multiple strategies in our budgeting process to ensure sustainable growth.

G.2. How will the CCO allocate and monitor expenditures across all categories of services?

UHA allocates and monitors expenditures through multiple domains, including during the annual budgeting and rate setting process, through monthly financial variance reports, our Utilization Review committee, and routine system reports (such as the Continuity of Care and Clinic Cohort Cost Reports).

During the budgeting process the organization focuses on maintaining a rate of growth within 3.4%. During this process, the organization looks at trends in each service category to identify potential overage of expenditures. UHA then looks at the opportunities it has to implement activities to stay within the rate of growth through enhanced care coordination and utilization activities. Also, the organization uses this information to determine if different contracting is needed in order to fully account for any applicable trend and program enhancements.

As to monthly financial variance reports, UHA prepares financial reports that are presented to the Board of Directors to identify how the plan is performing against the budget. Depending on the feedback from the Board, UHA staff then take additional activities to help curb any

variances. Such activities may include additional utilization management, contract changes, or other program enhancements.

UHA also has a Utilization Management committee with the sole task of reviewing the organization's expenditures against expected trends, past prior years performance, and budget expectation. Chaired by the organization's Chief Medical Officer, the Utilization Management committee, meets monthly and reviews detail financial and utilization reports to ascertain performance. The Committee may make additional recommendations and actions that are then reported out to the Board of Directors for any needed support.

Lastly, the organization has made substantial investments in bringing in top tier talent to run analytics to analyze and develop strategies for effective cost control. This team supplies these reports throughout the organization to assist in strategizing and decision making.

G.3. What strategies will the Applicant utilize related to Value-Based Payment arrangements to achieve a sustainable expenditure growth?

UHA strategically improves efficiency and quality in service delivery at the provider level by encouraging network providers to operate at the highest tier level of PCPCH. UHA distributes quality pool dollars through its Value-Based Care Program (VBCP), which is a pay-for-performance model. [redacted]

Pharmacy is another important component of achieving sustainable expenditure growth. Prescription drug coverage management helps us achieve growth targets. By maintaining local control and management of our formulary and consistently applying utilization management policies, UHA has been able to stay below 3.4% growth rates in the past. Any changes to the PDL approach would have to incorporate efficiency and careful monitoring of pharmacy costs.

As noted earlier, during the annual budget process, UHA sets target MLRs that are attached to the SGR. [redacted]

G.4. What strategies will the Applicant utilize to contain costs, while ensuring quality care is provided to Members?

Providers receive compensation for improving quality in service delivery as evident by successfully meeting or exceeding the CCO Quality Measure benchmarks. The CCO quality metrics encompass multiple areas of health care quality, touching on parts of a member's lifespan and health outcomes. By aggressively shifting our delivery system to a PCPCH model, UHA has embraced a model of health care that has been shown to ensure health care quality while containing costs. In addition, health-related services (HRS) and transformational care is simply part of the budgeting process and UHA.

UHA uses a multi-pronged approach to examine costs and quality metrics:

- UHA utilizes InterQual for evaluation of IP hospitalization and available ambulatory services to ensure medical appropriateness of delivered services. InterQual also allows for Inter-Rater Reliability testing to ensure the quality of our internal reviews.
- UHA's Utilization Management committee produces reports of utilization trends for all medical services and allows for drill downs at an actionable level to ensure the following:
    - Payment for covered services per the Prioritized List (PL)
    - Attention to new behaviors by providers (e.g. up-coding or unbundling)
    - Possible underutilization due to network adequacy gaps or other causes

  At the level of utilization review, UHA has adopted a discerning, not disciplinary use of our Prior Authorization system to ensure PL is followed. The committee allows for recognizing when clinical or social circumstances dictate coverage of below the line (BTL) conditions by exception to rule when the overall cost to the system is predicted to be less AND the member benefits.
- Regular communications (such as Provider Newsletters, forums, or direct communications) address medical waste utilizing Health Evidence Review Committee (HERC) information and the Choosing Wisely campaign (described in Section A above).

G.5. Has the Applicant achieved per-Member expenditure growth target of 3.4% per year in the past?

Please specify time periods.

For 2018 UHA successfully achieved a per-member expenditure growth target below 3.4%. Previously UHA per-member expenditure growth target of 3.4% was not achieved.

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.

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.)

Umpqua Health Alliance currently carries a reinsurance policy which renews annually on June 1st. The anticipated reinsurance policy will carry an attachment point of claims greater than $200K and coinsurance of 90% (insurer retains 10%) with an unlimited annual maximum. The policy covers losses that are incurred beginning June 1st through May 31st of the following year; claims must be paid and reported by November 30 of the following year and submitted for reimbursement by December 31st of the following year. The eligible services include inpatient hospital services, inpatient rehabilitation services, skilled nursing facility services, outpatient

health services, physician services, drug-related services (including specialty and retail pharmacy), mental health, and transplant services.

H.2. What is the Applicant's reasoning for selecting the reinsurance policy described above?

Umpqua Health Alliance selects reinsurance to provide additional coverage for high cost members with a recovery mechanism for unanticipated losses to control risk and cost. The reinsurance program also includes forensic claim review for high cost claims and other health-related services with added benefits, such as the Rose and Rosebud programs described below.

H.3. What aspects of its reinsurance policy are the most important to the Applicant?

Umpqua Health Alliance utilizes the added benefits provided with the contract as described below, but finds the policy as a whole extremely important.

Rose Program Consulting Services: Rose health services consultants provide case management and claims consultation services at no extra charge. They provide the following:

- Provide information on treatment options, providers and costs.
- Identify claims appropriate for case management.
- Offer consultation regarding case management programs.
- Identify cost containment opportunities.
- Research specific topics of interest.
- Complimentary Educational Services that include: and Annual ROSE conference, Bi-monthly webinars, and Quarterly ROSE Resource and ROSEBUD Fast Facts Newsletters.

Rose BUD Program (Babies Undelivered and Delivered): They provide a staff of experienced perinatal and neonatal nurse consultants:

- Special Delivery pregnancy screening and education program.
- Case management for high-risk pregnancies and infants.
- Program development consultation and training.

H.4. Does existing or previous reinsurance contract allow specific conditions or patients to be excluded, exempted, or lasered out from being covered?

Umpqua Health Alliance's existing reinsurance contract does not have specific members/patients excluded or without coverage, however, based on data provided to the reinsurance contract it is possible that the reinsurance vendor may exclude a specific member in the future.

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?

Umpqua Health Alliance is able to leave the existing reinsurance arrangement at any time. There is no cancellation penalty. At the effective date of cancellation, Umpqua Health Alliance will have the same claim guidelines: 6 months to pay and report the claims to reinsurer, and 7

months to submit claims to reinsurer. Regardless if the coverage term is 12 months or shortened due to cancellation, the per-member deductible remains the same, as it is listed in the Schedule of Insurance.

Umpqua Health can request modification to the reinsurance agreement. This would require underwriting review, which may impact the rates as listed in the Schedule of Insurance.

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.

I.1. Please describe Applicant's past sources of capital.

Umpqua Health's past sources of capital include member contributions from our Provider owner's Mercy Medical and DCIPA, LLC. Each made contributions and are 50% owners of Umpqua Health Alliance.

I.2. Please describe Applicant's possible future sources of capital.

Umpqua Health's possible future sources of capital include contributions from the current owner's as well as potential funding from the parent company, Umpqua Health, LLC.

I.3. What strategies will the Applicant use to ensure solvency thresholds are maintained?

UHA monitors its equity and net worth against the State of Oregon solvency requirements, ensuring compliance each quarter. Specific operational steps being taken including, but are not limited to:

- Calculating the restricted reserve and net worth threshold requirements quarterly.
- Developing an annual budget that ensures profitable net income performance
- Reviewing actual performance monthly against monthly and annual budget projections and identifying any potential performance shortfall and needed corrective courses of action.
- Ensuring adequate balance sheet reserves are established for claims payments and other liabilities. The claim liability reserve is evaluated on a monthly basis by an outside actuarial firm to ensure adequacy of the reserve.

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.

The Applicant is a wholly-owned subsidiary of Umpqua Health, LLC, from which it can receive cash contributions if additional capital is needed.

J. Encounter Data Validation Study

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.

UHA regularly audits claims through its Claims Analyst. Both the third-party administrator (TPA) and UHA Claims Analyst are able to monitor claim submissions to prevent payment of claims that either contain errors or lack certain information for the claims to be properly processed.

UHA has documented policies regarding the monitoring of claims and encounter data for completeness and accuracy. UHA's Encounter Data Analyst monitors and tracks the claims and encounters submitted to OHA. The organization uses a report called the 2019 Encounter Data Tracking Sheet (attached), which is used to report to the UHA executives that OHA's Administrative Performance (AP) Standard are being met and that no there will not be an AP Withhold taken from UHA's capitation payments. The report also allows UHA to have oversight on the encounter submissions of its subcontractors. The report demonstrates a detailed oversight of the completeness and accuracy of UHA's claims by comparing the number of submitted encounters to the Rejected and Accepted Encounters which identifies any denial or omission issues.

In addition, UHA staff answer all provider inquiries regarding claims processing and payment. This role enables UHA to confirm the correctness of our TPA and helps the plan identify errors in provider contracts, demographics, and claims processing. Errors reported are then investigated by UHA's Claims Analyst who conducts routine claims audits on a weekly basis.

In 2019, UHA will expand its Encounter Data Validation (EDV) audit program to also include claims review at the chart level. The EDV audit program will consists of:

- Comparing encounter data submission trends in 2018 with data trends in 2019
- Investigate any data anomalies found. Findings could result in a member level chart review consisting of comparing the individual encounter with the medical record to determine if the diagnosis and service information submitted was complete and accurate.
- A defined quarterly audit of claims submitted to encounter Sample size will reflect the percentage of claims processed that quarter.

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.

UHA completes chart reviews to validate if the medical record substantiates what the provider has billed. Focus areas for review are driven by utilization, and then claims/encounters will be selected at random from that data set. Reviews include timeliness, correctness, sufficiency of documentation, and omission of encounters. If errors in provider billing are identified, UHA will take action which may include provider training, corrective action plans, or possible recoupment; in accordance with Oregon Administrative Rules and contractual requirements.

UHA also monitors the accuracy of claims processed on a weekly basis. UHA's Claims Analyst performs routine claims processing audits which are targeted in scope and include the following: the submission of capitated/zero pay claims, claims paid for not enrolled members, claims billed under a locum provider, claims denied as duplicates, claims paid without a PA, and claims for providers who have been recently assigned a contract.

APPLICANT NAME: **Umpqua Health Alliance**

INTRODUCTION: This supplemental report is to be completed in conjunction with the NAIC UCAA Form 13H.

CALENDAR YEAR:	**2020**
CALENDAR YEAR START DATE:	**1/1/2020**
CALENDAR YEAR ENDING DATE:	**12/31/2020**

INSTRUCTIONS:

1 Prior to completing the UCAA Form 13H, first complete the "Company Assumptions" tab of this template. Identify the geographic area (Desired Locations) and the corresponding Member Months to be used in developing the Pro Formas.

2 The UCAA Balance Sheet and P and L input data comes directly from Form 13H. Three separate Form 13H templates will need to be created and submitted with the applicaion for each of the three scenarios described in the Reference Document. Copy and paste the values from Form 13H to the tabs in this template for each of the three scenarios.

3 Calculate and input the Authorized Control Level (ACL) into "UCAA Balance Sheet" Line 25 for each of the three years and each of the three scenarios (9 ACLs in total) as instructed in the Reference Document.

4 Enter your information in the yellow cells only. All other cells are calculated.

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

			2020	2021	2022
1.	Desired Service Area (List Counties):				
	Douglas County		343,388	344,185	343,231
			62,700	183,250	
2.	Membership totals for Desired Service Area:		28,616	28,682	28,603
3.	Best Estimate Membership Percentage:		100%	100%	100%
4.	Best Estimate Member Months	(BE MM)	343,388	344,185	343,231
5.	Estimated Minimum viable Membership Percentage:		75%	75%	75%
6.	Minimum Member Months	(MIN MM)	257,541	258,139	257,423
7.	Estimated Maximum viable Membership Percentage:		125%	125%	125%
8.	Maximum Member Months	(MAX MM)	429,235	430,231	429,039
	Administrative Costs:				
9.	What is the total "fixed" administrative costs for CCO Operations?	(BE MM)	3,061,625	3,172,647	3,276,697
10.	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		$ 26.75	$ 27.65	$ 28.64
	What is the total "fixed" administrative costs for CCO Operations?	(MIN MM)	2,296,219	2,379,485	2,457,523
	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		$ 26.75	$ 27.65	$ 28.64
	What is the total "fixed" administrative costs for CCO Operations?	(MAX MM)***	3,827,031	3,965,809	4,095,872
	What is the variable administrative costs for CCO Operations on a Per Member Per Month basis:		$ 26.75	$ 27.65	$ 28.64

*** Added MIN MM and MAX MM as 9 and 10 not specified as to MM.

UHA "purchases all administrative services through a service agreement from a related party a cost of 8% of premium each month. 25% is estimated to be related to fixed costs and 75% to variable.

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Scenario Summary

	2020	2021	2022
Best Estimate MM:	343,388	344,185	343,231
Net Income	2,586,441	2,991,074	2,919,929
Net Income Claims +2%	(35,296)	280,198	116,883
MLR Claims +2%	87%	87%	87%
RBC Claims +2%	1.749	2.409	2.777
Net Income Claims +4%	(2,657,034)	(2,430,679)	(2,686,163)
MLR Claims +4%	89%	89%	89%
RBC Claims +4%	1.363	1.968	2.335
Minimum MM:	257,541	258,139	257,423
Net Income	1,939,906	2,243,292	2,189,919
Net Income Claims +2%	(26,397)	210,135	87,635
MLR Claims +2%	87%	87%	87%
RBC Claims +2%	2.131	2.550	2.864
Net Income Claims +4%	(1,992,700)	(1,823,023)	(2,014,650)
MLR Claims +4%	89%	89%	89%
RBC Claims +4%	1.708	2.121	2.440
Maximum MM:	429,235	430,231	429,039
Net Income	3,233,052	3,738,843	3,649,912
Net Income Claims +2%	(44,120)	350,247	146,104
MLR Claims +2%	87%	87%	87%
RBC Claims +2%	1.657	2.326	2.703
Net Income Claims +4%	(3,321,292)	(3,038,349)	(3,357,704)
MLR Claims +4%	89%	89%	89%
RBC Claims +4%	1.266	1.876	2.253

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

Administrative Costs Summary

	Pro Forma Ref	2020	2021	2022
Best Estimate MM:		343,388	344,185	343,231
Fixed Administrative Costs	Assumptions Line 9	3,061,625	3,172,647	3,276,697
Variable Administrative Costs	Assumptions Line 10	9,184,875	9,517,941	9,830,092
Total Administrative Costs	calculated	12,246,500	12,690,589	13,106,789
Reported Administrative Costs	P and L Lines 17, 18	12,246,500	12,690,589	13,106,789
Difference (should be 0)	calculated	-	-	-
Minimum MM:		257,541	258,139	257,423
Fixed Administrative Costs	Assumptions Line 9	2,296,219	2,379,485	2,457,523
Variable Administrative Costs	Assumptions Line 10	6,888,656	7,138,456	7,372,569
Total Administrative Costs	calculated	9,184,875	9,517,941	9,830,092
Reported Administrative Costs	P and L Lines 17, 18	9,184,875	9,517,941	9,830,092
Difference (should be 0)	calculated	-	-	-
Maximum MM:		429,235	430,231	429,039
Fixed Administrative Costs	Assumptions Line 9	3,827,031	3,965,809	4,095,872
Variable Administrative Costs	Assumptions Line 10	11,481,094	11,897,427	12,287,615
Total Administrative Costs	calculated	15,308,125	15,863,236	16,383,487
Reported Administrative Costs	P and L Lines 17, 18	15,308,125	15,863,236	16,383,487
Difference (should be 0)	calculated	-	-	-

UHA "purchases all administrative services through a service agreement from a related party a cost of 8% of premium each month. 25% is estimated to be related to fixed costs and 75% to variable.

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds			
2.	Stocks (Preferred & Common)			
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	23,152,164	27,738,606	30,658,535
5.	Other Invested Assets	11,884,000	11,884,000	11,884,000
6.	Aggregate Write-Ins For Invested Assets			
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**35,036,164**	**39,622,606**	**42,542,535**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	10,514,367	10,914,036	11,285,113
10.	Unpaid Claims Adjustment Expenses	331,700	344,309	356,015
11.	Aggregate Health Policy Reserves	542,303	562,917	582,056
12.	Ceded Reinsurance Premiums Payable		-	
13.	Amounts Due To Parents, Subsidiaries & Affiliates		-	
14.	MLR Rebates	-	-	
15.	Premiums Received In Advance	-	-	
16.	All Other Liabilites	9,134,318	10,296,795	9,894,872
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**20,522,689**	**22,118,056**	**22,118,056**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	2,000,000	2,000,000	2,000,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	12,513,475	15,504,550	18,424,479
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	14,513,475	17,504,550	20,424,479
25.	Liabilities and Surplus (Lines 17+24)	35,036,164	39,622,606	42,542,535

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	$6,800,426.00	$6,140,330.00	$6,345,574.00
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	213.4%	285.1%	321.9%

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (BE MM)

	2020	2021	2022
1. Member Months	343,388	344,185	343,231
2. Net Premium Income	153,081,250	158,632,357	163,834,869
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**153,081,250**	**158,632,357**	**163,834,869**
Hospital and Medical:			
9. Hospital/Medical Benefits	59,028,494	61,035,462	63,110,668
10. Other Professional Services	46,345,101	47,920,835	49,550,143
11. Prescription Drugs	18,010,365	18,622,717	19,255,890
12. Aggregate Write-Ins For Other Hospital and Medical	8,870,436	9,172,031	9,483,880
13. Subtotal (Lines 9+10+11+12)	**132,254,395**	**136,751,045**	**141,400,580**
Less:			
14. Net Reinsurance Recoveries	1,167,518	1,207,213	1,248,258
15. Total Hospital and Medical (Lines 13 - 14)	131,086,878	135,543,832	140,152,322
16. Non-Health Claims (net)	6,948,944	7,201,905	7,435,849
17. Claims Adjustment Expenses	332,987	344,309	356,015
18. General Administrative Expenses	12,246,500	12,690,589	13,106,789
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**150,615,309**	**155,780,634**	**161,050,976**
21. Net underwriting gain or loss (Lines 8 - 20)	2,465,941	2,851,723	2,783,893
22. Net investment income earned	120,500	139,351.48	136,036.91
23. Net investment gains (losses) (Lines 22 + 26)	120,500	139,351	136,037
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred			
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**2,586,441**	**2,991,074**	**2,919,929**
29. Capital and Surplus Prior Reporting Year	9,927,034	14,513,475	17,504,550
30. Net Income or (Loss)	2,586,441	2,991,074	2,919,929
31. Capital Changes	2,000,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**14,513,475**	**17,504,550**	**20,424,479**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	86%	85%	86%
36 Claim Expense Ratio (Line 17 / Line 2)	0%	0%	0%
37 Administrative Expense Ratio (Line 18 / Line 2)	8%	8%	8%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	94%	93%	94%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1055%	906%	802%
44 Authorized Control Level Risk-Based Capital	$6,800,426.00	$6,140,330.00	$6,345,574.00
45 Risk Based Capital Calculation	2.134	2.851	3.219

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON BE MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	35,036,164	39,622,606	42,542,535
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	11,884,000	11,884,000	11,884,000
Restricted Reserve	calculated	5,586,953	5,772,660	5,964,680
Liquid assets	calculated	23,152,164	27,738,606	30,658,535
Aggregate Health Policy Reserves	Bal Sht Line 11	10,514,367	10,914,036	11,285,113
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	331,700	344,309	356,015
Total claims reserves	calculated	10,846,067	11,258,344	11,641,128
Total liabilities	Bal Sht Line 17	20,522,689	22,118,056	22,118,056
Total capital and surplus	Bal Sht Line 24	14,513,475	17,504,550	20,424,479
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	14,513,475	17,504,550	20,424,479
Net Premium Income	P and L Line 2	153,081,250	158,632,357	163,834,869
Total Hospital and Medical (net)	P and L Line 15	131,086,878	135,543,832	140,152,322
Divided by months in year	given	12	12	12
Avg claims expense	calculated	10,923,906	11,295,319	11,679,360
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	5,336,953	5,522,660	5,714,680
Total Restricted Reserve Requirement	calculated	5,586,953	5,772,660	5,964,680
Minimum Net Worth Required	calculated	7,654,063	7,931,618	8,191,743
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	8,154,063	8,431,618	8,691,743
Liabilities to Liquid Assets	calculated	89%	80%	72%
Capital & Surplus/Liabilities	calculated	71%	79%	92%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	3	3
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	2	2	2
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	94%	93%	94%
Net underwriting gain or loss	P and L Line 21	2,465,941	2,851,723	2,783,893
Test #1 Combined Ratio plus 2 pts	calculated	96%	95%	96%
Additional underwriting expense	calculated	3,061,625	3,172,647	3,276,697
Test #2 Combined Ratio plus 4 pts	calculated	98%	97%	98%
Additional underwriting expense	calculated	6,123,250	6,345,294	6,553,395
Test #3 Combined Ratio plus 6 pts	calculated	100%	99%	100%
Additional underwriting expense	calculated	9,184,875	9,517,941	9,830,092
C&S after test #1	calculated	11,451,850	14,331,903	17,147,782
C&S after test #2	calculated	8,390,225	11,159,256	13,871,085
C&S after test #3	calculated	5,328,600	7,986,608	10,594,387

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds			
2.	Stocks (Preferred & Common)			
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	22,505,629	24,748,921	26,938,841
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	9,883,542	9,883,542	9,883,542
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**32,389,171**	**34,632,463**	**36,822,382**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	10,514,367	10,914,036	11,285,113
10.	Unpaid Claims Adjustment Expenses	331,700	344,309	356,015
11.	Aggregate Health Policy Reserves	542,303	562,917	582,056
12.	Ceded Reinsurance Premiums Payable		-	
13.	Amounts Due To Parents, Subsidiaries & Affiliates		-	
14.	MLR Rebates		-	
15.	Premiums Received In Advance		-	
16.	All Other Liabilites	9,133,860	8,700,969	8,299,046
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**20,522,231**	**20,522,230.5**	**20,522,231**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus			
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	11,866,940	14,110,232	16,300,152
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	11,866,940	14,110,232	16,300,152
25.	Liabilities and Surplus (Lines 17+24)	32,389,171	34,632,463	36,822,382
	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	4,645,882	4,735,786	
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	255.4%	297.9%	0.0%

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MIN MM)

	2020	2021	2022
1. Member Months	257,541	258,139	257,423
2. Net Premium Income	114,810,938	118,974,268	122,876,151
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**114,810,938**	**118,974,268**	**122,876,151**
Hospital and Medical:			
9. Hospital/Medical Benefits	44,271,370	45,776,597	47,333,001
10. Other Professional Services	34,758,826	35,940,626	37,162,607
11. Prescription Drugs	13,507,774	13,967,038	14,441,917
12. Aggregate Write-Ins For Other Hospital and Medical	6,652,827	6,879,023	7,112,910
13. Subtotal (Lines 9+10+11+12)	**99,190,797**	**102,563,284**	**106,050,435**
Less:			
14. Net Reinsurance Recoveries	875,638	905,410	936,194
15. Total Hospital and Medical (Lines 13 - 14)	98,315,158	101,657,874	105,114,241
16. Non-Health Claims (net)	5,211,708	5,401,429	5,576,887
17. Claims Adjustment Expenses	249,740	258,231	267,011
18. General Administrative Expenses	9,184,875	9,517,941	9,830,092
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**112,961,482**	**116,835,476**	**120,788,232**
21. Net underwriting gain or loss (Lines 8 - 20)	1,849,456	2,138,792	2,087,919
22. Net investment income earned	90,450	104,500	102,000
23. Net investment gains (losses) (Lines 22 + 26)	90,450	104,500	102,000
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred			
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**1,939,906**	**2,243,292**	**2,189,919**
29. Capital and Surplus Prior Reporting Year	9,927,034	11,866,940	14,110,232
30. Net Income or (Loss)	1,939,906	2,243,292	2,189,919
31. Capital Changes			
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**11,866,940**	**14,110,232**	**16,300,152**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	86%	85%	86%
36 Claim Expense Ratio (Line 17 / Line 2)	0%	0%	0%
37 Administrative Expense Ratio (Line 18 / Line 2)	8%	8%	8%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	94%	93%	94%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	967%	843%	754%
44 Authorized Control Level Risk-Based Capital	4,645,882	4,735,786	4,957,488
45 Risk Based Capital Calculation	2.554	2.979	3.288

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MIN MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	**32,389,171**	**34,632,463**	**36,822,382**
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	4,257,950	4,398,470	4,543,768
Liquid assets	calculated	32,389,171	34,632,463	36,822,382
Aggregate Health Policy Reserves	Bal Sht Line 11	10,515,241	11,821,261	12,223,184
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	331,700	344,309	356,015
Total claims reserves	calculated	10,846,941	12,165,570	12,579,199
Total liabilities	Bal Sht Line 17	20,522,231	20,522,231	20,522,231
Total capital and surplus	Bal Sht Line 24	11,866,940	14,110,232	16,300,152
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	11,866,940	14,110,232	16,300,152
Net Premium Income	P and L Line 2	114,810,938	118,974,268	122,876,151
Total Hospital and Medical (net)	P and L Line 15	99,190,797	102,563,284	106,050,435
Divided by months in year	given	12	12	12
Avg claims expense	calculated	8,265,900	8,546,940	8,837,536
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	4,007,950	4,148,470	4,293,768
Total Restricted Reserve Requirement	calculated	4,257,950	4,398,470	4,543,768
Minimum Net Worth Required	calculated	5,740,547	5,948,713	6,143,808
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	6,240,547	6,448,713	6,643,808
Liabilities to Liquid Assets	calculated	63%	59%	56%
Capital & Surplus/Liabilities	calculated	58%	69%	79%
Avg Mo Unpd Clms to Res & Surpl	calculated	3	3	3
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	2	2	3
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	94%	93%	94%
Net underwriting gain or loss	P and L Line 21	1,849,456	2,138,792	2,087,919
Test #1 Combined Ratio plus 2 pts	calculated	96%	95%	96%
Additional underwriting expense	calculated	2,296,219	2,379,485	2,457,523
Test #2 Combined Ratio plus 4 pts	calculated	98%	97%	98%
Additional underwriting expense	calculated	4,592,438	4,758,971	4,915,046
Test #3 Combined Ratio plus 6 pts	calculated	100%	99%	100%
Additional underwriting expense	calculated	6,888,656	7,138,456	7,372,569
C&S after test #1	calculated	9,570,721	11,730,747	13,842,629
C&S after test #2	calculated	7,274,503	9,351,262	11,385,106
C&S after test #3	calculated	4,978,284	6,971,776	8,927,583

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Balance Sheet (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

		12/31/2020	12/31/2021	12/31/2022
	Admitted Assets			
1.	Bonds			
2.	Stocks (Preferred & Common)			
3.	Real Estate/Mortgage Loans on Real Estate			
4.	Cash/Cash Equivalents/Short-Term Investments	27,798,775	35,696,539	43,406,449
5.	Other Invested Assets			
6.	Aggregate Write-Ins For Invested Assets	10,000,000	10,000,000	10,000,000
7.	All Other Assets			
8.	Total Admitted Assets (Lines 1+2+3+4+5+6+7)	**37,798,775**	**45,696,539**	**53,406,449**
	Liabilities			
9.	Losses (Unpaid Claims for Accident and Health Policies)	13,142,959	13,642,545	14,106,391
10.	Unpaid Claims Adjustment Expenses	414,625	430,386	445,019
11.	Aggregate Health Policy Reserves	677,879	703,647	727,570
12.	Ceded Reinsurance Premiums Payable		-	
13.	Amounts Due To Parents, Subsidiaries & Affiliates		-	
14.	MLR Rebates	-	-	
15.	Premiums Received In Advance	-	-	
16.	All Other Liabilites	6,403,225	10,021,033	13,578,628
17.	Total Liabilities (Lines 9+10+11+12+13+14+15+16)	**20,638,689**	**24,797,610**	**28,857,608**
	Capital and Surplus			
18.	Capital Stock			
19.	Gross Paid In And Contributed Surplus	4,000,000	4,000,000	4,000,000
20.	Surplus Notes			
21.	Unassigned Funds (Surplus)	13,160,086	16,898,929	20,548,841
22.	Aggregate Write-ins for Other-Than-Special Surplus Funds			
23.	Less Treasury Stock (Common and Preferred)			
24.	Total Capital and Surplus (Lines 18+19+20+21+22-23)	17,160,086	20,898,929	24,548,841
25.	Liabilities and Surplus (Lines 17+24)	37,798,775	45,696,539	53,406,449

	Risk-Based Capital Analysis			
25.	Authorized Control Level Risk-Based Capital	$ 8,377,784	$ 7,526,788	$ 7,784,555
26.	Calculated Risk-Based Capital (Line 24 / Line 25)	204.8%	277.7%	315.4%

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

COPY VALUES OVER FROM FORM 13H (MAX MM)

	2020	2021	2022
1. Member Months	429,235	430,231	429,039
2. Net Premium Income	191,351,563	198,290,446	204,793,586
3. Fee For Service			
4. Risk Revenue			
5. Change In Unearned Premium Reserves and Reserve for Rate Credits			
6. Aggregate Write-Ins For Other Health Care Related Revenue			
7. Aggregate Write-Ins For Other Non-Health Revenue			
8. Total (Lines 2+3+4+5+6+7)	**191,351,563**	**198,290,446**	**204,793,586**
Hospital and Medical:			
9. Hospital/Medical Benefits	73,785,617	76,294,328	78,888,335
10. Other Professional Services	57,931,376	59,901,043	61,937,679
11. Prescription Drugs	22,512,956	23,278,397	24,069,862
12. Aggregate Write-Ins For Other Hospital and Medical	11,088,045	11,465,038	11,854,850
13. Subtotal (Lines 9+10+11+12)	**165,317,994**	**170,938,806**	**176,750,726**
Less:			
14. Net Reinsurance Recoveries	1,459,397	1,509,016	1,560,323
15. Total Hospital and Medical (Lines 13 - 14)	163,858,597	169,429,790	175,190,402
16. Non-Health Claims (net)	8,686,180	9,002,382	9,294,812
17. Claims Adjustment Expenses	416,234	430,386	445,019
18. General Administrative Expenses	15,308,125	15,863,236	16,383,487
19. Increase In Reserves For Life & Accident And Health Contacts			
20. Total underwriting deductions (Lines 15+16+17+18+19)	**188,269,136**	**194,725,793**	**201,313,720**
21. Net underwriting gain or loss (Lines 8 - 20)	3,082,427	3,564,654	3,479,866
22. Net investment income earned	150,625	174,189	170,046
23. Net investment gains (losses) (Lines 22 + 26)	150,625	174,189	170,046
24. Aggregate write in for other income or expenses			
25. Federal and Foreign Income Taxes Incurred			
26. Net Realized Capital Gains (Losses)			
27. Less Capital Gains Tax			
28. Net Income (Lines 21 + 23 + 24 - 25)	**3,233,052**	**3,738,843**	**3,649,912**
29. Capital and Surplus Prior Reporting Year	9,927,034	17,160,086	20,898,929
30. Net Income or (Loss)	3,233,052	3,738,843	3,649,912
31. Capital Changes	4,000,000		
32. Other Increases (Decreases)			
33. Dividends to Stockholders			
34. Capital and Surplus End of Reporting Year (Lines 29 + 30 + 31 + 32 - 33)	**17,160,086**	**20,898,929**	**24,548,841**
Ratio Analysis			
35 Medical Loss Ratio (as calculated for insurers) (Line 15 / Line 2)	86%	85%	86%
36 Claim Expense Ratio (Line 17 / Line 2)	0%	0%	0%
37 Administrative Expense Ratio (Line 18 / Line 2)	8%	8%	8%
38 Combined Medical Loss and Expense Ratio (Line 35 + Line 37)	94%	93%	94%
39 Ratio of Total Revenue to Capital and Surplus (Line 8 / Line 34)	1115%	949%	834%
44 Authorized Control Level Risk-Based Capital	$ 8,377,784	$ 7,526,788	$ 7,784,555
45 Risk Based Capital Calculation	2.048	2.777	3.154

Umpqua Health Alliance
(Health Company)
Pro Forma Statutory Profit & Loss Statement (Nationwide)
(In Whole Numbers)

BASED ON MAX MM IDENTIFIED IN ASSUMPTIONS

	Pro Forma Ref	2020	2021	2022
Financial Statement Data				
Total Admitted Assets	Bal Sht Line 8	37,798,775	45,696,539	53,406,449
Real Estate/Mortgage Loans on Real Estate	Bal Sht Line 3	-	-	-
Stocks (Preferred & Common)	Bal Sht Line 2	-	-	-
Restricted Reserve	calculated	6,952,442	7,184,575	7,424,600
Liquid assets	calculated	37,798,775	45,696,539	53,406,449
Aggregate Health Policy Reserves	Bal Sht Line 11	13,142,959	13,642,545	14,106,391
Ceded Reinsurance Premiums Payable	Bal Sht Line 12	414,625	430,386	445,019
Total claims reserves	calculated	13,557,584	14,072,930	14,551,410
Total liabilities	Bal Sht Line 17	20,638,689	24,797,610	28,857,608
Total capital and surplus	Bal Sht Line 24	17,160,086	20,898,929	24,548,841
Capitol stock	Bal Sht Line 18	-	-	-
Surplus	calculated	17,160,086	20,898,929	24,548,841
Net Premium Income	P and L Line 2	191,351,563	198,290,446	204,793,586
Total Hospital and Medical (net)	P and L Line 15	163,858,597	169,429,790	175,190,402
Divided by months in year	given	12	12	12
Avg claims expense	calculated	13,654,883	14,119,149	14,599,200
Ratio/Financial Analysis				
Primary Restricted Reserve	calculated	250,000	250,000	250,000
Secondary Restricted Reserve	calculated	6,702,442	6,934,575	7,174,600
Total Restricted Reserve Requirement	calculated	6,952,442	7,184,575	7,424,600
Minimum Net Worth Required	calculated	9,567,578	9,914,522	10,239,679
Working capital	given	500,000	500,000	500,000
Total Initial Required Net Worth	calculated	10,067,578	10,414,522	10,739,679
Liabilities to Liquid Assets	calculated	55%	54%	54%
Capital & Surplus/Liabilities	calculated	83%	84%	85%
Avg Mo Unpd Clms to Res & Surpl	calculated	2	2	3
Avg Mo Unpd Clms to Res & Surpl (excl minimum C&S)	calculated	2	2	2
Stress Test Results				
Combined Medical Loss and Expense Ratio	P and L Line 38	94%	93%	94%
Net underwriting gain or loss	P and L Line 21	3,082,427	3,564,654	3,479,866
Test #1 Combined Ratio plus 2 pts	calculated	96%	95%	96%
Additional underwriting expense	calculated	3,827,031	3,965,809	4,095,872
Test #2 Combined Ratio plus 4 pts	calculated	98%	97%	98%
Additional underwriting expense	calculated	7,654,063	7,931,618	8,191,743
Test #3 Combined Ratio plus 6 pts	calculated	100%	99%	100%
Additional underwriting expense	calculated	11,481,094	11,897,427	12,287,615
C&S after test #1	calculated	13,333,055	16,933,120	20,452,969
C&S after test #2	calculated	9,506,023	12,967,311	16,357,097
C&S after test #3	calculated	5,678,992	9,001,502	12,261,225

Please provide any text, tables, numbers, etc. that you would like to communicate but were not able to include within the preceding reports.

	2019	2020	2021	2022
Avg Premium Rate	448.77	463.13	477.95	492.28

Fixed/Variable Administrative Cost Calculations

	Allocated %	2020	2021	2022
MIN MM:			-	
Fixed Administrative Costs	25%	2,296,219	2,379,485	2,457,523
Variable Administrative Costs	75%	6,888,656	7,138,456	7,372,569
Total Administrative Costs	100%	9,184,875	9,517,941	9,830,092
BE MM:		-	-	-
Fixed Administrative Costs	25%	3,061,625	3,172,647	3,276,697
Variable Administrative Costs	75%	9,184,875	9,517,941	9,830,092
Total Administrative Costs	100%	12,246,500	12,690,589	13,106,789
MAX MM:				
Fixed Administrative Costs	25%	3,827,031	3,965,809	4,095,872
Variable Administrative Costs	75%	11,481,094	11,897,427	12,287,615
Total Administrative Costs	100%	15,308,125	15,863,236	16,383,487

Attachment 13 — Attestations

Applicant Name: Umpqua Health Alliance LLC

Authorizing Signature: _____

Printed Name: Brent Eichman

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?

[X] Yes [ ] No

If "no" please provide explanation: _____

b. Is Applicant willing to satisfy Readiness Review standards by September 30, 2019?

[X] 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?

[X] 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?

[X] Yes [ ] No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to provide to OHA unredacted copies of written agreements with Subcontractors?

[X] Yes [ ] No

If "no" please provide explanation: _____

_____

3. Third Party Liability and Personal Injury Lien

a. Is Applicant willing to identify and require its Subcontractors and Providers to identify and promptly report the presence of a Member's Third Party Liability?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Is Applicant willing to document all efforts to pursue financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Is Applicant willing to report and require its Subcontractors to report all financial recoveries from third party insurers?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Is Applicant willing to provide and require its Affiliated entities and Subcontractors to provide to OHA all information related to TPL eligibility to assist in the pursuit of financial recovery?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

4. Oversight and Governance

a. Is Applicant willing to provide its organizational structure, identifying any relationships with subsidiaries and entities with an ownership or Control stake?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

B. Provider Participation and Operations Attestations (Attachment 7)

1. General Questions

a. Will Applicant have an individual accountable for each of the operational functions described below?

- Contract administration
- Outcomes and evaluation
- Performance measurement
- Health management and Care Coordination activities
- System coordination and shared accountability between DHS Medicaid-funded LTC system and CCO
- Behavioral Health (mental health and addictions) coordination and system management
- Communications management to Providers and Members
- Provider relations and network management, including credentialing
- Health information technology and medical records
- Privacy officer
- Compliance officer
- Quality Performance Improvement
- Leadership contact for single point of accountability for the development and implementation of the Health Equity Plan
- Traditional Health Workers Liaison

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

b. Will Applicant participate in the Learning Collaboratives required by ORS 442.210?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

c. Will Applicant collect, maintain and analyze race, ethnicity, and preferred spoken and written languages data for all Members on an ongoing basis in accordance with standards jointly established by OHA and DHS in order to identify and track the elimination of health inequities?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

d. Will Applicant (i) authorize the provision of a drug requested by the Primary Care Physician (PCP) or Referral Provider, if the approved prescriber certifies medical necessity for the drug such as: the formulary's equivalent has been ineffective in the treatment or the formulary's drug causes or is reasonably expected to cause adverse or harmful reactions to the Member and (ii) reimburse Providers for dispensing a 72-hour supply of a drug that requires Prior Authorization?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

e. Will Applicant comply with all applicable Provider requirements of Medicaid law under 42 CFR Part 438, including Provider certification requirements, anti-discrimination requirements, Provider participation and consultation requirements, the prohibition on interference with Provider advice, limits on Provider indemnification, rules governing payments to Providers, and limits on physician incentive plans?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

f. Will Applicant ensure that all Provider, facility, and supplier contracts or agreements contain the required contract provisions that are described in the Contract?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

g. Will Applicant have executed Provider, facility, and supplier contracts in place to demonstrate adequate access and availability of Covered Services throughout the requested Service Area?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

h. Will Applicant have all Provider contracts or agreements available to OHA in unredacted form?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

i. Will Applicant's contracts for administrative and management services contain the OHA required Contract provisions?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

j. Will Applicant establish, maintain, and monitor the performance of a comprehensive network of Providers to ensure sufficient access to Medicaid Covered Services, including comprehensive behavioral and oral health services, as well as supplemental services offered by the CCO in accordance with written policies, procedures, and standards for participation established by the CCO? Participation status will be revalidated at appropriate intervals as required by OHA regulations and guidelines.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

k. Will Applicant have executed written agreements with Providers (first tier, downstream, or related entity instruments) structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

l. Will Applicant have executed written agreements with Local Mental Health Authorities throughout its Service Area, structured in compliance with OHA regulations and guidelines?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

m. Will Applicant develop a comprehensive Behavioral Health plan in collaboration with the Local Mental Health Authority and other Community partners?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

n. Will Applicant coordinate and collaborate on the development of the Community health improvement plan (CHP) under ORS 414.627 with the Local Mental Health Authority's comprehensive local plan for the delivery of mental health services (ORS 430.630)?

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

o. Will Applicant, through its contracted Participating Provider Network, along with other specialists outside the network, Community resources or social services within the CCO's Service Area, provide ongoing primary care, Behavioral Health care, oral health care, and specialty care as needed and will guarantee the continuity of care and the integration of services as described below?

- Prompt, convenient, and appropriate access to Covered Services by Members 24 hours a day, 7 days a week;
- The coordination of the individual care needs of Members in accordance with policies and procedures as established by the Applicant;
- Member involvement in decisions regarding treatment, proper education on treatment options, and the coordination of follow-up care;
- Effectively addressing and overcoming barriers to Member compliance with prescribed treatments and regimens; and
- Addressing diverse patient populations in a linguistically diverse and culturally competent manner.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

p. Will Applicant establish policies, procedures, and standards that:

- Ensure and facilitate the availability, convenient, and timely access to all Medicaid Covered Services as well as any supplemental services offered by the CCO;
- Ensure access to medically necessary care and the development of medically necessary individualized care plans for Members;
- Promptly and efficiently coordinate and facilitate access to clinical information by all Providers involved in delivering the individualized care plan of the Member while following Timely Access to Services standards;
- Communicate and enforce compliance by Providers with medical necessity determinations; and
- Do not discriminate against Medicaid Members, including providing services to individuals with disabilities in the most integrated Community setting appropriate to the needs of those individuals.

☒ Yes ☐ No

If "no" please provide explanation: _____

_____

q. Will Applicant have verified that contracted Providers included in the CCO Facility Table are Medicaid certified and the Applicant certifies that it will only contract with Medicaid certified Providers in the future?

☒ Yes ☐ No

If "no" please provide explanation: _____

r. Will Applicant provide all services covered by Medicaid and comply with OHA coverage determinations?

☒ Yes ☐ No

If "no" please provide explanation: _____

s. Will Applicant have an Medicare plan to serve Fully Dual Eligibles either through contractual arrangement or owned by Applicant or Applicant parent company to create integrated Medicare-Medicaid opportunities during the contract period? [Plan can be a Dual Special Needs Plan or MA plan that offers low premiums and integrated Part D medications options].

☒ Yes ☐ No

If "no" please provide explanation:

t. Will Applicant, Applicant staff and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities), and Subcontractor staff be bound by 2 CFR 376 and attest that they are not excluded by the Department of Health and Human Services Office of the Inspector General or by the General Services Administration? Please note that this attestation includes any member of the board of directors, key management or executive staff or major stockholder of the Applicant and its Affiliated companies, subsidiaries or Subcontractors (first tier, downstream, and related entities).

☒ Yes ☐ No

If "no" please provide explanation: _____

u. Is it true that neither the state nor federal government has brought any past or pending investigations, legal actions, administrative actions, or matters subject to arbitration involving the Applicant (and Applicant's parent corporation, subsidiaries, or entities with an ownership stake, if applicable) or its Subcontractors, including key management or executive staff, or major shareholders over the past three years on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services?

☐ Yes ☒ No

If "no" please provide explanation: In January of 2015, Umpqua Medical Group, LLC, a subsidiary of Umpqua Health Alliance, LLC's parent company, self-disclosed to the Centers for Medicare & Medicaid Services a potential violation of the Stark Self-Referral Law. The potential violation involved the compensation methodology used by the group to compensate physicians practicing in the group. The matter was settled in February 2018 and the related investigation was closed. Umpqua Medical Group, LLC is no longer operational. All other physician groups that are subsidiaries of Umpqua Health, LLC use a compensation methodology that is compliant with the Stark law.

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: Yes, so long as no trade secrets are divulged.

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: _____

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: Yes, but the program must conform to the 1115 waiver cost containment requirement of 3.4%

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?

[X] 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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?

[X] 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: Umpqua Health Alliance

Authorizing Signature: _____

Printed Name: Brent Eichman

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.

- UHA ensures covered services are provided to members in a timely manner and within the access requirements of OAR 410-141-3220. To assess services needed by members, UHA utilizes the Community Needs Assessment which also serves to identify needs for the Community Health Improvement Plan. For evaluation of meeting geographic requirements and needs UHA uses geo-mapping when it conducts its annual multidimensional Network Adequacy Study. The study, combined with Access to Care Surveys, are continuously to monitor the delivery network and providers' services. UHA members may also use Non-Emergent Transportation to assist with accessing care. For members with limited English proficiency or who are in need of other physical or mental accommodations, they may access the online UHA Provider Directory (or request an alternate format from UHA Member Services) to see which offices meet their needs. Additionally, the requirement to adhere to Americans with Disability Act (ADA) is a contractual requirement for each UHA provider. Provider's adherence to access and compliance standards are monitored by both the Provider Network Department as well as the Compliance Department.

b. Medicaid Assurance #2 – 42 CFR § 438.207 Assurances of adequate capacity and services.

- To maintain a network of providers that is sufficient in mix, and geographic distribution, to meet the needs of the anticipated number of members in the service area UHA relies on its multidimensional Network Adequacy Study and Community Needs Assessment. Together these tools aid in network planning. Information from these tools helps UHA ensure the network has a sufficient range of preventative, primary care, specialty services, and LTSS that is adequate for the anticipated number of members in its service area.

c. Medicaid Assurance #3 – 42 CFR § 438.208 Coordination and continuity of care.

- UHA delivers care to and coordinates services for all its members. This begins by providing newly enrolled members with Health Risk Assessment (HRA) Surveys to assess for long-term services and supports (LTSS) as well as other special health care needs (e.g. high health needs, multiple chronic conditions, behavioral health issues, etc.). The HRA survey is immediately sent to newly enrolled members and follow-up attempts (via mail and/or telephone) are made if mailers are not returned in a best effort to gain responses within the first 90-days of the member's effective date. For all members, UHA works to coordinate services between settings, including discharge planning for short term and long-term hospital and institutional stays, as well as with any services members receive from other health plans, fee-for-service Medicaid, and through community and social support services. UHA also reviews HRA survey results, utilization, readmissions and quality metrics data to monitor trends in the needs of members and to plan for its impact on case management and care coordination. Additionally, UHA uses PreManage to monitor hospitalizations and ED utilizations. For members with special health care needs, including LTSS, treatment plans are devised collaboratively with the member, case managers, and interdisciplinary teams.

d. Medicaid Assurance #4 – 42 CFR § 438.210 Coverage and authorization of services.

- UHA ensures coverage and authorization of services are sufficient in amount, duration, or scope to reasonably achieve the intended purpose of furnished services. This is achieved by using the Prioritized List of Health Services, guidelines from the Health Evidence Review Committee, and Milliman Care

Guidelines, as well as any applicable nationally recognized evidence based decision-making tools as the criteria for basing authorization decisions. Decisions for standard authorizations, expedited authorizations, and covered outpatient drugs are made within the timeframe requirements of 42 CFR §438.210 and by professionals knowledgeable to make such determinations. If a requested service is denied or reduced in amount, duration or scope UHA's Chief Medical Officer, a trained and licensed medical doctor, reviews the adverse benefit determination for appropriateness. If the denial or reduction is upheld, a Notice of Adverse Benefit Determination, meeting all requirements of 42 CFR §438.404, is sent to the member. UHA performs monitoring throughout the day to ensure timely handling of new and pending requests as a means of gauging compliance with decision timeliness requirements. Furthermore, UHA utilizes key performance indicators to show the average turn-around-times of decisions on a monthly basis.

e. Medicaid Assurance #5 – 42 CFR § 438.214 Provider selection.

- UHA is committed to having a well-rounded panel of providers for its members. To do so, any provider may apply to be part of UHA's network by completing and submitting a questionnaire. If leadership reviews the questionnaire and determines that the network is in need of such a provider, the provider will then be asked to begin the credentialing process. All applicants begin by submitting the Oregon Practitioner Credentialing Application (OPCA) along with requested deliverables. The process then follows the standards set by the National Committee for Quality Assurance (NCAQ); these standards are also used in UHA's recredentialing process. In accordance with state and federal requirements, UHA does not discriminate against particular providers that serve high-risk populations or that specialize in conditions that require costly treatment. Last, UHA will not enter into or maintain a relationship with any individual or entity who is found excluded from participation in Federal health care programs.

f. Medicaid Assurance #6 – 42 CFR § 438.224 Confidentiality.

- UHA takes the safeguarding of its members individually identifiable health information seriously and takes great care to ensure its safety. Safeguarding efforts are done through staff training at onboarding and annually thereafter, policies and procedures, and technical safeguards. The organization's expectations and requirements around protecting privacy are also conveyed to personnel, subcontractors, providers, and the board through the Compliance Plan, the Code of Conduct, the Provider Handbook, and contract languages.

g. Medicaid Assurance #7 – 42 CFR § 438.228 Grievance and Appeal systems.

- UHA's robust grievance and appeals system ensures attention to member's concerns and needs; collects and tracks all information received; and reviews the obtained information and data for quality improvement purposes. Members are informed about the grievance and appeals process at enrollment, upon denial of a requested service, upon discontinuance of previously authorized service or failure to meet required timeframes, or anytime its requested by the member. Providers and subcontractors are educated on this process through requirements in their contract's with the organization and/or UHA's Provider Handbook. The process also ensures adherence to the policy and procedure, confidentiality, notification, timeliness, and decision requirements as outlined in 42 CFR Part 438 Subpart F.

h. Medicaid Assurance #8 – 42 CFR § 438.230 Subcontractual relationships and delegation.

- Although UHA maintains subcontractual relationships and delegations it retains ultimate responsibility for adhering to or otherwise complying with all terms and conditions of its contract with OHA. To assure subcontractual relationships and delegations comply with what UHA asks of them, contract and agreement language is written to clearly address: responsibilities; provisions for termination; performance expectations and monitoring, including auditing by UHA, OHA, or other governing entities; record retention practices; and requirement to follow all Medicaid laws, regulations and guidance. In such relationships, it is agreed that subcontractors will fully participate and cooperate with audits, evaluations, or inspections for a period of up to 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. For services that are delegated, UHA performs routine monitoring, annual audits, and engage in applicable corrective action plans.

i. Medicaid Assurance #9 – 42 CFR § 438.236 Practice guidelines.

- UHA selectively adopts peer-reviewed, evidence-based clinical practice guidelines from national and/or

international professional organizations. UHA's Clinical Advisory Panel is consulted when practice guidelines are selected. Each is selected based on quality and population health initiatives and the prevalence of the condition among Douglas County Medicaid members. The guidelines are then disseminated to providers and members via posting on the UHA website. Annually, the Chief Medical Officer, Director of Clinical Pharmacy Services, and the Director of Quality Improvement will review and update the practice guidelines in consultation with the Clinical Advisory Panel. Any UHA decisions for utilization management, member education, coverage of services, or other areas to which practice guidelines apply, are consistent with the adopted guidelines with the exception of services conflicting with the Health Evidence Review Commission (HERC) guidelines or Oregon Administrative Rules (OARs).

j. Medicaid Assurance #10 – 42 CFR § 438.242 Health information systems.

- UHA maintains a health information system that collects, analyzes, integrates, and reports data. The systems provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. UHA's system allows for the following types of activities: claims processing and retrieval; collecting data on member and provider characteristics as well as on all services furnished to members through encounter data system or other methods; verify accuracy and completeness of data received from all UHA providers including timeliness of reported data; and screening data for completeness, logic, and consistency. UHA's health information system also allows for the collecting of data from providers in a standardized format, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. Last, the system provides for the collection and maintenance of enrollee encounter data sufficient to identify the provider delivering the service(s) or item(s). It also allows for the submission requirements of enrollee encounter data to OHA.

Attachment 15 — Representations

Applicant Name: Umpqua Health Alliance

Authorizing Signature: _____

Printed Name: Brent Eichman

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: Umpqua Health Alliance (UHA) contracts with an affiliate Umpqua Health Management that is a management services company and licensed worker leasing company that provides services such as financial services, human resources, employee leasing, medical management, utilization review, data processing, claims processing, record maintenance and other services to support UHA.

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: UHA contracts with Umpqua Health Management to perform portions of the system or information technology. Additionally, UHA contracts with PhTech that provides a claims system to assist in claims processing.

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: UHA contracts with PhTech to perform 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: UHA contracts with PhTech who loads the 834 files into its system.

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: UHA contracts with Umpqua Health Management to perform credentialing functions. Additionally, UHA contracts with other delegates for credentialing, including: Compass, Adapt, Advantage Dental, Vituity, Centennial Medical Group East

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: UHA contracts with Umpqua Health Management to perform utilization management functions. UHA maintains the adjudication if appeals.

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: UHA contracts with Umpqua Health Management to perform quality improvement operations. UHA ultimately provides oversight and monitoring of Quality Improvement activities.

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: UHA contracts with Umpqua Health Management to perform its call center operations.

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: UHA contracts with Umpqua Health Management to perform its financial services.

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: UHA contracts with Bay Cities to administer the non-emergent medical transportation (NEMT) benefit. Additionally, UHA contracts with MedImpact as its Pharmacy Benefit Manager. Lastly, UHA contracts with Advantage Dental to administer the dental benefit.

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: UHA does not intend at this time to have additional contracts with any related entities, contractors, subcontractors to perform, implement or operate any aspect of the CCO operation, other than what was disclosed 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: UHA sub-capitates a portion of its dental premium to Advantage Dental. UHA sub-capitates a portion of its NEMT premium to Bay Cities Brokerage. UHA currently sub-capitates a portion of the substance use benefit to Adapt, but will be looking at modifying the arrangement by 2020.

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: Applicant currently has a 2019 CCO contract with the Oregon Health Authority.

ATTACHMENT 16 — MEMBER TRANSITION PLAN

Page limit is 10 pages.

16.1. Background and Supporting Sources

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 a 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

This section should describe the Applicant's plan to coordinate with other CCOs as the Transferring and/or Receiving CCO. This includes 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.

UHA is experienced in collaborating and coordinating with other CCOs and with OHA. UHA has been an active participant in this rule-making process as well as discussions related to rule implementation and operationalization. After further direction from the OHA on how to operationalize this rule, UHA will implement and maintain a transition of care policy that meets the requirements defined in OAR 410-141-3061 and 42 CFR 438.62(b). As part of this process, UHA will work in collaboration with the OHA and other CCOs to implement policies and procedures that align the operations of both the predecessor and the receiving CCO.

A focus will be placed on the following members:

1. Medically fragile children;
2. Breast and Cervical Cancer Treatment program members;
3. Members receiving CareAssist assistance due to HIV/AIDS;
4. Members receiving services for end stage renal disease, prenatal or postpartum care, transplant services, radiation, or chemotherapy services; and
5. Any members who, in the absence of continued access to services, may suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

The OHA will need to provide direction on how to identify these special populations and may need to broker the information. These members are particularly at risk and in need of special care. UHA anticipates that the majority members within these groups would be identified and engaged in some level of case management. As such, UHA expects that both predecessor and receiving CCO would have a standardized process that can still take into consideration the individual needs of each member.

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.

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).

While UHA is able to securely relay member-specific information with other CCOs via SFTP, data transfer processes will be established following additional guidance from the OHA. UHA will work with the OHA and other CCOs to develop an effective and secure method to share the required information.

This information will include data points pertinent to the member's transition and an indicator for what additional documentation or coordination may be needed. UHA will comply with requests from the receiving CCO for complete historical utilization data:

1. Data shall be provided in a HIPAA-compliant format to facilitate transitions of care;
2. The minimum elements provided are:
    a. Current prior authorizations and pre-existing orders;
    b. Prior authorizations for any services rendered in the last 24 months;
    c. Current behavioral health services provided;
    d. List of all active prescriptions;
    e. Current ICD-10 diagnosis.

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).

Each member is assigned a primary care provider indicated in UHA's existing clinical integration management (CIM) system. Additional providers, such as the dental care organization, behavioral health, and other specialty providers, would be identified through system reports and/or care plans. This information can be provided to the receiving CCO in multiple formats. This would allow the receiving CCO an opportunity to provide a match for each provider actively treating the member. Further instruction is needed from the OHA regarding the file format for this data.

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).

Following notification, UHA will report to the receiving CCO the appropriate information to ensure continuity of care. UHA will furnish documentation of prior authorization of ongoing covered services to the receiving CCO, along with the member's status with case management and care plans. Transportation information and involvement of community partners may also be provided for the members at risk.

UHA understands that the receiving CCO is not responsible for payment of inpatient hospitalization or post-hospital extended care, for which UHA as the predecessor was responsible under its contract. However, UHA will work with the receiving CCO to ensure the transition of care plan provides seamless service.

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.

UHA will work with other CCOs to develop a standardized process to have transparent communication with providers and members on their coverage and transition. For example, written communication would be sent to members notifying them of the change in coverage. This would include contact information and general information. UHA's member services and case management teams would also receive additional training to help facilitate any inquiries for these transitions. Whenever possible for high-need members, UHA's Care Coordinators will perform warm handoffs to the receiving CCO's Care Coordination team.

16.2.d. Receiving CCOs with Incoming Members

1) 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.

While UHA is able to securely relay member-specific information with other CCOs via SFTP, data transfer processes will be established following additional guidance from the OHA. UHA will work with OHA and other CCOs to develop an effective and secure method to share the required information.

This information will include data points pertinent to the member's transition and an indicator for what additional documentation or coordination may be needed. The predecessor will provide UHA with complete historical utilization data:

1. Data shall be provided in a HIPAA-compliant format to facilitate transitions of care;
2. The minimum elements provided are:
    a. Current prior authorizations and pre-existing orders;
    b. Prior authorizations for any services rendered in the last 24 months;
    c. Current behavioral health services provided;
    d. List of all active prescriptions;
    e. Current ICD-10 diagnosis.

Once a system is established, UHA will develop a standardized process to validate and distribute the pertinent information to the appropriate teams and providers and to load relevant information into operating systems.

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.

UHA will review the data from the predecessor to assign a PCP. The UHA provider network would offer a match of specialty providers. However, every effort would be made to support the member in maintaining their existing DMAP-enrolled provider if barriers to reasonable access were identified by UHA. This could include negotiating single case agreements with the provider, pursuing a contract with the provider, or authorizing services out-of-network.

UHA will ensure members have continued access to care during the transition period as defined in OAR 410-141-3061 (2)(a) previously authorized and permit them to retain their previous provider, regardless of the provider's participation. However, there may be an exception:

1. After the minimum or authorized prescribed course of treatment has been completed; or
2. If the reviewing provider concludes the treatment is no longer medically necessary. For specialty care, treatment plans must be reviewed by a qualified provider;
3. Notwithstanding OAR 410-141-3061 (6)(a) and (b), UHA will be responsible for continuing the entire course of treatment with the recipient's previous provider as described in the service-specific continuity of care period situations below:
    a. Prenatal and postpartum care;
    b. Transplant services through the first-year post-transplant;
    c. Radiation or chemotherapy services for the current course of treatment; or
    d. Prescriptions with a defined minimum course of treatment that exceeds the continuity of care period.
4. Where OAR 410-141-3061 (6) allows the member to continue using the member's previous provider, UHA will reimburse non-participating providers consistent with OAR 410-120-1295 at no less then Medicaid fee-for-service rates.

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.

UHA will obtain written documentation as necessary for transition of care from the following:

1. The Division's clinical services for members transferring from FFS;

2. Other CCOs as needed; and
3. Previous providers with member consent when necessary.

During the transition of care period, UHA will honor any written documentation of prior authorization of ongoing covered services. UHA will not delay service authorization if written documentation of prior authorization is not available in a timely manner. In such instances, UHA will approve claims for which it has received no written documentation during the transition of care time period, as if the services were prior authorized.

UHA will follow all service authorization protocols outlined in OAR 410-141-3225 and give the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or when reducing a previously authorized service authorization. The notice will meet the requirements of 42 CFR §438.404 and OAR 410-141-3240.

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.

UHA will work with other CCOs to develop a standardized process to have transparent communication with providers and members on their coverage and transition. This would include contact information and general information. UHA's member services and case management teams would also receive additional training to help facilitate any inquiries for these transitions.

16.2.b. Reference Documents:

- 2019 Contract Extension, Contract Termination and Closeout Requirements
- OAR 410-141-3061 Transition of Care Requirements
- OAR 410-141-3258 Contract Termination and Closeout Requirements
- Oregon's K Plan web page
- Oregon's Application for a 1915(c) HCBS Waiver