



Report of Independent Auditors and
Financial Statements for

Health Share of Oregon

December 31, 2014 and 2013

MOSS-ADAMS_{LLP}

Certified Public Accountants | Business Consultants

CONTENTS

	PAGE
REPORT OF INDEPENDENT AUDITORS	1-2
FINANCIAL STATEMENTS	
Statements of financial position	3
Statements of activities and changes in net assets	4
Statements of cash flows	5
Notes to financial statements	6-21

REPORT OF INDEPENDENT AUDITORS

To the Board of Directors
Health Share of Oregon

We have audited the accompanying financial statements of Health Share of Oregon, which comprise the statements of financial position as of December 31, 2014 and 2013, and the related statement of activities and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

REPORT OF INDEPENDENT AUDITORS (continued)

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Health Share of Oregon as of December 31, 2014 and 2013, and the results of its operations and its cash flows for the years ended December 31, 2014 and 2013 in accordance with accounting principles generally accepted in the United States of America.

Miss Adams LLP

Portland, Oregon

June 1, 2015

**HEALTH SHARE OF OREGON
STATEMENTS OF FINANCIAL POSITION**

ASSETS		December 31,	
	2014	2013	
CURRENT ASSETS			
Cash and cash equivalents	\$ 8,414,593	\$ 488,784	
Capitation receivable	1,585,785	5,812,078	
Maternity case rate receivable	4,262,773	4,506,830	
Quality management incentive receivable	13,462,693	4,062,041	
Health reimbursement adjustment receivable	-	31,526	
Innovation grants receivable	63,688	26,246	
Prepaid expenses	120,567	90,615	
Interest receivable	56,781	17,523	
Other receivables	309,709	128,385	
Total current assets	28,276,589	15,164,028	
ASSETS LIMITED AS TO USE			
Cash and cash equivalents - contractual reserves	3,958,501	6,745,349	
Investments - contractual reserves	28,834,540	16,691,619	
Total assets limited as to use	32,793,041	23,436,968	
FURNITURE AND EQUIPMENT			
	546,737	157,562	
OTHER LONG-TERM ASSETS			
	22,453	-	
Total assets	\$ 61,638,820	\$ 38,758,558	
LIABILITIES AND NET ASSETS			
CURRENT LIABILITIES			
Capitation payable	\$ 1,921,144	\$ 5,696,204	
Maternity case rate payable	4,176,926	4,416,111	
Quality management incentive payable	13,462,693	4,062,041	
Risk adjustment payable	1,618,869	305,724	
Deferred grant revenue	633,231	-	
Accounts payable and accrued expenses	649,400	241,771	
Accrued leased employee costs	449,422	275,402	
Managed care taxes payable	-	74,718	
Accrued professional services and consulting	154,554	46,668	
Innovation grants payable	32,394	-	
Deferred rent	1,257	-	
Health reimbursement adjustment payable	397,777	-	
Total current liabilities	23,497,667	15,118,639	
NET ASSETS			
Unrestricted	21,557,060	7,139,919	
Temporarily restricted	16,584,093	16,500,000	
Total net assets	38,141,153	23,639,919	
Total liabilities and net assets	\$ 61,638,820	\$ 38,758,558	

HEALTH SHARE OF OREGON
STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS

	Total			
	Unrestricted	Temporarily Restricted	Year Ended December 31, 2014	Year Ended December 31, 2013
REVENUE				
Premiums	\$ 1,103,056,996	\$ -	\$ 1,103,056,996	\$ 658,821,173
Contributions	-	112,124	112,124	-
Quality management incentive revenue	23,120,785	-	23,120,785	4,062,041
Grant revenue	2,201,602	-	2,201,602	298,016
Hospital reimbursement adjustment	(168,345,344)	-	(168,345,344)	(125,301,661)
Managed care organization taxes	-	-	-	(5,050,744)
Net assets released from restrictions	28,031	(28,031)	-	-
Net operating revenues	<u>960,062,070</u>	<u>84,093</u>	<u>960,146,163</u>	<u>532,828,825</u>
OPERATING EXPENSES				
Purchased healthcare	915,914,332	-	915,914,332	517,918,168
Quality management incentive expense	20,092,726	-	20,092,726	4,062,041
Professional services & consulting	2,235,187	-	2,235,187	1,716,387
Leased employee costs	4,054,557	-	4,054,557	3,389,408
Other administrative expenses	3,390,225	-	3,390,225	1,277,460
Total operating expenses	<u>945,687,027</u>	<u>-</u>	<u>945,687,027</u>	<u>528,363,464</u>
REVENUES OVER OPERATING EXPENSES	14,375,043	84,093	14,459,136	4,465,361
OTHER INCOME (EXPENSE)				
Investment income	42,098	-	42,098	34,489
CHANGE IN NET ASSETS	14,417,141	84,093	14,501,234	4,499,850
NET ASSETS, beginning of period	<u>7,139,919</u>	<u>16,500,000</u>	<u>23,639,919</u>	<u>19,140,069</u>
NET ASSETS, end of period	<u>\$ 21,557,060</u>	<u>\$ 16,584,093</u>	<u>\$ 38,141,153</u>	<u>\$ 23,639,919</u>

HEALTH SHARE OF OREGON STATEMENTS OF CASH FLOWS

	Year Ended December 31,	
	2014	2013
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	\$ 14,501,234	\$ 4,499,850
Adjustments to reconcile net worth to net cash from operating activities:		
Depreciation and amortization	69,059	41,329
Realized and unrealized gain on investments	26,534	3,504
Net fixed income investment discount and premium amortization	148,654	48,647
Changes in assets and liabilities:		
Capitation receivable	4,226,293	(5,812,078)
Maternity case rate receivable	244,057	8,165,762
Quality management incentive receivable	(9,400,652)	(4,062,041)
Patient centered primary care home receivable	-	1,046,447
Health reimbursement adjustment receivable	31,526	(31,526)
Innovation grants receivable	(37,442)	104,773
Prepaid expenses	(29,952)	(23,993)
Interest receivable	(39,258)	2,378
Other receivables	(181,324)	(117,124)
Other long-term assets	(22,453)	-
Capitation payable	(3,775,060)	5,696,204
Maternity case rate payable	(239,185)	(8,091,250)
Quality management incentive payable	9,400,652	4,062,041
Risk adjustment payable	1,313,145	305,724
Deferred grant revenue	633,231	-
Accounts payable and accrued expenses	407,629	111,734
Accrued professional services and consulting	107,886	(226,266)
Managed care taxes payable	(74,718)	(1,471,283)
Patient centered primary care home payable	-	(1,025,518)
Accrued leased employee costs	174,020	(209,675)
Innovation grants payable	32,394	-
Deferred rent	1,257	-
Health reimbursement adjustment payable	397,777	(137,239)
Net cash flows from operating activities	<u>17,915,304</u>	<u>2,880,400</u>
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from investment sales and maturities - contractual reserves	22,976,000	23,236,366
Purchase of investments - contractual reserves	(32,507,261)	(28,569,150)
Purchase of furniture and equipment	(458,234)	(48,997)
Net cash flows from investing activities	<u>(9,989,495)</u>	<u>(5,381,781)</u>
NET CHANGE IN CASH AND CASH EQUIVALENTS	7,925,809	(2,501,381)
CASH AND CASH EQUIVALENTS, beginning of year	<u>488,784</u>	<u>2,990,165</u>
CASH AND CASH EQUIVALENTS, end of year	<u>\$ 8,414,593</u>	<u>\$ 488,784</u>

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 1 – Nature of Business and Organization

Health Share of Oregon (Health Share or Organization), an Oregon non-profit public benefit corporation, was created in April 2012 as a Coordinated Care Organization (CCO) as defined in the Oregon statutes. Health Share is organized and operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986 as an integrated community-based health care plan that strives to achieve better care, better health, and lower costs for the Medicaid population in the three counties around Portland, Oregon.

The Organization entered into a risk contract with the State of Oregon, acting by and through Oregon Health Authority (OHA), effective September 1, 2012, to provide physical and mental health coverage under the Oregon Health Plan (OHP) to enrollees in Clackamas, Multnomah, and Washington counties of Oregon (Tri-County Region). Effective January 1, 2014, these services were expanded to include dental coverage under a new OHA contract expiring on December 31, 2018. The Organization started to offer dental coverage on January 1, 2014. During 2014, OHA contract was further amended, and the Organization assumed responsibility for an additional service, non-emergent medical transportation (NEMT). This benefit was implemented on January 1, 2015.

In 2012, the Centers for Medicaid and Medicare (CMS) approved Oregon's 1115 Medicaid Waiver that was necessary to implement Medicaid transformation in Oregon, in conjunction with the Patient Protection and Affordable Care Act (ACA). Changes under the CMS Medicaid Waiver and ACA significantly increased Medicaid eligibility in the state of Oregon beginning in 2014. As a result, the Organization experienced a significant increase in membership due to increased Medicaid eligibility in the state of Oregon.

The Organization contracts with fourteen independent Risk Accepting Entities (RAE) to provide, or arrange to provide, covered health services to enrollees assigned to the RAE on a fully capitated basis. The fourteen RAE's are as follows: CareOregon, Inc., Kaiser Foundation Health Plan, Providence Health Assurance, Tuality Health Alliance, Clackamas County Health Department, Multnomah County Health Department, Washington County Department of Health and Human Services, Access Dental Plan, Advantage Dental, Capitol Dental Care, Family Dental Care, Managed Dental Care, ODS Community Health, and Willamette Dental Group.

The Organization is a tax exempt organization under Section 501(c)(3) of the Internal Revenue Code.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting and presentation – The accompanying financial statements have been prepared in accordance with Generally Accepted Accounting Principles in the United States of America (U.S. GAAP). The Organization has prepared its financial statements in accordance with Accounting Standards Codification (ASC) 958, *Not-for-Profit Entities*. The reporting period included in these financial statements includes the years ended December 31, 2014 and 2013.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Use of estimates – In preparing the financial statements in conformity with U.S. GAAP, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the statement of financial position, and revenues and expenses for the reporting period. Actual results could differ from those estimates and assumptions.

Significant estimates in these financial statements include maternity case rate receivable and payable, Special Needs Rate Group (SNRG) risk corridor settlement receivable and payable, ACA minimum medical loss ratio rebate, and Quality Management Performance Measures incentive receivable and payable.

Concentrations of risk – Financial instruments, which potentially subject the Organization to concentrations of credit risk, consist of cash and cash equivalents and investments. The Organization maintains its cash in accounts that, at times, may exceed federally insured limits. The Organization makes such deposits with high credit quality entities and has not incurred any losses in such accounts. Investments are primarily fixed income securities and by their nature are subject to market interest rate fluctuations. Potential concentrations of credit risk exist due to market concentrations of high quality fixed income investments which react similarly to changing economic conditions.

The Organization's revenues are received almost entirely from the contract with OHA. A reduction in rates paid under this contract or a loss of the contract due to non-renewal, federal or state policy changes or decreased legislative funding could materially affect the financial position of the Organization. The current OHA contract is effective through December 31, 2018.

The Organization delegates the insurance risk and administration of the assigned enrollees to the RAEs. Loss of a contract with one of the RAEs, most notably CareOregon, who manages approximately 62% of the Organization's physical health members, could materially affect the Organization's ability to serve the assigned members. The Organization's personnel, members, and provider networks are geographically concentrated in the Clackamas, Multnomah and Washington counties of Oregon.

Fair value measurements – Fair value is the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants at the measurement date. Market participants are buyers and sellers, who are independent, knowledgeable, and willing and able to transact in the principal (or most advantageous) market for the asset or liability being measured.

Fair value is based on quoted market prices, when available, for identical or similar assets or liabilities. In the absence of quoted market prices, management determines the fair value of the Organization's assets and liabilities using valuation models or third-party pricing services, both of which rely on market-based parameters when available, such as interest rate yield curves, option volatilities, and credit spreads. The valuation techniques used are based on observable and unobservable inputs.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Observable inputs are those assumptions which market participants would use in pricing the particular asset or liability. These inputs are based on market data and are obtained from a source independent of the Organization.

Unobservable inputs are assumptions based on the Organization's own information or estimate of assumptions used by market participants in pricing the asset or liability. Unobservable inputs are based on the best and most current information available on the measurement date.

ASC 820, *Fair Value Measurements and Disclosures*, establishes a three-level valuation hierarchy for determining fair value that is based on the transparency of the inputs used in the valuation process. The inputs used in determining fair value in each of the three levels of the hierarchy are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities.

Level 2 – Either: (i) quoted prices for similar assets or liabilities; (ii) observable inputs, such as interest rates or yield curves; or (iii) inputs derived principally from or corroborated by observable market data or other pricing sources with reasonable levels of transparency.

Level 3 – Unobservable inputs.

The hierarchy gives the highest ranking to Level 1 inputs and the lowest ranking to Level 3 inputs. The level in the fair value hierarchy, within which the fair value measurement in its entirety falls, is determined based on the lowest level input that is significant to the overall fair value measurement.

The following methods and assumptions were used by the Organization in estimating fair values of each class of financial instruments for which it is practicable to estimate that value, in accordance with the provisions of ASC 825, *Financial Instruments*:

Cash and cash equivalents – The carrying amount approximates fair value because of the short maturity of these instruments.

Accounts receivable, accounts payable and accrued expenses – The carrying amounts are at historical costs; their respective estimated fair values approximate carrying values due to their current nature.

Investments – The carrying amount approximates fair value, and amounts are based on quoted market prices or alternative pricing sources with reasonable levels of transparency.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Cash and cash equivalents – The Organization considers cash to be cash in the bank or on hand and available for current use. Cash equivalents are investments maturing three months or less from date of purchase. The investments are readily marketable securities and are classified as current assets. Net interest income earned from cash and cash equivalents was \$24,896 and \$15,722, during 2014 and 2013, respectively.

Cash and cash equivalents – contractual reserves – These contractual reserves are maintained to meet the primary and secondary reserve requirements under the OHA contract. OHA requires the reserves funds to be held and used for the purpose of making payments to providers in the event of the Organization's insolvency. These include US Treasury securities with future maturities ranging from one month to three months.

Investments – contractual reserves – These contractual reserves are maintained to meet the primary and secondary reserves requirements under the OHA contract. OHA requires the reserves funds to be held and used for the purpose of making payments to providers in the event of the Organization's insolvency. These include US Treasury securities with future maturities ranging from four months to eight months. Net interest income earned from contractual reserves was \$192,389 and \$70,918, during 2014 and 2013, respectively.

Investments are stated at fair market value based on quoted market prices as of the statement of financial position date (see Notes 3 and 4). The Organization uses the specific identification method for determining the cost basis and gain or loss on its investments, and transfers between levels in the fair value hierarchy.

Receivables – Receivables consist primarily of Capitation receivable, Quality Management Performance Measures incentive receivables, amounts owed to the Organization for maternity case rate premiums, and grant receivables. The Organization does not require collateral or other security to support the recorded receivables amounts.

Furniture and equipment – Furniture and equipment are stated at cost, and are depreciated or amortized using the straight-line method over the estimated useful life. Useful lives are determined by the asset type, and can range from one to three years. Significant additions and improvements that increase the estimated useful life of an asset are capitalized. Expenditures for maintenance and repairs are expensed as incurred. Furniture and equipment purchases totaling less than \$2,000 are expensed when purchased.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Net assets – The financial statements report net assets and changes in net assets in three classes that are based upon the existence or absence of restrictions on use that are placed by its donors, as follows:

Unrestricted net assets – Unrestricted net assets are resources available to support operations. Included in the unrestricted net assets as of December 31, 2014 and 2013 is \$16,330,485 and \$6,940,541, respectively, of board designated funds set aside to meet OHA restricted reserve requirements, most of which is included in the investment – contractual reserve balance as of December 31, 2014 and 2013. The only limits on the use of unrestricted net assets are the broad limits resulting from the nature of the organization, the environment in which it operates, the purposes specified in its by-laws and articles, and any limits resulting from contractual agreements with members and others that are entered into in the course of its operations.

Temporarily restricted net assets – Temporarily restricted net assets are resources that are restricted by a donor for use for a particular purpose or in a particular future period. The Organization's unspent contributions are classified in this class if the donor limited their use, as are the unspent appreciation of its donor-restricted funds. When a donor's restriction is satisfied, either by using the resources in the manner specified by the donor or by the passage of time, the expiration of the restriction is reported in the financial statements by reclassifying the net assets from temporarily restricted to unrestricted net assets (See Note 6).

Permanently restricted net assets – Permanently restricted net assets are resources whose use by the organization is limited by donor-imposed restrictions that neither expires by being used in accordance with a donor's restriction nor by the passage of time. There are no permanently restricted net assets as of December 31, 2014 and 2013.

Revenue recognition – Premium payments are recognized in the period to which the healthcare services coverage relates. Maternity case rate premiums are recognized in the period that a birth occurs.

Hospital Reimbursement Adjustment (HRA) and Managed Care Organization (MCO) tax revenue are received as part of the premium payment and are recorded in premium revenue when received. HRA and MCO amounts received are to be paid in full to designated entities and are also recorded as a liability and adjustment to revenue upon receipt.

HRA revenue for the years ended December 31, 2014 and 2013 was \$168,345,344 and \$125,301,661, respectively. MCO tax revenue for the years ended December 31, 2014 and 2013 was \$129,372 and \$5,050,744, respectively. HRA and MCO received but not paid out prior to year end are recorded as HRA and MCO payables. The MCO tax was discontinued on September 30, 2013. There are no remaining unpaid amounts related to the MCO tax at December 31, 2014.

PCPCH case rate revenue earned totaled \$1,174,200 and \$1,812,051 for the years ended December 31, 2014 and 2013, respectively, and is recorded in premium revenue. The PCPCH case rate program ended effective September 30, 2013, any revenue recorded in 2014 was for retroactive payment. There are no remaining unpaid amounts at December 31, 2014.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Special Needs Rate Groups (SNRG) – The Organization receives a specific case rate for patients who have been identified with specific high-risk medical conditions. The SNRG case rates are paid to the CCOs and then monitored against actual claims, to provide a revenue risk corridor protection for the CCOs and State as this newer rate group risk was transferred to the CCOs in 2013. The SNRG risk corridor is structured to reimburse CCOs with actual claims costs that exceed revenues, and inversely to recoup revenues exceeding actual claims costs. Completion for data submissions to OHA for the SNRG risk corridor are due no later than June 30, 2015 for both calendar year 2013 and 2014 risk corridor periods. Initial settlement estimates for 2013 include a payable due to OHA for \$883,470, and related receivables from RAE organizations of \$865,800; resulting in a net impact to the Organization of \$17,670. Information to calculate a reasonable estimate for 2014 is not currently determinable, as additional claims data is needed. Preliminary estimates for 2014 reflect a potential liability ranging from \$0 to \$3,792,757. 98% of any amount due related to 2014 will be received back from the RAE organizations.

CCO Minimum Medical Loss Ratio requirements for the ACA Expansion Population - Effective July 1, 2014 the State requires a minimum medical loss ratio (MMLR) of 80% on the ACA expansion population rate groups. Specifically, the Organization is required to expend at least 80% of the capitation revenue received for this population on allowable medical expenses. The initial reporting period under the CCO contract for this new requirement is 18 months: July 1, 2014 – Dec 31, 2015, with claims run-out through March 31, 2016 and final reporting submissions due by June 30, 2016. Subsequent years are to be calculated based upon the calendar year. The terms of the ACA MMLR requirement is pending CMS approval, so the terms and conditions of the requirement are subject to change. Reliable estimates for any potential recoupments owed by the Organization for the initial 6 months are not currently determinable, requiring additional RAE claims data and financial performance information. Should the CCO be below the required MMLR for the measurement period, the CCO will need to recoup the funds from the RAE's to remit back to the State. The Organization's net liability is the administrative fees associated with the ACA Expansion Population net premium revenues. Total ACA premium revenues from July 1, 2014 to December 31, 2014 total \$230 million. Preliminary estimates indicate the potential liability due to OHA for the six months ended December 31, 2014 are between \$0 and \$20.1 million. 98% of any amount due back to OHA will be received back from the RAE organizations.

Contributions – Contributions are recognized as revenue when received. All contributions are reported as increases in unrestricted net assets unless use of the contributed assets is specifically restricted by the donor. Amounts received that are restricted by the donor to use in future periods or for specific purposes are reported as increases in either temporarily restricted or permanently restricted net assets, consistent with the nature of the restriction (See Note 6).

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Grant revenue – Grant revenue is recognized when qualifying costs are incurred for cost-reimbursement grants or contracts or when a unit of service is provided for performance grants.

Center for Medicare and Medicare Innovation (CMMI) – The Organization supports the goal of improving the health of its members and the community through the CMMI program. The CMMI program identifies and funds innovative provider-based projects. The Organization has a sub-award contract with Providence Health and Services – Oregon for innovative healthcare delivery and transformation efforts to improve population health in the Tri-County Region.

The sub-award will be received between July 1, 2012 and June 30, 2015. The maximum sub-award for the period of July 1, 2012 through June 30, 2013 was \$409,500, the maximum sub-award for the period of July 1, 2013 through June 30, 2014 was \$534,600, and the maximum sub-award for the period of July 1, 2014 through June 30, 2015 was \$215,475, subject to fulfillment of conditions prescribed under the sub-award contract. These grants are accounted for as revenue in the period the conditions are satisfied. The related program expenses are accrued as incurred. For the year ended December 31, 2014 the Organization recognized \$515,734 in revenue and expense related to this grant. For the year ended December 31, 2013 the Organization recognized \$298,016 in revenue and expense related to this grant.

Assertive Community Treatment (ACT) and System of Care Wraparound Initiative (Wraparound) – Effective March 2014, the Organization began participating in the expansion of Assertive Community Treatment (ACT) and System of Care Wraparound Initiative (Wraparound) programs. These programs were implemented to improve community's capacity to provide ACT and Wraparound treatment services for adults suffering from serious and persistent mental illness and children with complex behavioral health issues. Under OHA agreement, the maximum award for the period of March 1, 2014 through June 30, 2015 is \$572,881. These grants are accounted for as revenue in the period the conditions are satisfied. The related program expenses are accrued as incurred. For the year ended December 31, 2014, the Organization recognized \$535,540 in revenue and expense related to this grant.

Transformation Funds – Effective December 2013, the Organization entered into a grant award contract with the Oregon Health Authority (OHA), for the purpose of funding health care transformational projects designed to support the Triple Aim of better health, better care, and lower costs. The award will be received between March 1, 2014 and June 30, 2015, with a total maximum funding amount of \$3,256,965. The funds are to be utilized by December 31, 2015. The grant is accounted for as revenue in the period the conditions are satisfied. The related program expenses are accrued as incurred. For the year ended December 31, 2014, the Organization recognized \$1,144,948 in revenue and expense related to this grant. As of December 31, 2014, the Organization had \$633,231 recorded as deferred grant revenue.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Quality Management Performance Measures incentive revenue – OHA established a quality pool as part of the agreement with the Center for Medicare and Medicaid Services (CMS) as required by the Special Term and Conditions (STCs) of Oregon’s Section 1115 demonstration. The quality pool holds CCOs responsible for spending on health care as well as quality of care provided. The total funding allocated to the 2013 quality pool was 2% of aggregate premium payments for the calendar year 2013 services paid through March 31, 2014. In 2014, quality pool increased to 3% of aggregate premium payments for the calendar year 2014 services paid through March 31, 2015. Quality Management Performance Measures revenues are recognized when earned and when management can reasonably estimate related metrics have been met.

Each CCO is eligible for a maximum amount of quality pool funds up to 3% and 2% of their actual paid premiums for the calendar year 2014 and 2013, respectively. In addition, the CCOs have the opportunity to share in any remaining unallocated statewide quality pool funds on an annual basis, known as challenge pool funds.

To qualify for 100% of the 2013 quality pool funds each CCO had to meet 13 of the 17 specified incentive measures and benchmarks (metrics), of which 25% was paid out if the technology plan was submitted prior to February 1, 2014 and was approved. To qualify for the 2013 challenge pool funds CCOs had to meet a subset of four incentive measures that focused on the integration of care and health outcomes, rather than measuring levels of services provided. The Organization met 12.8 of the 2013 quality management performance measures, including 3 challenge pool measures, and received 104% of total quality pool funds of \$13,720,133, of which \$10,689,924 were paid out to the RAEs for distribution. The remaining \$3,030,209 was retained to support continued improvements and expansion of three technology plan measures, to be overseen by Health Share. As of December 31, 2013, the Organization recorded an estimate of \$4,062,041. The additional quality pool funds received for 2013 metrics of \$9,658,092 was recorded as revenue during 2014.

To qualify for 100% of the 2014 quality pool funds each CCO must fulfill all of the following requirements: (a) meet or exceed the benchmark or the improvement target, or the measurement and reporting requirements for the clinical measures, on at least 75% of the incentive measures (12 of 16 measures); (b) meet or exceed the benchmark or improvement target for the Electronic Health Record adoption measure as one of the 12 measures; and (c) score at least 0.60 on the PCPCH enrollment measure using the tiered formula. As of December 31, 2014, the Organization estimates it met 7.6 of the metrics and recorded an estimate of \$13,462,693 in revenue for metrics met, of which all amounts will be paid out to the RAEs for distribution. As of February 27, 2015 the total available quality pool funds to be earned by the Organization is \$30,515,438.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 2 – Summary of Significant Accounting Policies (continued)

Net investment income – Investment income consists of interest earnings, dividends and both realized and unrealized gains and losses. Premiums and discounts on fixed income securities are recognized as adjustments to investment income using the straight-line method. Interest on fixed income securities is recognized in income on an accrual basis. Investment income is presented net of investment transaction, custodial and advisory fees, which are expensed as incurred. Interest represents amounts earned on investment holdings, and are accrued when earned. Realized investment gains and losses represent capital gains and losses. Unrealized gains or losses represent net changes to appreciation or depreciation in fair market value.

Purchased healthcare – Purchased healthcare consists of sub-capitation, maternity case rate and PCPCH paid or due to the RAEs. The amount paid in purchased healthcare is based upon the revenue earned less a 2% administrative fee. Purchased healthcare expenses are recognized in the period the services are provided. Amounts paid in purchased healthcare to the RAEs are intended to cover all related physical, mental, and dental health care costs, any administrative costs, and any net gain or losses realized by the RAEs.

Other operating expenses – All other operating expenses are recorded in the period the expense is incurred. Professional services and consulting costs include external actuarial services, legal costs and costs associated with the Management Services Agreement with CareOregon. Leased employee costs represent the cost of employees leased from CareOregon and other related member organizations. See Note 7 for more information on related parties.

Revenues over operating expenses – The performance indicator of revenues over operating expenses is the excess of total operating revenues over operating expenses.

Income taxes – The Organization is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. Accordingly, no provision for income taxes is included in the financial statements. The Organization had no unrecognized tax benefits which would require an adjustment to the beginning balance of net assets and had no unrecognized tax benefits at December 31, 2014 or 2013. The Organization is subject to examinations by federal taxing authorities for three years from the filing of a tax return. Contributions to the Organization are tax-deductible to donors under Section 170 of the IRC.

Reclassification – Certain amounts were reclassified in the prior year for consistency and comparison with the current year presentation.

Subsequent events – Subsequent events are events or transactions that occur after the balance sheet date but before financial statements are issued. The Organization recognizes in the financial statements the effect of all subsequent events that provide additional evidence about conditions that existed at the date of the balance sheet, including the estimates inherent in the process of preparing the financial statements. The Organization's financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the balance sheet but arose after the balance sheet date and before financial statements are issued (See Note 11).

**HEALTH SHARE OF OREGON
NOTES TO FINANCIAL STATEMENTS**

Note 3 – Investments – Contractual Reserves

Investments – Contractual Reserves as of December 31, 2014 and 2013 consist of U.S. Treasury notes. These investments are restricted as to their use, and are held to satisfy required primary and secondary reserves requirements under the OHA contract. As of December 31, 2014 and 2013, the total contractual reserves held were \$32,793,040 and \$23,436,968, respectively.

Note 4 – Fair Value of Investments

The table below shows the Organization’s investments as of December 31, 2014 and 2013 measured at fair value on a recurring basis, and indicates the fair value hierarchy of the valuation techniques utilized by the Organization to determine such fair value. Assets and liabilities are considered to be “fair value on a recurring basis” if fair value is regularly measured.

Fair Value Measurements at December 31, 2014				
	Total Fair Value	Level One	Level Two	Level Three
Government				
U.S. Treasury Notes	\$ 32,768,675	\$ 32,768,675	\$ -	\$ -
Money market funds	24,366	24,366	-	-
	\$ 32,793,041	\$ 32,793,041	\$ -	\$ -
Fair Value Measurements at December 31, 2013				
	Total Fair Value	Level One	Level Two	Level Three
Government				
U.S. Treasury Notes	\$ 22,990,141	\$ 22,990,141	\$ -	\$ -
Money market funds	446,827	446,827	-	-
	\$ 23,436,968	\$ 23,436,968	\$ -	\$ -

While estimates of fair value are based on management’s judgment of the most appropriate factors, there can be no assurance that, had the Organization disposed of such items at December 31, 2014 and 2013, the estimated fair values would necessarily have been achieved at that date. Since market values may differ depending on various circumstances, the estimated fair values as of December 31, 2014, should not necessarily be considered to apply at subsequent dates.

As of December 31, 2014 and 2013, there were no investments that were in a continuous loss position for twelve months or longer. In accordance with the Organization’s impairment policy, there are no other-than-temporary impairment losses recorded during the reporting period ended December 31, 2014 and 2013.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 5 – Furniture and Equipment

Furniture and equipment includes work-in-process fixed assets purchased but not yet placed in service, and consisted of the following at December 31:

	<u>2014</u>	<u>2013</u>
Furniture	\$ 273,835	\$ 89,698
Equipment	54,199	35,523
Computer hardware	124,430	45,405
Computer software	78,548	4,617
Leasehold improvements	126,113	-
Work in process	<u>-</u>	<u>23,648</u>
	657,125	198,891
Less accumulated depreciation and amortization	<u>(110,388)</u>	<u>(41,329)</u>
	<u><u>\$ 546,737</u></u>	<u><u>\$ 157,562</u></u>

Depreciation of \$69,058 and \$41,329 was recognized during 2014 and 2013, respectively.

Note 6 – Restricted Net Assets

Temporarily restricted net assets are donor restricted for the following purposes at December 31:

	<u>2014</u>	<u>2013</u>
Contractual reserve requirements	\$ 16,500,000	\$ 16,500,000
Private grant funds	<u>84,093</u>	<u>-</u>
	<u><u>\$ 16,584,093</u></u>	<u><u>\$ 16,500,000</u></u>

Temporarily restricted net assets includes \$16,500,000 for the purpose of maintaining primary and secondary reserves under the OHA contract, which were contributed by CareOregon, a member of the Organization. These net assets are held in the reserves account for the purposes of making payment to providers in the event of the Organization's insolvency.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 6 – Restricted Net Assets (continued)

The Organization is required to return all or the portion of the contribution to CareOregon in the event of dissolution or winding up on or before September 1, 2022 or if OHA terminates its agreement with the Organization on or before September 1, 2022. The amount of contribution to be returned to CareOregon would be the amount remaining after discharge of all liabilities and obligations of the Organization. Further, if the Organization is in existence on September 1, 2022 and under the terms of the OHA contract, the amount of the primary and secondary reserve requirements for the Organization on September 1, 2022 is less than the amount of the grant, then the Organization shall return to CareOregon any portion of the grant that is in excess of the minimum reserves amount required to be maintained. As of December 31, 2014 and 2013, the reserve requirements are more than the grant amount (See Note 9).

During 2014, the Organization received contributions of \$112,124 from the RAEs to be used only for the purposes of funding additional employees, and related overhead expenses, for the oversight and improvement of the Mental and Physical Health Assessments of Children in DHS Custody Quality Incentive Metric. The Organization incurred expenses of \$28,031 for the purposes of funding additional employees and overhead during the year ended December 31, 2014.

Note 7 – Related Party Transactions

Board of Directors – The Organization's Board of Directors includes representatives from the following entities that maintain contractual agreements or have had other transactions with the Organization: Adventist Health, CareOregon, Inc., Central City Concern, Clackamas County Health Department, Kaiser Foundation Health Plan, Legacy Health, Multnomah County Health Department, Oregon Health & Science University, Providence Health Assurance, Tuality Health Alliance, and Washington County Department of Health and Human Services.

The contractual agreements include risk accepting arrangements, a management services agreement, CMMI projects, transformation community projects, ACT and Wraparound programs, and contributions.

Contributions – The Organization received contributions from entities that maintain contractual agreements or have had other transactions with the Organization. During 2012, the Organization received \$16,500,000 from CareOregon, Inc. for the purpose of maintaining primary and secondary reserves under the OHA contract.

During 2014, the Organization received \$38,733 from CareOregon, Inc., \$7,502 from Providence Health Assurance, \$5,373 from Kaiser Foundation Health Plan, \$4,160 from Tuality Health Alliance, \$8,651 from Clackamas County Health Department, \$29,274 from Multnomah County Health Department, and \$18,431 from Washington County Department of Health and Human Services for the purpose of funding an additional employee, and related overhead expenses, for the oversight and improvement of the Mental and Physical Health Assessments of Children in DHS Custody Quality Incentive Metric.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 7 – Related Party Transactions (continued)

Innovation Grant – CMMI grant revenue earned from Providence Health and Services totaled \$515,734 and \$298,016 and is recorded in grant revenue for the years ended December 31, 2014 and 2013, respectively. Total CMMI program expenses for the years ended December 31, 2014 and 2013 were \$524,958 and \$398,548, respectively, included in leased employee costs.

Purchased healthcare – Purchased healthcare to related entities under the risk accepting agreements totaled \$915,914,332 and \$517,918,168 for the years ended December 31, 2014 and 2013, respectively.

The purchased healthcare includes the following:

	2014	2013
Sub-capitation	\$ 878,446,914	\$ 483,916,282
Maternity case rate	37,159,018	32,168,906
SNRG risk corridor adjustment	(865,800)	-
PCPCH case rate	1,174,200	1,832,980
	<u>\$ 915,914,332</u>	<u>\$ 517,918,168</u>

Management Service Agreement – The Organization contracts with CareOregon, Inc., to provide certain management services including the following: human resources, financial services, information technology services, customer service, space, furnishings, and supplies. The agreement is for a five-year term and can be terminated without cause by either party upon 180 days written notice. Management services costs incurred total \$1,443,286 and \$1,102,500, of which \$1,313,960 and \$972,135 are recorded in professional services and consulting, \$111,852 and \$111,851 in rental costs and \$17,474 and \$18,514 in computer maintenance costs are recorded in other administrative expenses for the years ended December 31, 2014 and 2013, respectively.

Consulting Service Agreement – The Organization contracts with Providence Health System-Providence Portland Medical Center d/b/a Center for Outcomes Research & Education (CORE), to share data, analytic, and scientific capabilities in order to produce a set of performance measurement to monitor quality, plan for care transformation, and assess the success of interventions over time. The agreement is in effect from May 1, 2013 through April 30, 2015 with an automatic annual renewal unless either party provides a 90-day notice of termination. Contract expenses for the years ended December 31, 2014 and 2013 totaled \$295,309 and \$163,334, respectively, and are included in professional services & consulting.

The Organization contracts with Performance Health Technology, Inc., (PHTech), an independent third party administrator for claims administration and processing on behalf of Clackamas County Health Department, Multnomah County Health Department, and Washington County Department of Health and Human Services (the mental health RAEs). The Organization is fully reimbursed for these costs from the mental health RAEs.

HEALTH SHARE OF OREGON NOTES TO FINANCIAL STATEMENTS

Note 7 – Related Party Transactions (continued)

Leased employee costs – The Organization is leasing management and other employees from related member organizations. Leased employee costs were \$4,403,515 and \$3,269,548 from CareOregon, Inc.; \$0 and \$74,740 from Tuality Healthcare; \$0 and \$43,474 from Legacy Health; and \$0 and \$1,646 from Adventist Health for these leased employees for the years ended December 31, 2014 and 2013, respectively.

Quality Management Performance Measures incentive payments - The Organization paid \$10,689,924 to the RAEs in distribution of the quality management funds during 2014. Payments to RAE's were \$4,926,931 to CareOregon, Inc.; \$1,040,770 to Kaiser Foundation Health Plan; \$1,250,021 to Providence Health Assurance; \$849,883 to Tuality Health Alliance; \$681,535 to Clackamas County Health Department; \$1,126,251 to Multnomah County Health Department; and \$814,533 to Washington County Department of Health and Human Services.

Transformation Funds – Transformation expenses paid to related parties were \$45,000 to Providence Health Assurance; \$45,000 to Multnomah County Health Department; and \$123,737 to Washington County Department of Health and Human Services.

ACT and Wraparound grants –Wraparound expense paid to related parties was \$67,500 to Clackamas County Health Department.

Healthy Columbia Willamette Project – Effective June 1, 2013 through January 30, 2015, the Organization contracted with twenty other participants, including entities that maintain contractual agreements or have had other transactions with the Organization. The project is to develop a single health needs assessment across hospital, public health and coordinated care organization (CCO) participants in the four-county region comprised of Washington, Multnomah, Clackamas and Clark counties (Four-County Participants), to help eliminate duplicate efforts and lead to effective prioritization of needs and enable joint efforts for implementing and tracking improvement activities. Under the agreement Health Share is liable for \$40,000 of an \$80,000 fee due from the CCOs involved in the contract. \$40,000 and \$40,000 were paid to Multnomah County Health Department, the designated Community Convener of the project, during the years ended December 31, 2014 and December 31, 2013, respectively.

Note 8 – Tax Status

The Organization applied for tax-exempt status from federal income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code. The Organization received approval of the tax exempt status application from the Internal Revenue Service in a letter dated May 21, 2014. Therefore, no income tax provision has been recognized for the years ended December 31, 2014 and 2013.

HEALTH SHARE OF OREGON

NOTES TO FINANCIAL STATEMENTS

Note 9 – Restricted Reserve and Net Worth Requirements

Under the OHA contract, the Organization is required to meet financial solvency requirements on a quarterly basis. Financial solvency is demonstrated by two key measures; the restricted reserve requirement and the net worth requirement. The restricted reserve requirement has the Organization establish a Restricted Reserve Account and maintain adequate funds in the account to meet OHA's primary and secondary restricted reserve requirements. The restricted reserve requirement is approximately half of a month's average medical costs and includes \$250,000 for the primary restricted reserve, and all amounts in excess of \$250,000 as the secondary restricted reserve. The net worth requirement is approximately 5% of annualized medical costs.

As of December 31, 2014, the Organization has excess of approximately \$1.05 million for the restricted reserve requirement. As of December 31, 2014, the Organization has an approximate excess of \$167,000 for the net worth requirement.

Note 10 – Commitments

Lease Agreement

During 2014, The Organization entered into a new lease agreement for rental space in the Broadway building. The lease term is December 1, 2014 through May 31, 2020. The lease agreement allows the Organization the right to terminate the lease early, on March 31, 2018 if certain conditions are met. Total rental expense was \$137,146 and \$111,851 for the years ended December 31, 2014 and 2013, respectively.

Future minimum lease payments under the non-cancelable operating leases are as follows:

Year ending December 31:		
2015	\$	247,943
2016		278,658
2017		287,081
2018		295,505
2019 and thereafter		<u>433,789</u>
	\$	<u>1,542,976</u>

Note 10 – Commitments

Future Commitments – CMMI Health Commons Project – In 2012, Providence Health and Services submitted and was awarded the CMMI Health Commons Grant by the Centers for Medicare and Medicaid Services (CMS). The grant award is for \$17.3 million and covers a three-year period. The Organization entered into a participation agreement with Providence in which the Organization has a sub-award contract and a commitment to provide an additional investment of up to \$5.016 million for work associated with the CMMI project over the same three-year period. The additional investment by the Organization will be used to provide necessary funding to fill budgeted shortfalls for the implementation of the following grant initiatives: Interdisciplinary Community Care Teams, Care Transitions, Standardized Discharge Program, Intensive Transition Teams, and the ED Guides Program. Actual future investment total in the CMMI project by the Organization will be based upon actual incurred costs, reinvestment of potential program-generated savings, and adherence to timeline and budget benchmarks. No such funds have been needed from Health Share through the date of this report.

Supporting Third Party Administration – The Organization contracts with Performance Health Technology, Inc., (PHTech) to host and provide 270 and 271 transaction processing, a provider web portal and supporting administrative services to allow the verification of enrollment, eligibility, primary care provider assignment and RAE assignment of the Organization’s members. The contract became effective April 1, 2013 for a period of three years unless otherwise terminated.

Note 11 – Subsequent Events

Beginning January 1, 2015, the Organization reduced its administrative fee from 2% to 1.8% for purchased healthcare.

Since December 31, 2014, the Organization has met the year two requirements for three technology metrics of the Quality Management Performance Measures incentive pool and received \$2,692,539 in Quality Management Performance Measures incentive revenue.

The Affordable Care Act (ACA) Medicaid expansion brought approximately 85,000 additional members in 2014 to the Organization. An undeterminable amount of the ACA expansion members are pending review and determination of eligibility to be completed by OHA. The review process has subsequently been delayed from the original target date of December 31, 2014 to April 30, 2015. A resulting decrease in the Organization’s membership is pending the completion of the OHA eligibility review.

Beginning January 1, 2015, the Organization integrated non-emergent medical transportation (NEMT) benefits as part of the core offering of healthcare services and received new risk revenue from OHA related to this benefit. The delivery of NEMT benefits is being subcontracted to an independent contractor to serve as a broker of NEMT provider services.