

# Oregon's Health System Transformation Quarterly Legislative Report

Q4 2016



Published July 2017

Q4 2016 Legislative Report

Oregon Health Authority



## About this report

Welcome to OHA's quarterly report to the Legislature on Oregon's Health System Transformation progress for Q4 and 2016 (October-December).

This report was developed to address legislatively established reporting requirements for health system transformation and coordinated care organizations (CCOs).<sup>1</sup>

On a quarterly basis, this report will provide updates on the Oregon Health Plan population and CCOs' efforts to further the transformation of our health system.

For questions or comments about this report, or to request this publication in another format or language, please contact the Oregon Health Authority Director's Office at:

503-947-2340 or  
OHA.DirectorsOffice@state.or.us

<sup>1</sup>Requirements include Senate Bill 1580 (2012), Oregon Revised Statutes 414.620 and 414.629, and House Bill 3650 (2011), which established Oregon's integrated and coordinated health care delivery system in which CCOs are used to improve health, quality, access, and outcomes.

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## Table of Contents

Director's Message	3
Health System Performance	5
Oregon Health Plan Demographics	9
Health Disparities	11
Finance	12
Eligibility and Enrollment	18
Appendix A: Enrollment by County	19
Appendix B: CCO Profile	20
Appendix C: Additional Transformation Reports	21

# Director's Message

Dear partners in transformation,

Key features of this quarter's report are:

**1. A breakdown of the Medicaid expansion population that have been added to the Oregon Health Plan (OHP) through the ACA** including where they live, their employment status and the services they use. Medicaid expansion members have far fewer hospitalizations and use the emergency department less frequently than adults with non-ACA Medicaid coverage.

Statewide, almost half (47%) of Oregonians who receive Medicaid coverage through the ACA are employed.



**2. Information about recommendations from the Behavioral Health Collaborative and the new Behavioral Health Mapping Tool.** Both the recommendations and the mapping tool are key strategies to continue integrating behavioral health into physical and oral health and making sure that every Oregonian has easy access to the services they need.

**3. A new CCO incentive measure beginning in 2018 that is aimed at addressing health disparities.** Emergency department (ED) usage has been declining in Oregon since 2011, however, CCO members with severe and persistent mental illness (SPMI) use the ED at more than double the rate of members overall. Therefore, in January the Metrics and Scoring Committee elected to add ED utilization among members with SPMI as an incentive measure to address this health disparity.

OHP adults with severe and persistent mental illness use the emergency department at more than twice the rate of OHP adults overall.  
(Per member per month, statewide, mid-2016)



# Director's Message

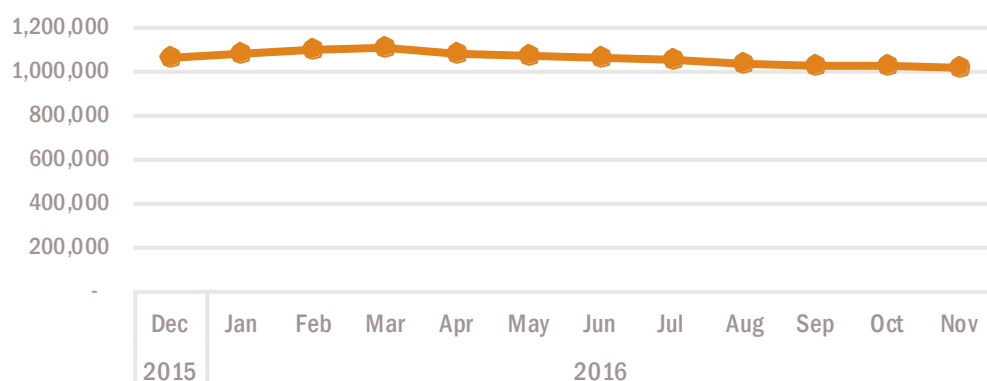
4) **An update on eligibility and enrollment in OHP.** Medicaid enrollment declined 8% between March and November 2016. However, overall enrollment has remained relatively flat over the past year. Over the past few weeks, the Medicaid eligibility and enrollment process has been in the news. OHA testified before the Legislature and provided context and information. Please review that testimony and additional information here:

<https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/130448>

The transition from Cover Oregon to the new ONE eligibility system is still underway. We are in the final stages and anticipated clean-up of individual cases has begun. We have an action plan in place to complete all clean up case renewals by August 31.

## OHP enrollment

OHP members may gain or lose coverage within the month. Data labels in the above chart indicate net change from previous month. Enrollment actuals are finalized 90 days after the month ends.



There is continuing need for improving health system performance. OHA takes that responsibility seriously, as well as the need to continue to improve agency performance and accountability. We welcome your questions and engagement.

Sincerely,

Lynne Saxton, Director  
Oregon Health Authority

# Health System Performance

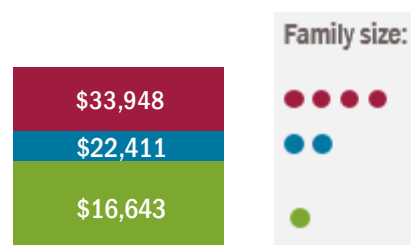
## Medicaid Expansion Population

When Oregon expanded Medicaid, nearly 400,000 Oregonians were able to receive health care. This report gives a snapshot of the Medicaid expansion population in Oregon and what services they are accessing.

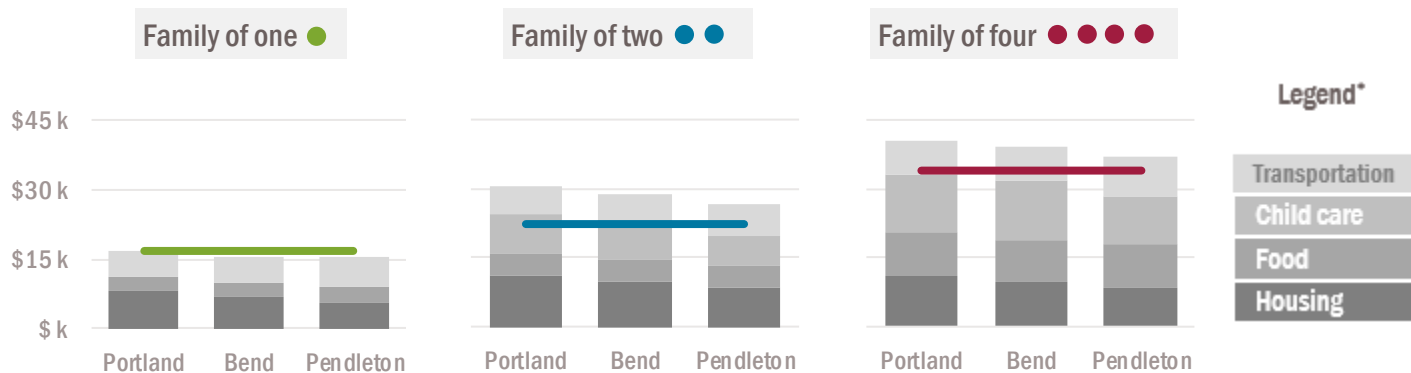
Medicaid eligibility was expanded to Oregonians who earn up to 138% of the federal poverty level (FPL). The bar chart at right shows the maximum annual income families can make to be eligible for Medicaid coverage under the ACA.

Families who earn 138% of the federal poverty level have a hard time making ends meet. The grey bars below show the average cost of basic living needs in three cities, and the colored lines show 138% of the FPL for that family size.

Medicaid income eligibility under the ACA by family size.



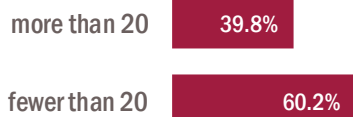
## Basic cost of living and Medicaid income eligibility by family size:



\*Cost of living estimates are from Economic Policy Institute (<http://www.epi.or/resources/budget>) and are in 2014 dollars

Statewide, almost half (47%) of Oregonians who receive Medicaid coverage through the expansion are employed. Among those employed:

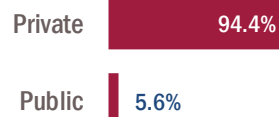
### Hours worked per week



### Employer size (# of employees)



### Employer type

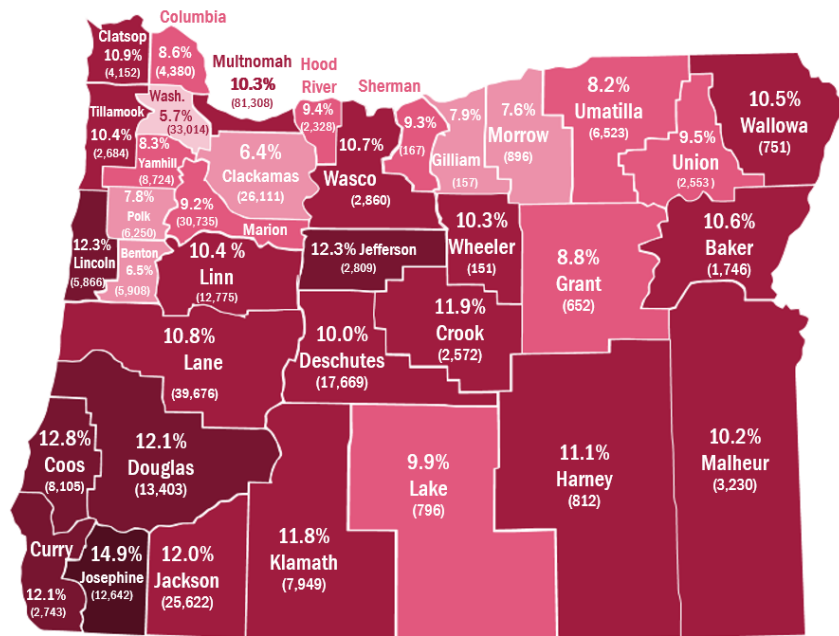


# Health System Performance

## Medicaid Expansion Population

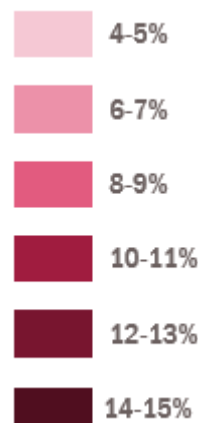
The percent of Oregonians who receive coverage due to the expansion of Medicaid varies by county.

(Total number of Oregonians receiving Medicaid coverage due to the ACA shown in parentheses)



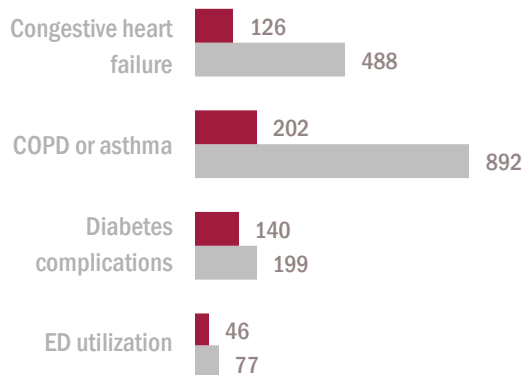
**380,818**

Oregonians receive Medicaid coverage because of the Affordable Care Act.



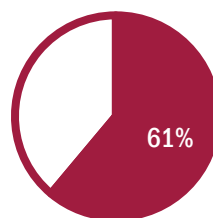
## Expansion members...

Have fewer hospitalizations for preventable conditions and use the emergency department less frequently than adults with traditional (non-expansion) Medicaid coverage  
(Lower is better.)



Hospitalization rates are reported per 100,000 member years  
ED utilization is reported per 1,000 member months

Use primary care services....



And behavioral health services....

**118,906**  
received prescriptions for mental health drugs

**87,330**  
received mental health services

**42,564**  
received substance use disorder services

# Health System Performance

## Behavioral Health Collaborative

Behavioral health touches every Oregonian. Everyone has a friend, a loved one, or a neighbor who has experienced a mental health issue or substance use disorder – and many Oregonians experience these challenges themselves. While Oregon has made progress, there is still much work to do integrating behavioral health with the physical and oral health systems in the coordinated care model, and making sure that every Oregonian has access to needed services.

The Oregon Health Authority (OHA) convened the Behavioral Health Collaborative (BHC) last summer to develop recommendations by building on Oregon’s coordinated care model to identify and address system and operational barriers that prevent individuals and their families from getting the right support at the right time.

**The four recommendations from the BHC include:**

- 1 Governance and finance: Regional governance model for behavioral health** – builds off the CCO community governance model and integrates community mental health services
- 2 Standards of care and competencies** – set a minimum standard of care for all behavioral health workers
- 3 Workforce** – develop a well-trained behavioral health workforce, inclusive of certified, licensed and peer support specialists and community health workers throughout the state
- 4 Information exchange and coordination of care** – strengthen use of health information technology and develop an outcomes focused health measurement framework aligned with the coordinated care model

When taken together these recommendations will transform Oregon’s behavioral health system from one that is fragmented, to one that is integrated, properly resourced, and capable of providing better health and better care at a lower cost.

For more information about the BHC, the recommendations and the behavioral health mapping tool see: [www.oregon.gov/oha/hpa/csi-bhp/Pages/Behavioral-Health-Collaborative.aspx](http://www.oregon.gov/oha/hpa/csi-bhp/Pages/Behavioral-Health-Collaborative.aspx)

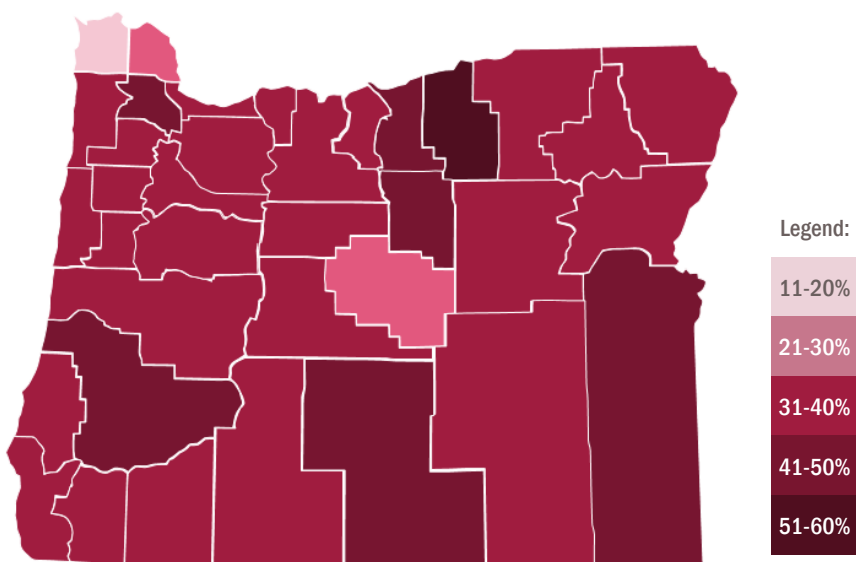
# Health System Performance

## Oral health metrics

In March, the Oregon Health Authority released the first in-depth report on oral health care data for Oregon's CCOs ([www.oregon.gov/oha/hpa/analytics/Documents/oral-health-ccos.pdf](http://www.oregon.gov/oha/hpa/analytics/Documents/oral-health-ccos.pdf)). Oral health is critical to overall health. Historically, oral health care has been delivered separately from medical care. Oregon's coordinated care model is committed to integrating physical, oral and behavioral health care to treat the whole person and this report provides Oregon's CCOs and policy makers with comprehensive oral health data to advance integration.

Individuals with low incomes are disproportionately likely to experience poor oral health, and people of color are also at risk. Recognizing the importance of oral health across the lifespan, Oregon is one of 13 states that offers comprehensive dental benefits to all adults with Medicaid, as well as children.

### Percent of OHP members receiving any dental service (2015)



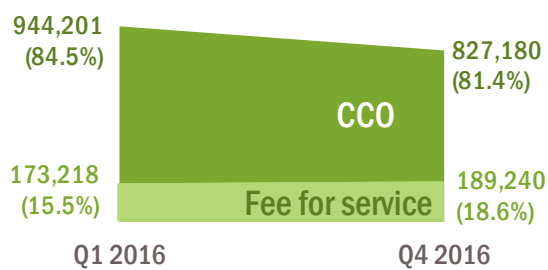
Key information in the report includes:

- ◆ **The percent of OHP members receiving any dental service varies by county** (see map at right). Any dental service includes preventive, diagnostic, and treatment services.
- ◆ **Adult CCO members receive oral health services at lower rates than children.** Only about 1 in 3 adults receive dental services in a given year, compared with a little more than half of children. Adults are also less likely to report having a regular dentist.
- ◆ **Many members do not receive preventive dental services**, like regular cleanings, fluoride treatments, and dental sealants. Only 1 in 5 adults and just over half of children (50.1%) had a preventive service between July 2015 and June 2016.
- ◆ **When stratified by race/ethnicity, the data show variation between groups.** Members who identify as Hawaiian/Pacific Islander consistently receive services at lower rates than other members. Members identifying as Asian American generally have higher rates of utilization and follow-up.

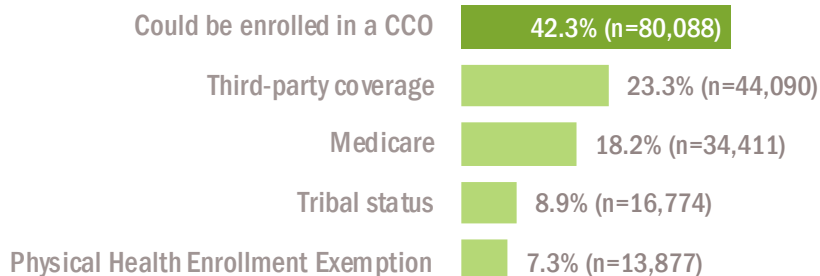
# Oregon Health Plan Demographics

Medicaid enrollment has increased almost 70 percent since the 2014 expansion, with total enrollment in December 2016 of 1,019,855. The majority of Medicaid members are enrolled in CCOs.

## Oregon Health Plan enrollment.



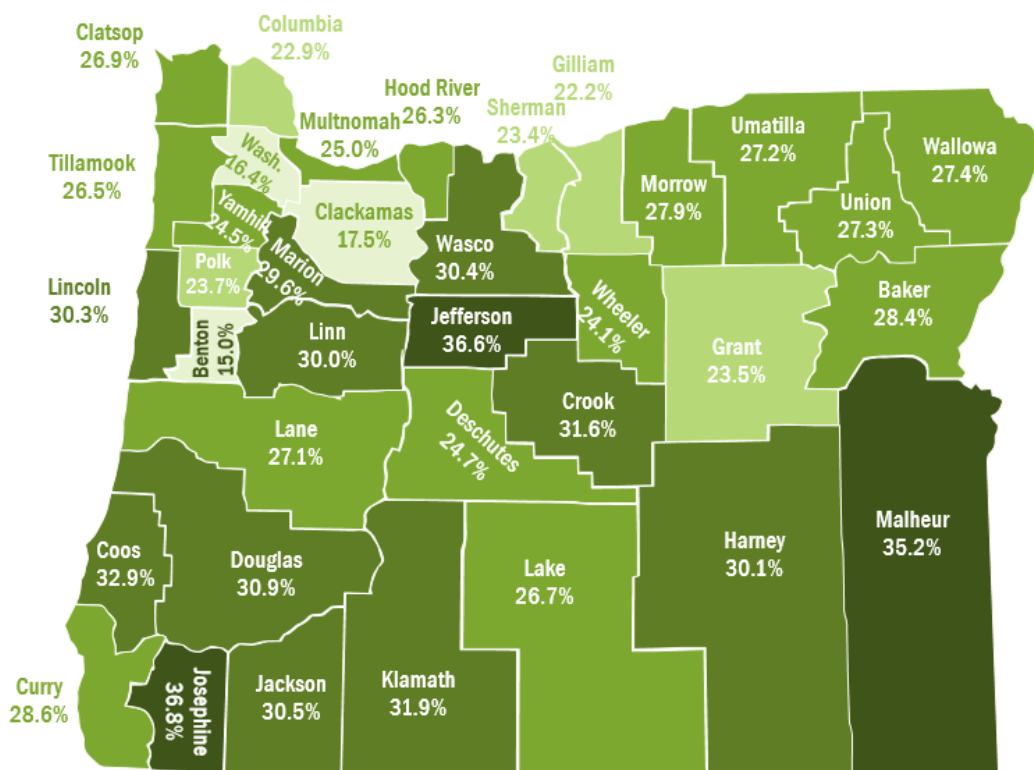
## More than 40% of fee for service could be enrolled in a CCO.



As OHA worked to implement ONE, the new eligibility system, redeterminations for Medicaid eligibility were delayed for large portions of the OHP population. The redetermination process accelerated in March 2016 and since then OHA has seen decreasing enrollment in OHP. Much of the decrease is associated with the MAGI (Modified Adjust Gross Income) populations who did not respond to redetermination requests. This has impacted the CCO enrolled populations. The fee for service population has slightly increased. OHA has a strategy to move this population to CCOs to the fullest extent possible.

## Percent of Oregon's population enrolled in OHP, by county.

December 2016. For more detailed enrollment by county, see Appendix A.



## Definitions:

### Oregon Health Plan (OHP)

Oregonians who receive comprehensive Medicaid benefits. OHP covers services such as regular check-ups, prescriptions, mental health care, addiction treatment, and dental care.

### Fee for service

OHP members who are not enrolled in a CCO or other managed care organization.

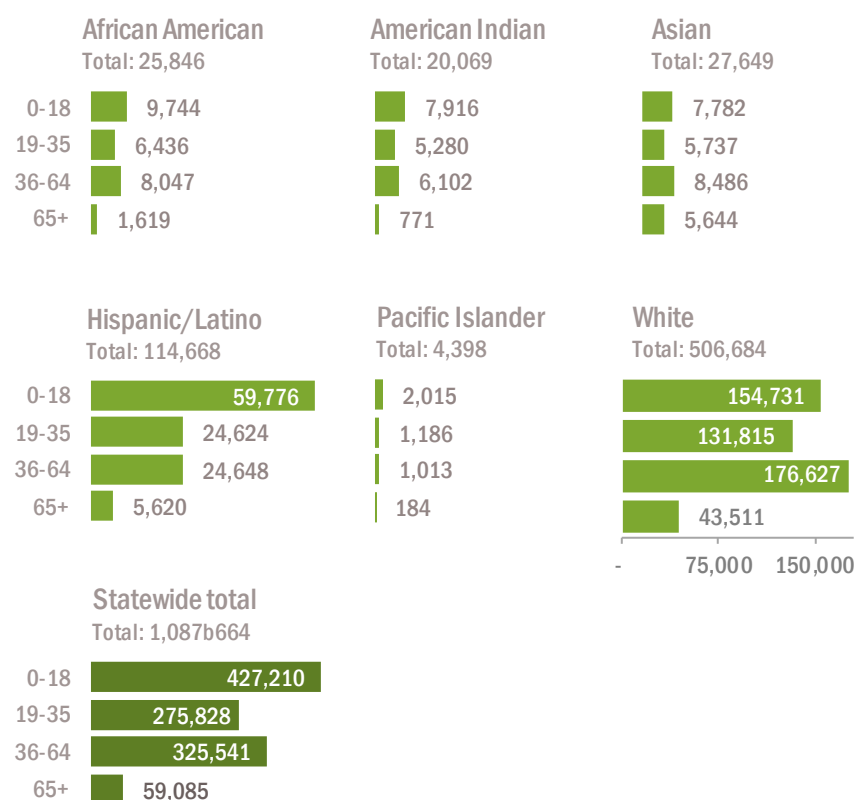
Map legend:	25-29%
	30-34%
	35-39%

# Oregon Health Plan Demographics

## OHP and Oregon populations, by race and ethnicity

The racial and ethnic makeup of the Oregon Health Plan population differs from Oregonians overall, but has remained fairly consistent, even with the inclusion of new members following Medicaid expansion.

### OHP enrollment by race, ethnicity, and age. December 2016



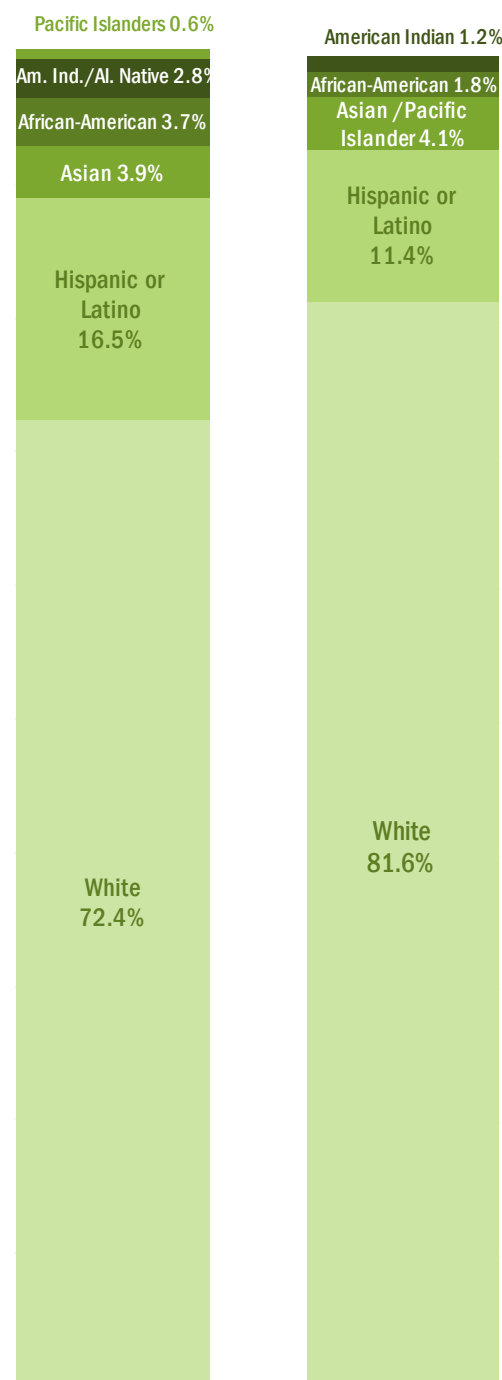
Data are missing for 4.8 percent of the population, and 30.3 percent are categorized “unknown other.” Percentages shown at right exclude unknown and missing data.

Missing data are where the race/ethnicity fields are blank on the member’s enrollment file; unknown/other is used when member information is provided, but is not clear or does not align with existing categories.

Race and ethnicity are collected separately, but reported together here. For example, an individual who indicates they are both White (race) and Hispanic/Latino (ethnicity) is counted as Hispanic/Latino. An individual who indicates that they are Native American (race) and non-Hispanic (ethnicity) is counted as Native American.

Oregon Overall: Source, 2010 US Census

### OHP members Oregon overall

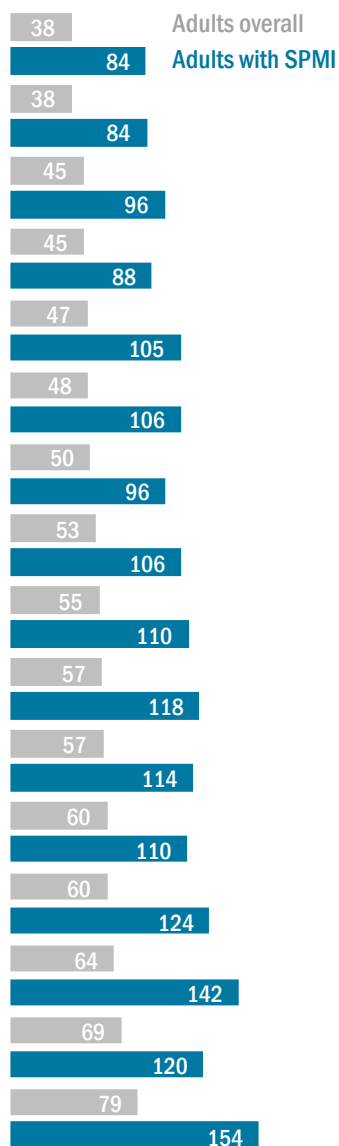


# Health Disparities

## New CCO incentive measure to address health disparities

The Metrics and Scoring Committee is responsible for selecting measures for the CCO incentive metrics program. Since 2016, the committee has been exploring ways to use the CCO quality pool structure to incentivize CCOs to focus on health disparities. This January, the committee elected to add **emergency department (ED) utilization among members with severe and persistent mental illness (SPMI)** to the incentive measure program beginning in 2018.

**ED utilization is higher among adults with SPMI across all 16 CCOs.**  
(Per 1,000 member months, mid-2016)

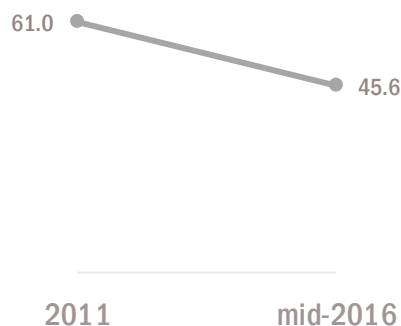


While ED utilization has been declining in Oregon since 2011 (see line graph), CCO members with severe and persistent mental illness use the ED at more than double the rate of members overall.

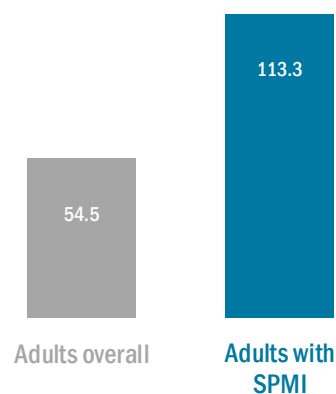
Incentivizing CCOs to focus on the challenge of their members with severe and persistent mental illness provides additional focus on behavioral health integration and care coordination, and aligns with the Oregon Performance Plan that is part of OHA's agreement with the US Department of Justice.

Moving forward, the committee will continue to explore ways to use the incentive measures program to address equity.

**Overall, ED utilization has improved since CCOs were started**  
(Per 1,000 member months, all ages, statewide)



**Members with SPMI use the ED at much higher rates**  
(Per 1,000 member months, statewide, mid-2016)



# Finance

The financial overview below provides highlights of operating performance on a comparative basis, including operating and total margins, and a description of the Member Services Ratio (MSR) and the Medical Loss Ratio (MLR). Details are also provided for CCO capitalization, focusing on net assets and liquidity. A critical factor for CCO success is the development of capitated rates paid for health services. A synopsis of the rate development process and description of financial risks and pressures facing the agency and CCOs is provided.

## Operating performance

OHA tracks two key metrics each quarter: the CCOs' operating margin and total margin (which includes the impact of non-operating income and expenses as well as income taxes). Operating margin is calculated by dividing operating income by total net operating revenue, resulting in a percentage.

On a statewide basis, CCO operating margins have been trending downward from their peak in 2014. Much of the increase in margins during 2014 was the result of cost and utilization assumptions used to develop the rates for the Medicaid expansion population. By 2015, OHA had adequate emerging experience (claims information) to begin to quantify the true underlying cost of the expansion population. The rates were appropriately aligned with this data and generally lowered to reflect the costs and risks of the CCOs' members.

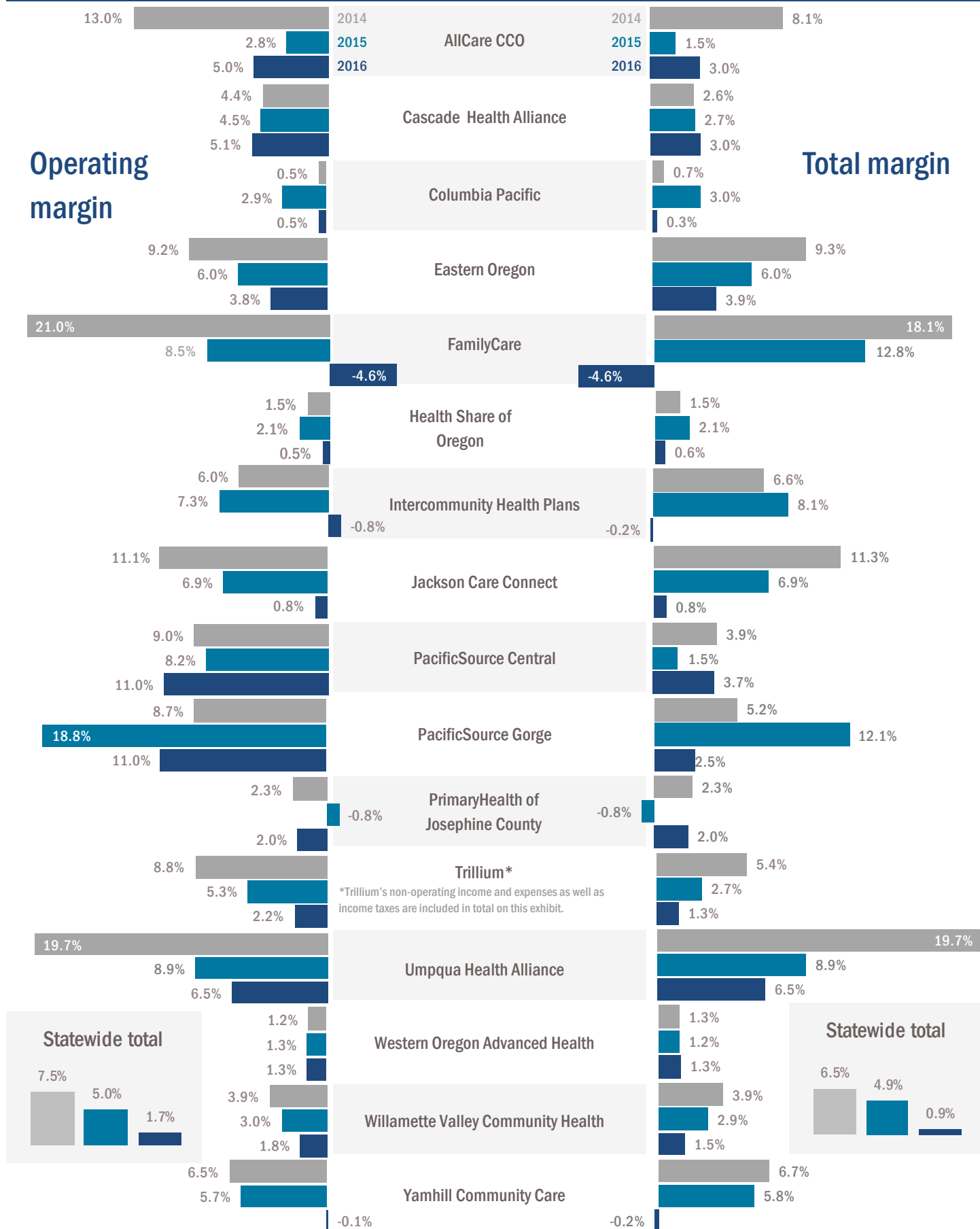
Below is a table that displays each CCO's operating margin and total margin for the past three complete years:

	Operating margin			Total margin*		
	\$ millions			\$ millions		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
AllCare CCO, Inc.	\$ 27.3	\$ 6.3	\$ 11.4	\$ 17.0	\$ 3.4	\$ 6.8
Cascade Health Alliance	\$ 2.1	\$ 3.6	\$ 4.2	\$ 1.2	\$ 2.1	\$ 2.5
Columbia Pacific	\$ 0.6	\$ 4.4	\$ 0.7	\$ 0.8	\$ 4.4	\$ 0.5
Eastern Oregon CCO	\$ 18.4	\$ 15.6	\$ 10.3	\$ 18.5	\$ 15.6	\$ 10.6
FamilyCare	\$ 85.5	\$ 46.4	\$ (23.0)	\$ 73.5	\$ 69.4	\$ (23.0)
Health Share of Oregon	\$ 14.5	\$ 22.5	\$ 5.6	\$ 14.5	\$ 22.6	\$ 6.0
Intercommunity Health Plans, Inc.	\$ 15.2	\$ 20.5	\$ (2.4)	\$ 16.8	\$ 22.8	\$ (0.6)
Jackson Care Connect	\$ 13.8	\$ 9.9	\$ 1.2	\$ 14.1	\$ 9.9	\$ 1.1
PacificSource Comm. Solutions - Central	\$ 19.6	\$ 22.2	\$ 28.6	\$ 8.4	\$ 4.1	\$ 9.5
PacificSource Comm. Solutions - Gorge	\$ 4.4	\$ 12.3	\$ 7.4	\$ 2.6	\$ 7.9	\$ 1.7
PrimaryHealth of Josephine County	\$ 1.0	\$ (0.4)	\$ 1.1	\$ 1.0	\$ (0.4)	\$ 1.1
Trillium Community Health Plan**	\$ 36.4	\$ 36.2	\$ 10.0	\$ 22.6	\$ 22.4	\$ 6.1
Umpqua Health Alliance	\$ 23.0	\$ 10.8	\$ 8.3	\$ 23.0	\$ 10.8	\$ 8.3
Western Oregon Advanced Health	\$ 1.2	\$ 1.4	\$ 1.5	\$ 1.2	\$ 1.4	\$ 1.4
Willamette Valley Community Health	\$ 14.1	\$ 13.4	\$ 8.1	\$ 14.1	\$ 12.7	\$ 6.8
Yamhill Community Care	\$ 5.3	\$ 6.1	\$ (0.1)	\$ 5.5	\$ 6.2	\$ (0.2)
<b>Consolidated Total</b>	<b>\$ 282.5</b>	<b>\$ 231.2</b>	<b>\$ 72.9</b>	<b>\$ 235.1</b>	<b>\$ 215.3</b>	<b>\$ 38.6</b>

\* Total margin includes the impact of non-operating income and expenses as well as income taxes.

\*\* Trillium's non-operating income and expenses as well as income taxes are included in total for 2014 and 2015.

# Finance: CCO operating and total margins



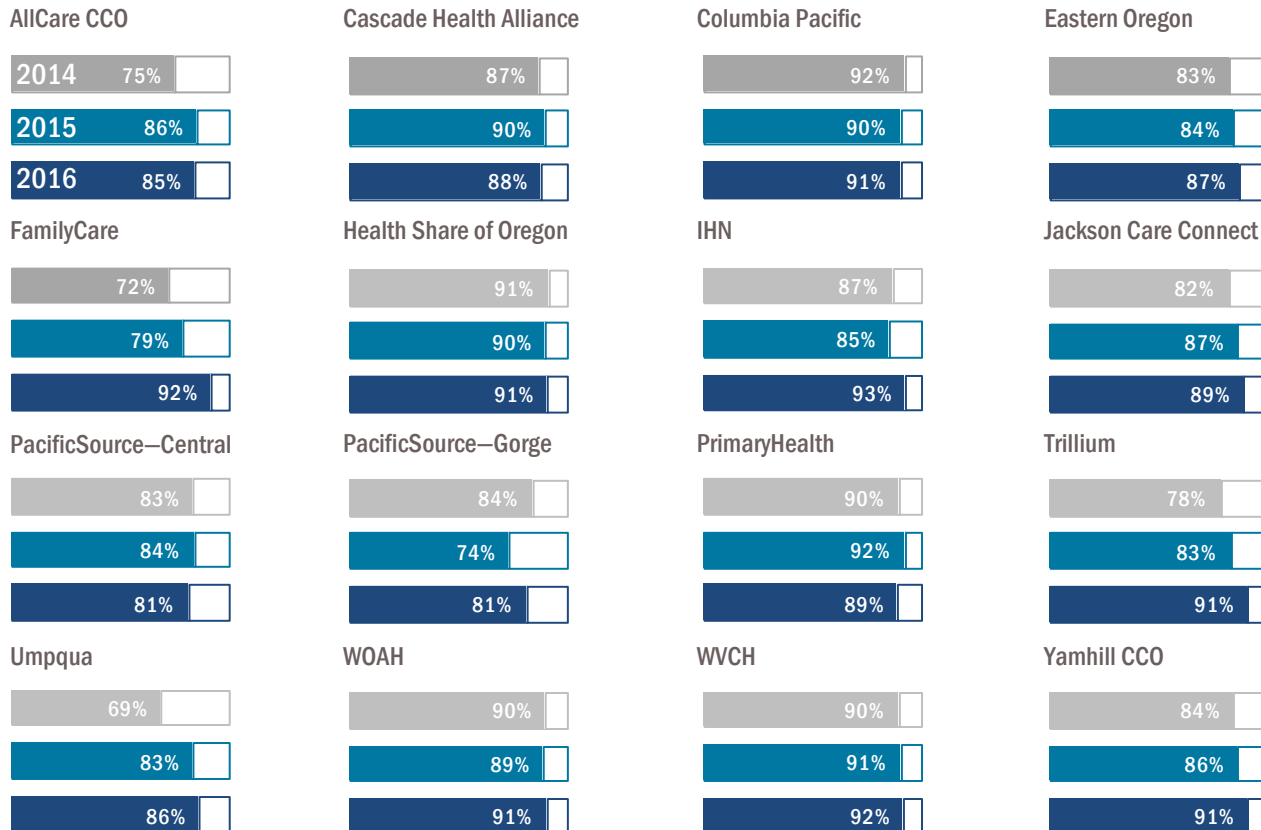
# Finance

## Member services ratio / medical loss ratio

CCO member services ratio (MSR) is a key financial metric that calculates the costs of services a CCO provided to its members (both medical and non-medical such as flexible services) as a percentage of total revenue. Member service expenditures are reported to OHA on the CCOs' financial statements, submitted on a quarterly basis. Closely correlated to the MSR is the medical loss ratio (MLR), which is a term used within the insurance industry and by the Centers for Medicare & Medicaid Services (CMS). The MLR is calculated using the MSR as the starting point and then allows certain defined administrative services to be included in the calculation, such as health care quality improvement expenses, and starting in 2017, fraud prevention expenses. Under new CMS Rules for Medicaid managed care organizations, all CCOs must meet a minimum MLR of 85 percent in 2018. Oregon first adopted a minimum MLR requirement in 2014 with Medicaid expansion and has developed a phased approach to achieve all of the CMS requirements for MLR in 2018.

OHA completed the first CCO MLR reporting requirement for the 18-month period ending December 31, 2015. Five CCOs did not meet the required MLR threshold and as a result rebated back to OHA \$29.6 million. Since the MLR requirement was for the expansion population only (funded entirely by CMS) all rebates were returned to CMS.

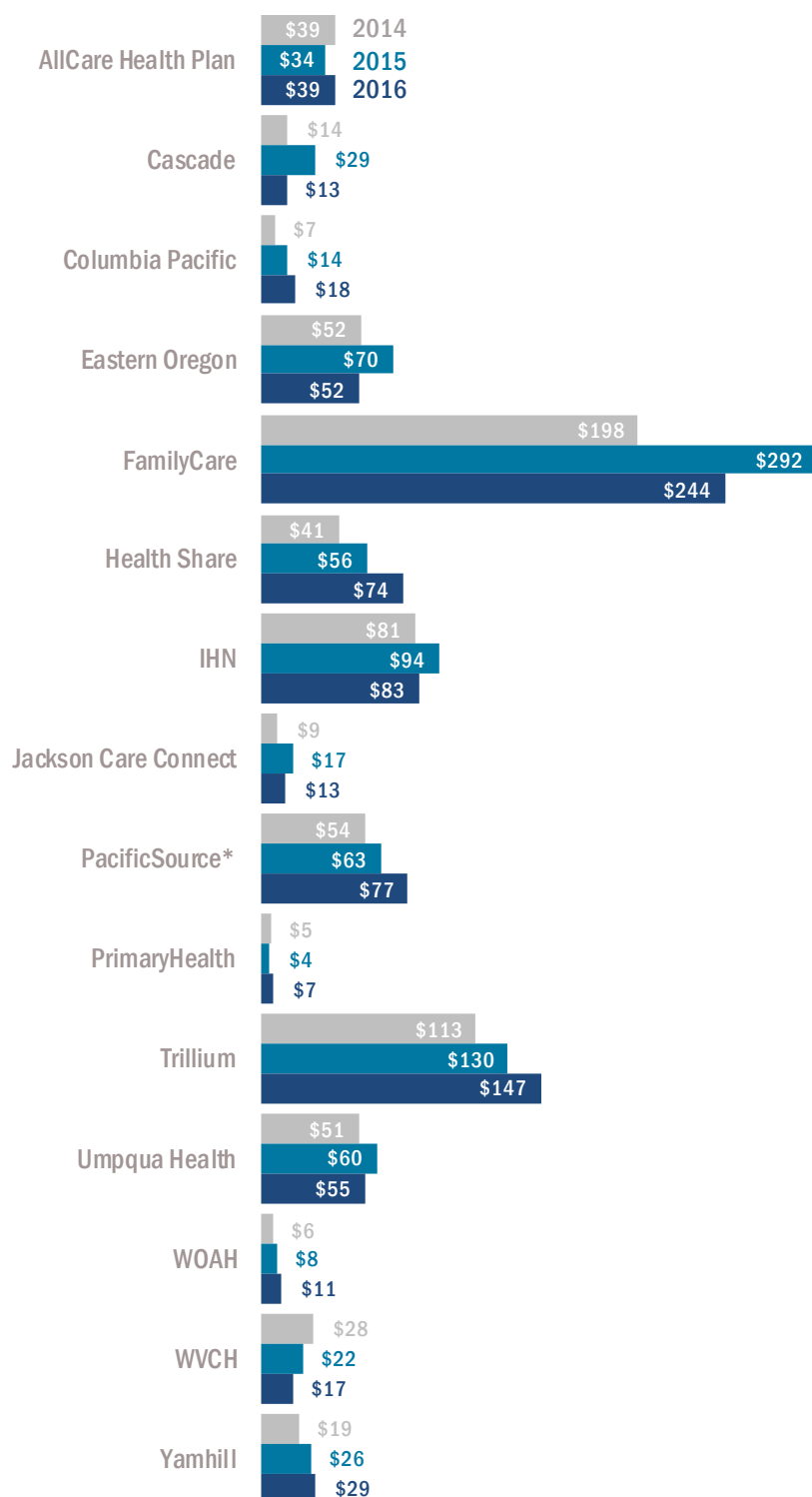
Below is a table that displays each CCO's MSR for the past three complete years:



Data in this section are drawn from CCO financial statements which are reconciled with annual audited financial statements as prepared by an independent accounting firm. 2016 annual audited financial statements are due at the end June 2017. It is important to note that the financial statements follow generally accepted accounting principles, which could include accrued contingencies and reserves per each CCO's individual financial reporting and business model.

# Finance

## Cash and investments, 2014 - 2016 (\$ millions)



CCOs are paid monthly capitation payments, commonly referred to as per member per month (PMPM) payments, to manage and deliver health care for their membership. CCOs have flexibility in allocating the capitation revenues, determining how best to provide, purchase and coordinate their members care.

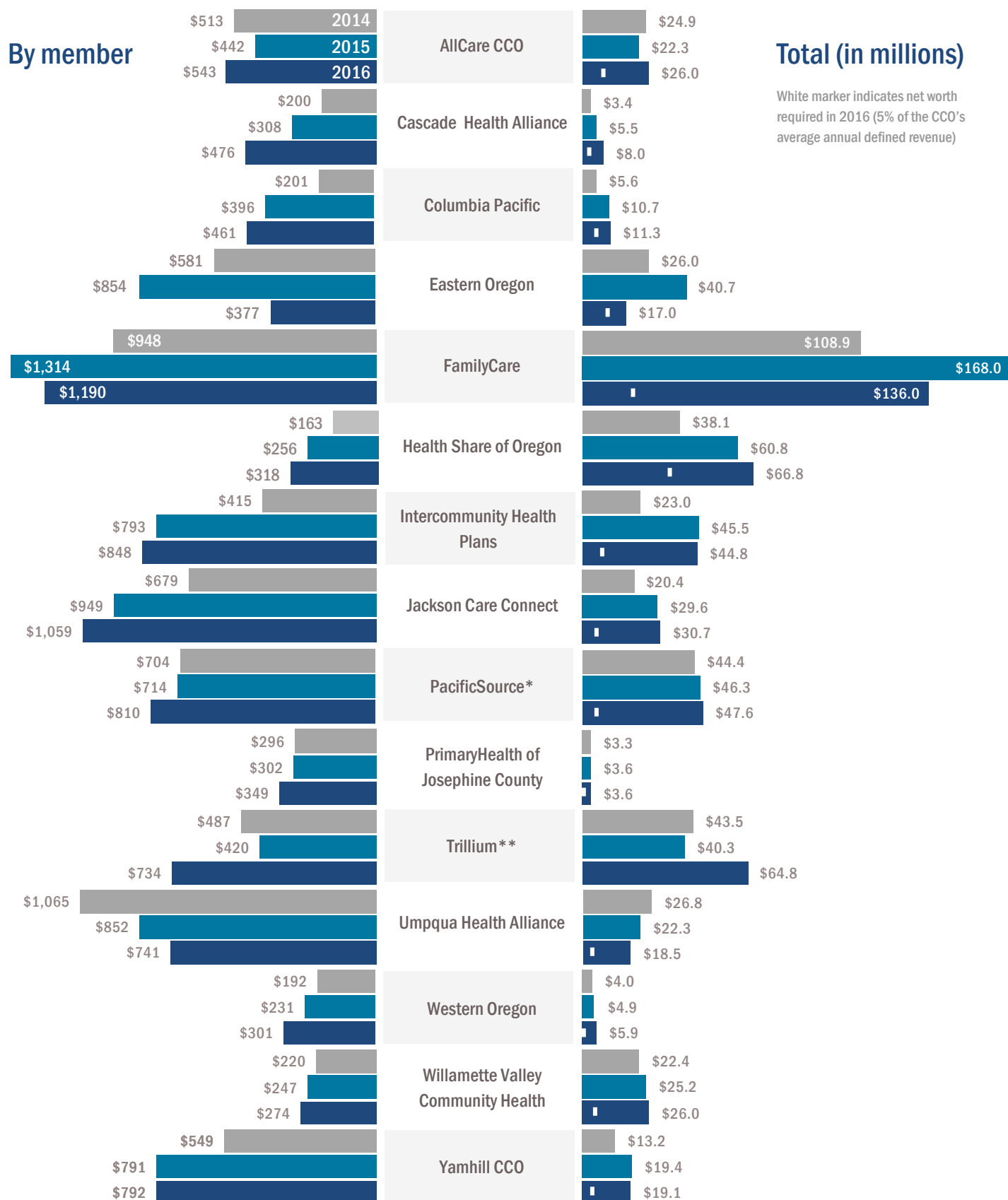
The increased membership resulting from expansion led to an increase in both the net asset and restricted reserve requirements. CCOs are currently required to maintain a net asset level of five percent of their average annual revenue (a rolling average of the past four quarters' adjusted revenue) as a minimum amount of operating capital. They are also required to maintain a restricted reserve account held in OHA's name as a safeguard against unanticipated losses.

See the graphs on the next page for CCOs' net assets in total compared to their required net assets. This is also reported by member, which allows for normalization between large and small CCOs.

The increase in CCO membership and the higher margins during 2014 also contributed to an increase in their cash and investments. The graph at left reflects each CCO's cash and investments at the end of each of the past three years.

\*Note that while PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon, only one corporate balance sheet is provided; financial data presented here represent PacificSource Community Solutions combined.

# Finance: Net assets by CCO, 2014 - 2016



\* PacificSource has two contracts, one for Columbia Gorge and one for Central Oregon. Only one corporate balance sheet is provided; financial data presented here are combined.

\*\*Trillium financial statements filed through Department of Consumer and Business Services with financial oversight based on NAIC oversight requirements.

## Rate Development

In March, CMS approved the OHA CCO contract and capitation rates for 2017, which finalizes the 2017 rates for all 16 CCOs. OHA engages Optumas, an external actuarial firm, to certify the CCO capitation payment rates. OHA moved to a regional rate development methodology in 2015, which matches payment to risk and meets applicable CMS and actuarial standards. Optumas and OHA are beginning the process for developing the 2018 CCO capitation payment rates; this process will continue through the summer.

During the 2017 rate development process, OHA and Optumas observed that CCOs reported significant increases in per member spending from 2014 to 2015. Optumas reviewed the drivers of this growth and found in some cases it was due to increased reimbursement and payout of surpluses to providers as incentives. Other factors included high pharmacy cost trends and increased small/rural hospital costs.

In order to continue to contain costs to the 3.4 percent per member annual growth, OHA and Optumas evaluated the high growth rate from 2014 to 2015. This analysis found that some of the growth was due to factors which were not necessarily within the CCOs' control, such as pharmacy cost growth, while other cost drivers were related to CCO business decisions, such as increased reimbursements or shared savings payouts. Therefore during the 2017 rate development process, if a CCO was outside of a reasonable growth rate and had increased reimbursement from 2014 to 2015, the CCO's financial information and reimbursement levels were adjusted down after isolating the business decisions. CCOs' financial information and

reimbursement for those that were within a reasonable rate of growth were not adjusted. This policy ensures business decisions of increased reimbursement levels that are outside the sustainable growth rate are not compounded into the next year's costs, however, the policy acknowledges the increased costs pressures (e.g. pharmacy costs) that are outside of the CCOs' control.

### Risks and pressures

The Medicaid program is facing a number of financial pressures. Cost sustainability is an important issue going forward. CCOs may experience additional pressure to slow per member cost growth more than the rate of growth cap of 3.4 percent.

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**In March, CMS approved the 2017 OHA-CCO contract and capitation rates.**

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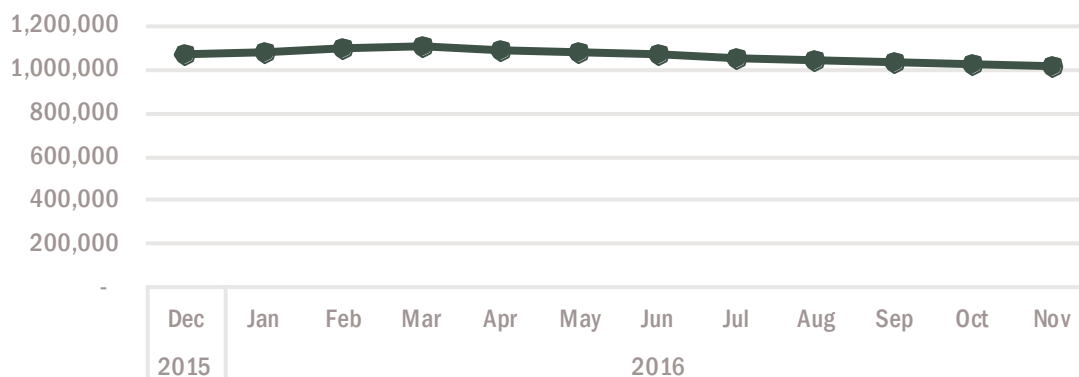
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# Eligibility and Enrollment

Medicaid enrollment declined 8 percent (about 90,000 Oregonians) between March and November 2016. Overall enrollment remained relatively flat over the past year. The transition from Cover Oregon to the new ONE eligibility system is still underway. We are in the final stages of this transition and the subsequent anticipated clean-up of individual cases. As part of this final clean-up, OHA has identified a number of individuals for whom further analysis is needed to determine what action, if any, is necessary. We have an action plan in place to complete all renewals by August 31.

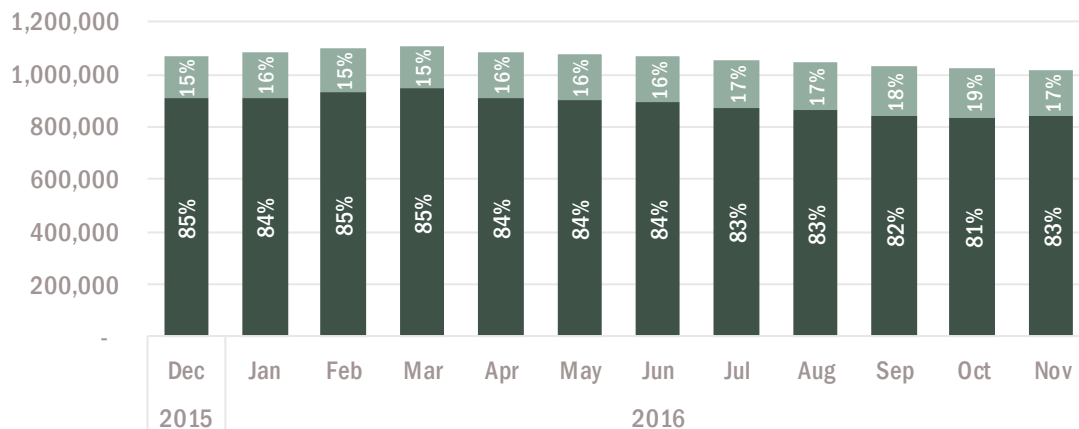
## OHP enrollment

OHP members may gain or lose coverage within the month.  
Enrollment actuals are finalized 90 days after the month ends.



## Total caseload: Fee-for-service and CCO enrollment

(Lighter bars are FFS)



# Appendix A: OHP Enrollment by County, Dec 2016

County	Total population	Total # Medicaid recipients	# receiving Medicaid due to ACA	% of total population receiving Medicaid	% of total population receiving Medicaid due to ACA	% of Medicaid population receiving Medicaid due to ACA
Baker	16,510	4,683	1,746	28.4%	10.6%	37.3%
Benton	91,320	13,733	5,908	15.0%	6.5%	43.0%
Clackamas	404,980	70,715	26,111	17.5%	6.4%	36.9%
Clatsop	38,225	10,281	4,152	26.9%	10.9%	40.4%
Columbia	50,795	11,644	4,380	22.9%	8.6%	37.6%
Coos	63,190	20,777	8,105	32.9%	12.8%	39.0%
Crook	21,580	6,823	2,572	31.6%	11.9%	37.7%
Curry	22,600	6,460	2,743	28.6%	12.1%	42.5%
Deschutes	176,635	43,611	17,669	24.7%	10.0%	40.5%
Douglas	110,395	34,137	13,403	30.9%	12.1%	39.3%
Gilliam	1,980	440	157	22.2%	7.9%	35.7%
Grant	7,410	1,738	652	23.5%	8.8%	37.5%
Harney	7,320	2,204	812	30.1%	11.1%	36.8%
Hood River	24,735	6,517	2,328	26.3%	9.4%	35.7%
Jackson	213,765	65,211	25,622	30.5%	12.0%	39.3%
Jefferson	22,790	8,336	2,809	36.6%	12.3%	33.7%
Josephine	84,675	31,161	12,642	36.8%	14.9%	40.6%
Klamath	67,410	21,524	7,949	31.9%	11.8%	36.9%
Lake	8,015	2,136	796	26.7%	9.9%	37.3%
Lane	365,940	99,077	39,676	27.1%	10.8%	40.0%
Lincoln	47,735	14,477	5,866	30.3%	12.3%	40.5%
Linn	122,315	36,678	12,775	30.0%	10.4%	34.8%
Malheur	31,705	11,146	3,230	35.2%	10.2%	29.0%
Marion	333,950	98,753	30,735	29.6%	9.2%	31.1%
Morrow	11,745	3,280	896	27.9%	7.6%	27.3%
Multnomah	790,670	197,274	81,308	25.0%	10.3%	41.2%
Polk	79,730	18,919	6,250	23.7%	7.8%	33.0%
Sherman	1,795	420	167	23.4%	9.3%	39.8%
Tillamook	25,920	6,865	2,684	26.5%	10.4%	39.1%
Umatilla	79,880	21,746	6,523	27.2%	8.2%	30.0%
Union	26,745	7,290	2,553	27.3%	9.5%	35.0%
Wallowa	7,140	1,958	751	27.4%	10.5%	38.4%
Wasco	26,700	8,113	2,860	30.4%	10.7%	35.3%
Washington	583,595	95,492	33,014	16.4%	5.7%	34.6%
Wheeler	1,465	353	151	24.1%	10.3%	42.8%
Yamhill	104,990	25,710	8,724	24.5%	8.3%	33.9%
(Unknown)		7,173	2,099			
STATE	4,076,350	1,016,855	380,818	24.9%	9.3%	37.5%

# Appendix B: CCO Profile

Although all of Oregon's 16 CCOs are community based in terms of local governance, there is a wide variety of legal and corporate structures under which they exist. All of the CCOs generally fit into one of the following corporate structures:

- Taxable Publicly Traded Corporation
- Taxable Private Corporation
- Tax-exempt Charitable Organization - 501(c)(3)
- Tax-exempt Non-Charitable Organization - 501(c)(4)
- Limited Liability Corporation - LLC

The table below describes the corporate structure of each CCO:

CCO	Corporate Status	Parent / Owner
AllCare CCO	Private corporation single owner	Mid Rogue AllCare Health Assurance, Inc. (multiple shareholders)
Cascade Health Alliance	LLC single owner	Cascade Comprehensive Care, Inc. (multiple shareholders)
Columbia Pacific	LLC single owner	CareOregon 501(c)(3)
Eastern Oregon CCO	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
FamilyCare	501(c)(4)	
Health Share of Oregon	501(c)(3)	
Intercommunity Health Plans	501(c)(4)	Samaritan Health Services, Inc. 501(c)(3)
Jackson County CCO	LLC single owner	CareOregon 501(c)(3)
PacificSource Community Solutions -Central	Private corporation single owner	PacificSource (not-for-profit holding company)
PacificSource Community Solutions -Gorge	Private corporation single owner	PacificSource (not-for-profit holding company)
PrimaryHealth of Josephine County	LLC single owner	Grants Pass Management Services (multiple shareholders)
Trillium Community Health Plan	Publicly traded corporation	Agate Resources, Inc./Centene Corp. (publicly traded on NYSE)*
Umpqua Health Alliance (DCIPA)	LLC single owner	Architrave Health, LLC (two owners)
Western Oregon Advanced Health	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
Willamette Valley Community Health	LLC multiple owners	Owners include both for-profit and not-for-profit organizations
Yamhill Community Care	501(c)(3)	

\* Agate Resources, Inc. was acquired by Centene Corporation (a publicly held corporation traded on the NYSE) as of 9/1/2015.

# Appendix C: Additional Transformation Reporting

This appendix summarizes OHA reports on health system transformation topics and provides links to full reports for additional information.

## Oregon Health Plan Demographics

OHA publishes a suite of Oregon Health Plan demographic, enrollment, and eligibility reports every month:  
[www.oregon.gov/oha/hsd/ohp](http://www.oregon.gov/oha/hsd/ohp)

Select by report type.

## Health Disparities

Metrics and Scoring Committee: [www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx](http://www.oregon.gov/oha/hpa/analytics/Pages/Metrics-Scoring-Committee.aspx)

## Finance

CCO annual audited financial statements and internal financial statements are available:  
[www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Financial-Information.aspx](http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/Oregon-CCO-Financial-Information.aspx)

## Eligibility and Enrollment

OHA's processing and customer service performance charts are presented monthly:  
[www.oregon.gov/oha/hsd/ohp/healthplan/pages/ohp-Update.aspx](http://www.oregon.gov/oha/hsd/ohp/healthplan/pages/ohp-Update.aspx)

DCBS posts quarterly enrollment reports:  
[www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx](http://www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx)



You can get this document in other languages, large print, braille or a format you prefer. Contact the Oregon Health Authority Director's Office at 503-947-2340 or OHA. [DirectorsOffice@state.or.us](mailto:DirectorsOffice@state.or.us).