RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant P
Western Oregon Advanced Health, LLC
abn Advanced Health

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Evaluation Overview

A brief overview of how reviewers applied criteria to score responses, developed deficiency assessments, and identified the level of difficulty associated with correcting known deficiencies.

Criteria Development

Using the RFA questions, teams comprised of cross-functional subject matter experts developed the preliminary criteria for evaluation. Criteria were refined by internal SMEs with doctoral-level expertise in research study methodology and reviewed by the contracted Special Assistant Attorney General (SAAG), prior to implementation.

Teams were asked to review blinded Applicant responses and score all responses according to a 5-point scale:

5	the answer is complete, responsive and exceptionally detailed regarding the essential themes or required components
4	the answer is complete, responsive, and detailed regarding the essential themes or required components
3	the answer is mostly complete, mostly responsive and provides a mostly detailed response to the essential themes or required components
2	the answer is mostly complete, somewhat responsive, provides limited detail regarding the essential themes or required components
1	the answer is incomplete, not responsive, provides very little detail regarding the essential themes or required components

Passing Score

Team Analysis

During scoring, reviewers documented why they scored 3 or below. These notes were used to inform the deficiency assessment and the overall recommendation which were developed during team analysis meetings. This discussion allowed the teams to assess the nature of the deficiency and the relative level of effort it would take to correct. Teams were asked to take into consideration the entire Application, rather than just one specific deficiency, in formulating the recommendation.

Where specific types are noted, it is meant to serve as a high-level view of the types of deficiencies that are described in more detail in the Deficiency Analysis below the table. It is not indicative that any single deficiency resulted in a recommendation to fail the Applicant.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Administrative Functions	6	17	34	X	X	X	X
Social Determinants of Health	3	10	15				
Health Information Technology	14	7	19	X			
Member Transition	19	14	3	X		X	X

Strong Fail		Weak Fail	Weak Pass		Strong Pass

After scoring was complete, a post-hoc analysis was performed to validate the results. This analysis was designed to ensure that:

- Individual reviewers were consistent in how they were scoring across all Applicants; and
- Reviewers were consistent with other members of their team when scoring the same Applicant.

The analysis showed that reviewers were overwhelmingly consistent both individually across Applicants and within their team.

Evaluation Results: Policy Alignment

To show how well the Applicant performed when looking at the overall policy objectives of CCO 2.0, scores were regrouped by policy area, in alignment with how the questions were originally developed. The numbers below represent each time the Applicant received a score from a reviewer on a single question. Scores are shaded to show the level of agreement amongst reviewers as to whether the responses were generally acceptable or generally insufficient. This was designed to show the number of times reviewers assessed the response as meeting or exceeding the criteria for passing, rather than an average score across reviewers.

For example, if there were 7 questions related to Value-Based Payment, and 3 reviewers, the Applicant received 28 scores in total *(top row)*:

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	0	7	21
Social Determinants of Health	16	32	65
Behavioral Health	55	62	60
Cost	11	13	10
Business Operations	201	111	78

Strong Fail		Weak Fail	Weak Pass		Strong Pass

The results show that reviewers were in strong agreement that the responses for Value-Based Payment met or came close to meeting the criteria for passing.

Evaluation Results: Informational Assessment

Informational questions were scored in the same manner as evaluative questions but scores were not assessed by the team during the development of the final recommendation. The same regrouping described above was performed. These questions were often worded to solicit information that would not have been appropriate for pass/fail evaluation, and but were assessed for completeness, responsiveness to the question, and level of detail.

Policy Areas	**1-2**	**3**	**4-5**
Cost	4	15	30
Behavioral Health	10	19	25
Social Determinants of Health	12	7	14
Value-Based Payment	22	15	19
Business Operations	46	27	10

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

Reviewing the Final Evaluation Report

This summary report is the result of a comprehensive review of each Applicant's submission and includes the following components:

The Executive Summary is a high-level overview of notable items within the report related to Applicant performance or information pertinent to the decision to award.

An analysis of the financial pro formas was performed by DCBS, with additional review by the Actuarial Services Unit (ASU) of the validity of the underlying financial assumptions.

The Service Area Analysis shows a map of the requested service area, any exceptions to county-wide coverage, and scoring of the information submitted to substantiate the exception request. The full exception request is available in the Appendix.

Enrollment Modeling is a two-part section designed to project the Applicant's likelihood of meeting minimum enrollment for viability based the number of applicants in the same area, the Applicant's stated provider network, and a series of assumptions which are detailed in full in the Appendix. This includes *preliminary* results of the member allocation test by matching members to providers listed in the Applicant's Delivery System Network report. The methodology for this modeling is described in the Appendix.

Note: the allocation test is based off the April 22, 2019 DSN submission. Applicants may expand their provider networks after contract award, increasing the likelihood of member match, and as such this projection should be considered only an approximation based on the available data.

Evaluation Results shows the scores for all Evaluative questions across all teams. Scores of 1-2 were considered failing, a score of 3 was considered marginal, and scores of 4-5 were passing. Each team provided an overall recommendation to pass or fail the Applicant based on their analysis after a team discussion of the relative strengths and weaknesses in the Application. Teams reached consensus on the recommendation.

In the team-specific reviews, scores are shown by section and shaded to show the level of relative agreement within the team. Lighter shading indicates less agreement within the team, and darker shades show stronger agreement.

The table also shows whether the deficiencies were related to:

- Lack of detail
- People – missing the right knowledge or qualified staff
- Process – lacking a clearly defined or feasible plan, a defined pathway to achieving the objective, or failed to provide evidence that activities are occurring
- Technology – missing the right amount or type of technology, infrastructure, tools or services

Ex:

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Value-Based Payment	4	5	11	X			
CCO Performance and Operations	5	6	4			X	
Cost	12	3	3	X			

Moderate agreement to pass in VBP, moderate agreement to fail in CCO Performance & Operations, and strong agreement to fail in Cost. Deficiencies related to level of detail and described processes.

Detailed deficiencies can be found below the table, including how difficult the team felt the deficiency would be to remedy, along with a summary of why the team opted for the recommendation.

Community Letters of Support is an inventory of the entities that submitted a letter on behalf of the Applicant, the category of community stakeholder, and any relevant notes from review. Full letters are available electronically.

Policy Alignment depicts the scores regrouped into the original policy areas to visualize how well the Applicant demonstrated the ability to achieve the policy objectives of CCO 2.0. Informational scores were used to identify areas of concern, but these scores were not reviewed by the teams when developing the overall recommendation.

A focused review of the Behavioral Health attachment in isolation was performed by subject matter experts to ensure sufficient analysis of the content.

The Appendix contains detailed methodology and statistical validation, the ASU comparison of the Applicant's pro forma submission to the previous year's Exhibit L financial reporting (where applicable), and the full text of any county-wide coverage exception request.

Executive Summary

Financial Analysis

- DCBS financial review found that the pro forma financials appear positive, but there is little to no margin for error if the Company's projections are higher than actual results. And cumulative results below their projections would be problematic and compound the issue.
- No information was provided about how amounts are determined and allocated in the administrative services and management agreements with two of Applicant's ownership entities which comprised over $14m in expenses in 2017.
- ASU noted that the risk of underestimated liabilities is likely minimal.

Service Area Analysis

- Advanced Health is requesting to cover the entirety of Coos and Curry counties. There are no service area exception requests.
- Advanced Health is the only applicant for Coos County, and one of two applicants in Curry County. There is a moderate risk that Advanced Health may not meet the minimum enrollment threshold.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Fail; responses were lacking detail and sometimes missing entirely. Deficiencies in FWA, TPL and encounter data validation. Deficiencies in member transition and SDOH.
- Care Coordination and Integration – Pass
- Clinical and Service Delivery – Fail; responses were missing small to moderate amounts of detail and some components were not responded to at all. Missing plans for care coordination, culturally competent SPMI, and monitoring services.
- Delivery System Transformation – Fail; lacking details about referrals and PAs, quality data systems, and communicating/enforcing standards. Missing details about the PCPCH system.
- Community Engagement – Pass

Community Letters of Support

- 50 letters were received from various provider groups and local entities
- Multiple letters contained a nearly identical paragraph expressing concern about the CCO 2.0 development process and the original legislative intent, local governance, and the potential impact on the local voice. Specific phrasing was repeated several times related to "de-emphasize local governance and community engagement in favor of a national business model".

Evaluation Results: Policy Alignment

The responses from Advanced Health show strong alignment with all of the policy objectives – Behavioral Health, Cost, Social Determinants of Health, VBP and Business Operations.

Evaluation Results: Informational Assessment

Advanced Health's responses to informational questions scored high in Behavioral Health, Cost, and VBP. The responses scored lower in Social Determinants of Health and Business Operations.

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 24, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Advanced Health

I have performed a review of Western Oregon Advanced Health dba Advanced Health that includes pro forma financial information, audited financials, Articles of Incorporation, and biographical affidavits.

The pro forma financial information reports services and risks will be transferred to the following privileged providers through capitation agreements:

- Physical and mental health services to Southwest Oregon IPA
- Dental services to Advantage Dental
- Non-emergent transportation services to HWG Services Inc., DBA Bay Cities Brokerage
- Addiction Treatment to Adapt

No information was provided about the amount of risk that the above four providers would receive in the capitated agreements. The pro forma financials for Advanced Health report $0 liability for losses, $0 liability for unpaid claims, and in most cases over $100 million in annual premium revenue. The scope of my review was limited to Advanced Health and did not include any of the above four providers that have the liability for the unpaid claims and the unpaid claims expense that is associated with roughly $100 million in premium revenue on the books of Advanced Health.

The pro forma balance sheet for the best estimate of enrollment projects RBC of 393.4%, 412.1%, and 440.2% the end of 2020, 2021, and 2022, respectively. The Company performed various stress tests on their projections that all resulted in RBC above 195%.

The pro forma calculations by the Company for expected, minimum, and maximum enrollment were loaded by DFR to include an extra percentage for hospital and medical expenses in order to estimate a scenario that the Company would enter a mandatory RBC control level. DFR estimates a 3.1% negative deviation in total hospital and medical benefits will result in a mandatory RBC control level at the end of 2022 at expected, minimum, and maximum enrollment.

A capital infusion could be used to improve liquidity should a negative deviation occur but no potential sources of additional capital were listed in the information received. The pro forma financials appear positive, but there is little to no margin for error if the Company's projections are higher than actual results. And cumulative results below their projections would be problematic and compound the issue.

There is a discrepancy in the ownership information provided for Advantage Dental. Advantage Dental is listed as a 10% owner in the top left corner of the organizational chart provided by the Company. Advantage Community Holding Company is listed as a 6% owner in the Company's response to General Questions No. B.1.a. Advantage Dental's Schedule Y in the 2018 Annual Statement shows it is 100% owned by Advantage Community Holding Company but it is unclear which of the two entities have ownership in Advanced Health and if that ownership is 10% or 6%.

I performed a very brief review of the NAIC/ISITE 5 year profile and quarterly profile for Advantage Dental and noted no material solvency concerns. Profitability was favorable from 2014 through 2016 and unfavorable in 2017 and 2018. The sum of the net loss for the five years was $3 thousand. The 3/31/2019 ratio of liquid assets and receivables to current liabilities was 2,1560.6% and increased by 381 points PYE. Advantage Dental reported 12/31/2018 RBC of 6,695.8%.

The audited financials for Advanced Health were reviewed and no material concern was noted. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in each of the four years from 2014 through 2017 and reported net income between $1.21 million and $1.44 million in each year. Totals members' equity was $3.9 million in 2015 and increased in each of the subsequent years to $6.96 million in 2017. DFR calculated a ratio of total current assets to total current liabilities of 179.7%, 170.9%, 177.0%, and 172.3% in 2014, 2015, 2016, and 2017, respectively. This is slightly below the considered "ideal benchmark" of 200%, but is within the current health insurance market average, which was 175.4% at 12/31/2018.

A credit risk was noted. Audited financials (Note 6) for 2017 and 2016 reported 100% of Advanced Health's total revenue comes from contracts with the State of Oregon. Receivables from the State of Oregon represented 100% of Advanced Health's healthcare and other accounts receivable as of year-end 2016. Receivables from DOCS Management Services (Southwest IPA owns 100% of DOCS and 60% of Advanced

Health) represented 75% of healthcare and other accounts receivable as of year-end 2017. DFR calculated the concentration of credit in the receivables from DOCS represented 31.3% of total members' equity in 2017.

Advanced Health paid DOCS Management Services $7.4 million in 2018 and $7.1 million in 2017 for administrative services, management services, and shared office space. Advanced Health paid Southwest Oregon IPA $75.3 million in 2018, and $72.5 million in 2017 for physical health services. Southwest Oregon IPA owns 60% of Advanced Health and 100% of DOCS Management Services.

Advanced Health has roughly $100 million in annual premium revenue and no liability for unpaid claims. Reviewing audited financial statements for the entities that have booked the unpaid claims liability associated with the $100 million annual premium would provide a better picture on their financial ability to fulfill policyholder obligations. There is a concern that if the entities receiving the capitated payments are unable to meet the requirements, Advantage Health may not have sufficient resources to fulfill the contractual requirements of the CCO.

A small deviation to claims expense could require a capital infusion in order to maintain adequate liquidity but no potential sources of additional capital were identified. A 2% negative deviation to total hospital and medical expenses would put RBC under 200% for all enrollment scenarios. A 3.1% negative deviation in total hospital and medical benefits will result in a mandatory RBC control level at the end of 2022 at expected, minimum, and maximum enrollment. Reviewing audited financial statements from the owners would better enable Oregon to determine their ability to make capital contribution when needed.

No concern was associated with the review of the biographical affidavits.

The Articles and Amended Articles were reviewed for compliance with ORS 63.047 and no concern was noted.

[End of summary]

ASU Analysis of Applicant Financial Assumptions

The Actuarial Services Unit performed an analysis of each Applicant's financial pro formas and the associated DCBS examination. This review was designed to assess whether the underlying assumptions were reasonable when compared to OHA's market assumptions. Applicants appeared to pull out the MCO tax from net premium income, and possibly took out a portion of Quality Pool amounts too. ASU's capitation rate estimates absent these considerations are higher than CCOs' estimates in most cases. CCOs estimates generally appear realistic and conservative.

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary. Focus of this review is given to reasonability of projected numbers stated in Balance Sheet and P&L pro formas (BE MM scenario) by comparing to most recent year's Exhibit L financial results (FY2018).

Enrollment					
Applicant Assumption (MM)	**OHA Assumption (MM)**	**Applicant High Assumption (MM)**	**Applicant Low Assumption (MM)**	**Percentage of OHA's Est to CCO's Est**	**Enrollment Flag**
237,780	229,622	269,558	206,828	97%	237,780

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$514.27		$528.02	$550.21	-7%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
89%	90%	-1%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.38%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.16%	0.25%

Admin load %

Compared to the historic admin load % in the past (8.2%-9.1% for FY2016-FY2018), the projected admin load 10% for FY2020 under BE scenario is high.

Underestimated liabilities

At end of FY2018 ADH showed a liability balance of $5.5M, however its projected liability balance for FY2020 under the BE scenario is only $1.8M (which is only 33% of FY2018's level). The sharp drop of $3.7M in liabilities possibly could be related to the projected increase of capital as well as the projected decrease in asset by FY2020 due to the business operational needs.

Risk: Likely minimal

Recommendation: Defer to DCBS on potential impact to liquidity

ADH's reported liabilities at 12/31/2020 are noticeably lower than as of 12/31/2018. In addition, ADH does not record claims-related liabilities due to subcapitation arrangements. That may provide some cause to review liabilities further, although 12/31/2018 C&S appears to exceed 300% of RBC.

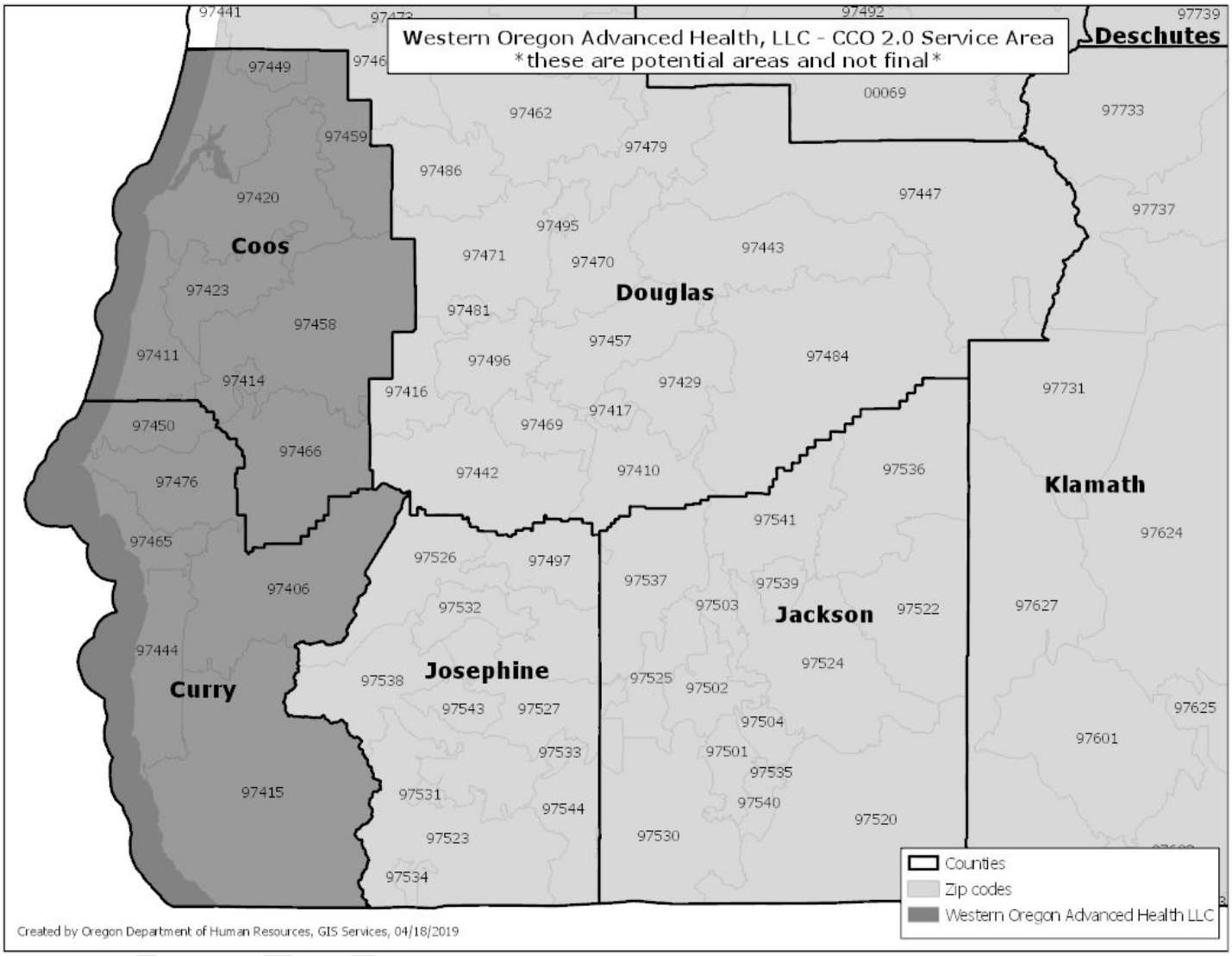
ADH is one of many CCOs that subcapitate substantially all of their claims to risk accepting entities (RAEs). If the RAEs go insolvent, these CCOs might not have enough C&S to cover the members' benefits even though the risk was technically transferred to the RAEs.

- Suggest OHA request additional financial information for RAEs whose CCOs subcapitate substantially all services, perhaps as part of readiness review, to perform further analysis. Such information could include corporate audits or DCBS filings/analysis for RAEs that account for a sufficiently large (however defined) portion of a CCO's total revenue.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Coos and Curry counties.



Full County Coverage Exception Request

Not applicable.

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

This model was designed to forecast the likelihood of an Applicant meeting the minimum enrollment threshold as defined in the financial pro formas. The projections rely on overall OHP enrollment by county, the number of Applicants proposing to serve each area, and initial assumptions assume all Applicants are awarded a contract. Alternative scenarios are presented below. The detailed assumptions for this modeling can be found at the end of this report.

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Coos and Curry	-	Applicant would be the only CCO serving Coos. One other (All Care) proposes to serve Curry	32% chance Advanced Health may not receive enough members. Applicant reported a minimum threshold of 17,236.	No scenarios show enrollment exceeding applicant's maximum	Medium risk

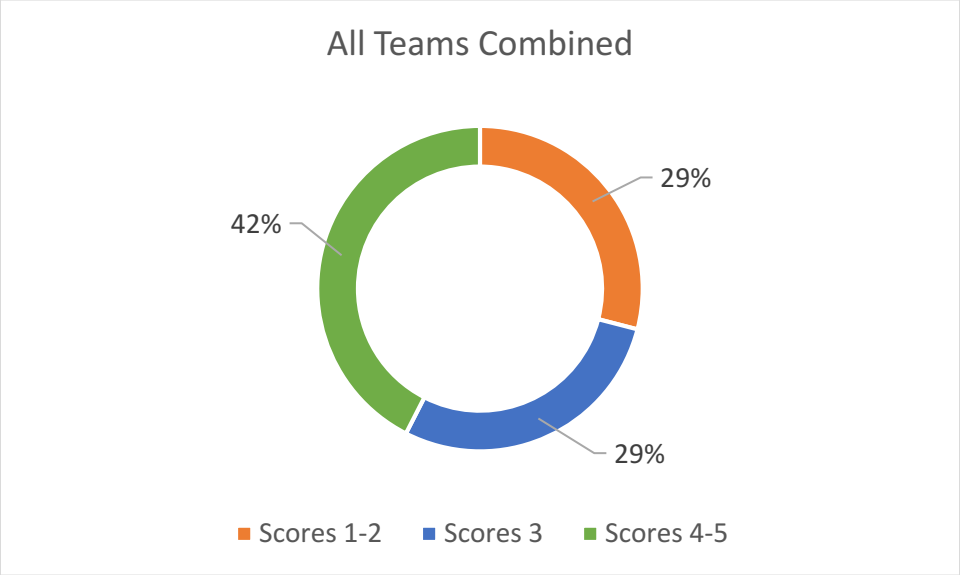
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Advanced Health is likely to receive approximately 17,549 members out of the 17,236 minimum required.

Note: the allocation test is based off the April 22, 2019 DSN submission. Applicants may expand their provider networks after contract award, increasing the likelihood of member match, and as such this projection should be considered only an approximation based on the available data. Special Populations such as members in ABAD, OAA, Foster Care, Tribal Members (HNA), and Medicaid-Medicare Dual Eligibles have been excluded from the allocation and may impact the final enrollment levels after January 1, 2020.

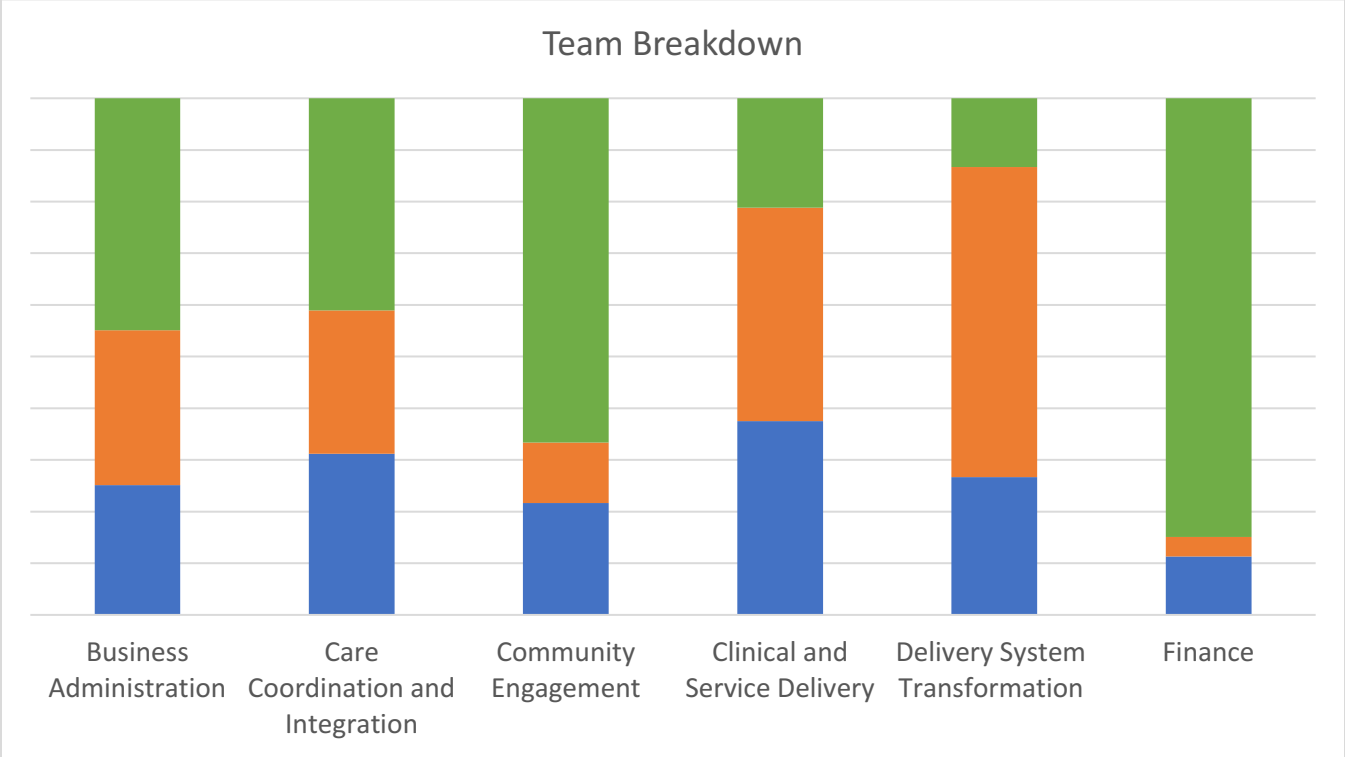
Evaluation Results – Overall Scores

The overall number of scores given to the applicant by all reviewers for all questions.



Scoring by Team

The scoring breakdown within individual teams from all reviewers for all questions



Overall Team Recommendations

Teams reviewed the final scoring and notes taken during the assessment and arrived at a consensus recommendation to pass or fail the Applicant. Reviewers were asked to take the entire Application's deficiencies and strengths under consideration.

Evaluation Team	Recommendation	Lacks Detail	People	Process	Tech
Finance	PASS				
Business Administration	FAIL	X		X	
Care Coordination and Integration	PASS	X		X	
Clinical and Service Delivery	FAIL	X	X	X	
Delivery System Transformation	FAIL	X		X	X
Community Engagement	PASS		X	X	

Evaluation Results: Policy Alignment

Scores for each question were aligned by policy area to show how well the Applicant demonstrated the ability to achieve the policy objectives of CCO 2.0.

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	4	2	30
Cost	1	7	26
Social Determinants of Health	22	27	64
Business Operations	135	114	142
Behavioral Health	56	64	57

Evaluation Results: Informational Assessment

Informational questions were scored in the same manner as evaluative questions but were not assessed by the team during the development of the final recommendation.

Policy Areas	**1-2**	**3**	**4-5**
Cost	4	15	38
Value-Based Payment	7	12	37
Behavioral Health	12	22	21
Business Operations	36	33	28
Social Determinants of Health	22	3	8

Finance

Evaluation of questions related to Pharmacy Benefit Manager arrangements, tracking and reporting of Social Determinants of Health and Health Equity expenditures and outcomes, quality pool funds, Health Related Services investments, managing within the global budget, and sustainable growth.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Value-Based Payment	0	1	19				
CCO Performance and Operations	0	3	12				
Cost	2	2	14	X			

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

Value-Based Payment

There were no concerns or deficiencies regarding value-based payment.

CCO Performance and Operations

There were no concerns or deficiencies regarding value-based payment.

Cost

The plan for coordination and integration of behavioral health services through delegation did not include a plan for how they would coordinate or integrate services. Additionally, the care coordination plan didn't adequately explain why this plan would be cost-effective.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Western Oregon Advanced Health, LLC be given a "pass" for the financial section.

Business Administration

Evaluation of questions related to CCO business operations, claims and prior authorization, Health Information Technology adoption, data collection, communication to providers, publication of coverage guidelines and criteria, encounter data processing and validation, member transition, including processing incoming members, identifying providers, communicating information to members, and supporting the migration of members during transition.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Health Information Technology	5	3	32				
Social Determinants of Health	10	8	10			X	
Administrative Functions	14	28	21	X		X	
Member Transition	21	3	12	X	X	X	

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

Administrative Functions

The response in this section were in general, high level. There was limited detail on FWA processes and no mention of essential procedures like claims review. There was limited detail on encounter validation processes, especially what tools or systems were used in this work. Very limited detail on TPL processes – what data sources are used and how it will be verified. Pharmacy admin section is missing how non-formulary changes will be communicated. In general, the responses in this section were too high level to adequately assess. If the low amount of detail is due to missing detail, then these deficiencies would take a **small amount of effort** to address. If deficiencies are due to missing processes or infrastructure, these deficiencies would take a **moderate to large amount of effort** to fix.

Health Information Technology

The responses in this section were largely responsive with only some detail missing. Risk stratification was described for hospitals but not for providers and it appears as if no risk stratification information will be available at the "go live" date. In the HIT/VBP section, responses didn't mention any other data sources outside of claims data. The deficiencies noted **could be remedied relatively quickly**.

Member Transition

The responses in this section were high level and many responses were missing entirely, which made evaluation difficult. Some answers were found under other questions. There are no data reception plan or transition/warm handoff activities. The deficiencies in this section would take a **moderate to large amount of effort to address.**

Social Determinants of Health

The answers in this section were high-level and some information was missing entirely. For the health equity section, there a lack of detail on promotional strategy and recruitment, no outcomes or methods for measuring diversity. There is no indication of how Applicant will be providing health equity training and health equity policies are missing. Language access plan is missing and lower levels of language services were reported indicting there might be capacity issues. Difficult to assess the level of these difficulties – there are many smaller deficiencies which could additively take **moderate amount of effort to address**.

Team Recommendation: **FAIL**

- In general, this Applicant's responses were lacking detail and sometimes missing entirely. It was difficult to assess whether the lack of detail and missing information was due to inadequate descriptions or to missing processes, technology and/or infrastructure.
- The deficiencies in FWA, TPL and encounter data validation processes would take **a moderate to large amount of effort** to adequately address, collectively.
- The deficiencies in the member transition section would take a **moderate to large amount of effort** to adequately address.
- The deficiencies in the SDOH-HE section could collectively take a **moderate amount of detail** to address.
- The quality of the answers and the multiple **moderate to large size deficiencies** led to a FAIL team recommendation.

Care Coordination and Integration

Evaluation of questions related to care coordination with outside entities including between CCOs, transitions of care between levels of service, Intensive Care Coordination, Medicare dual eligibles, the Oregon State Hospital, oral health integration, coordinating care for DHS-funded populations, and Indian Health Services.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	0	2	10				
Health Information Exchange	0	15	13				
Care Coordination	23	24	29	X		X	
Behavioral Health Covered Services	12	12	12			X	
Care Integration	13	1	7				

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

Applicant's responses on behavioral health benefit were well received by reviewers but lacked a feasible method to measure and mitigate gaps in the workforce.

Behavioral health covered services responses lacked significant detail on plans to overcome barriers to engagement as well as plans to implement solutions surrounding Children's system of care services. The Applicant provided little information on strategies for housing SPMI populations when transitioning out of OSH. Reviewers noted that responses displayed inconsistency from one question to another.

Care coordination responses lacked both responsiveness and detail showing a poor understanding of current state and revealing limited plans for future activity. Specifically the applicant failed to address processes for integrating care across systems, provided little detail on plans for transitions of care settings, and failed to include sufficient information special populations like children and tribes. No plan was provided for follow up activities.

Care integration responses did not address access to services or strategies for how to increase access. The Applicant provided no detail was provided on process for communication, documentation and monitoring. Plans for working with hospitals and specialty providers were missing and no description was provided of the Applicant's understanding of how to provide culturally relevant services.

Applicant's ability to support Health Information Exchanges (HIE) was well demonstrated.

Team Recommendation: **PASS**

Overall, reviewers felt that the deficiencies identified could be remedied **with strongly enforced work plans**. Shortcomings in care coordination are expected to be a **heavy lift**—it is recommended that focus be placed on coordination among the SPMI and tribal populations during readiness review. The lack of responsiveness and detail appeared to demonstrate a poor understanding of current state and unclear plans for future activities.

Clinical and Service Delivery

Evaluation of questions related to utilization monitoring, ensuring appropriate access to services, network adequacy, monitoring access and capacity, behavioral health services, internal clinical review, and complaints and grievances.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Covered Services	29	38	17		X	X	
Behavioral Health Benefit	12	11	10	X		X	
Administrative Functions	21	13	11	X		X	
Service Operations	24	16	6			X	X

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

Administrative Functions

The responses in this section were missing detail. The network adequacy section addresses physical health providers only and omits behavioral and oral health providers. The frequency of monitoring providers is also missing as well as how FTE is calculated. The Applicant relies on patient/provider ratios but doesn't explain how these ratios will be used to make decisions about network capacity. The grievance and appeal section is missing detail. It appears as if they only monitor complaints but do not use the rest of the grievance and appeal data. The deficiencies in this section would take a **small amount of effort to address**.

Behavioral Health Benefit

The responses in this section are missing detail. There is limited detail about billing barriers – the Applicant didn't identify any barriers which is unusual. There were no processes or strategies for how to implement in- home services and there were no timelines for discharge planning. The responses in this section would take a **small amount of effort to address**.

Behavioral Health Covered Services

The Applicant does not appear very involved in care coordination – leaves this up to PCP – and there is no description of monitoring to ensure members are receiving CC services. The chief medical officer decides where members are placed – there is no mention of member involvement in the provider selection process. And no discussion of how member is followed up with. There is no indication of how members are delegated to different levels of CC – no mention of how those levels are tracked. In general there appears to be no accountability for how care coordination is delivered. For the SPMI responses, there were no strategies for the delivery of prevention services in a culturally and linguistically competent manner. There were no methods for how these services were monitored or communicated to members. For Wraparound services, responses were missing methods for monitoring and tracking utilization across the provider

network. The majority of the deficiencies in this section would require **smaller amounts of effort to remedy**. However, the care coordination deficiencies noted **would require a large amount of effort to address** adequately as they would require the Applicant to implement new processes, provider relationships, monitoring systems, and other infrastructure, etc.

Service Operations

In general, the responses in this section were missing a moderate amount of detail. For the pharmacy services, there is missing detail on how Applicant communicates benefits to members. For the utilization management questions, there was no detail on utilization controls – Applicant simply stated that they have them and information on high needs or other targeted populations, was missing. For hospital services, acute and ambulatory care were not addressed separately as requested. The Applicant states that they have processes around hospital services but there is no detail provided. Member education on services is listed as the member handbook only and there appears to be no other monitoring of hospital services than the medical director reviewing them as needed. The very high-level responses provided in this section are suggestive of missing underlying processes, knowledge or infrastructure. These deficiencies are estimated to take a **moderate to large amount of effort** to address depending on what supporting processes or infrastructure is needed.

Team Recommendation: **FAIL**

- The responses in these sections were missing small to moderate amounts of detail and some components were not responded to at all.
- Care coordination responsibilities appeared to be largely delegated to PCPs with no system for monitoring. There is no indication that the Applicant is aware of their responsibilities regarding care coordination nor that different levels of care coordination exist.
- The SPMI service responses were missing moderate amount of detail on how they will be delivered in a culturally and linguistically competent manner and how these services are monitored and communicated to members.
- The majority of the Service Operations section contained very high-level details only and responses were suggestive of **moderate to large underlying deficiencies** in process, knowledge or infrastructure.
- Most of the deficiencies noted would require a small amount of effort to address however the care coordination and the service operation deficiencies were estimated to take a **moderate to large effort** to remedy.
- The quality of the responses and the presence of **multiple moderate to large, system-wide deficiencies**, led to a team recommendation of FAIL.

Delivery System Transformation

Evaluation of questions related to innovating in health care to improve overall care delivery, access and quality, Patient Centered Primary Care Homes (PCPCH) delivery system, access to culturally and linguistically appropriate care, quality improvement and the Transformation and Quality Strategy.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Delivery Service Transformation	6	2	4	X			X
Accountability and Monitoring	12	6	0	X		X	

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

Accountability and Monitoring:

Accountability – Applicant failed to provide details describing the measurement and reporting system, such as how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Applicant failed to provide details describing data systems and process, such as collecting data, performance benchmarks, and using the data to incentivize quality care. Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination specific to BH, Oral and PH services.

CCO Performance - Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REALD).

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data collection and analysis by sub-categories (by REALD). Lacking sufficient information on utilization of existing resources, including services specific to SPMI.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as tier levels, oversight, and engagement of potential new PCPCH providers. Lacking sufficient information about monitoring the non-PCPCH model to ensure fidelity. Lacking sufficient information about care coordination, evidence for success, effective wellness and prevention, and emphasis on whole person care.

Team Recommendation: **FAIL**

The responses provided by this applicant were insufficient. The following items are missing from the responses:

Accountability and Monitoring

- Referral and prior authorization system to support care continuity and quality
- Quality data systems and performance benchmarks
- Policies and staffing to support applicant's entire population for continuity of care
- Data reporting systems
- Process if providers/subcontractors are not meeting targets
- Process for communicating standards with providers

Delivery Service Transformation

- Details on the PCPCH system including site and tier levels
- Oversight process for PCPCH
- Encouragement of PCPCH system and outreach to potential new providers

Community Engagement

Evaluation of questions found in the RFA Community Engagement Plan, and questions aimed at an Applicant's level of community engagement during the development of the Application.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Governance and Operations	2	3	25			X	
Community Engagement Plan	6	13	41		X		
Community Engagement	0	5	5			X	
Social Determinants of Health	6	5	9			X	

Gradients show the degree of agreement between (1-2) and (3), and between (3) and (4-5)

Deficiency Analysis

- Community Engagement Plan did not include a mechanism for maintaining relationships with partners. Housing was not mentioned as a priority.
- Insufficient details on recruiting/engaging the CAC, ensuring representation from diverse populations and conforming to ORS requirements and how they would collaborate with CACs from other CCOs and what the board's accountability mechanism is, to the CAC.
- Community engagement with OHP consumers missing and with non-CAC members, and the role they will play in Quality Improvement activity.
- Missing information on how community input informs CCO decision making, how Applicant will mitigate any conflicts that arise.
- Missing information on who was involved in application development
- HRS spending lacks a clear role for tribes
- Unclear when and how they will vet SDOH priorities, how Applicant will ensure that this is a transparent and equitable process and how outcomes will be shared, or how conflicts of interest will be mitigated.

Team Recommendation: **PASS**

- Develop culturally and linguistically appropriate recruitment and engagement strategies for CAC members to reflect the diverse population
- Develop a plan to meaningfully engage with OHP consumer representatives
- Develop a plan for vetting SDOH priorities that includes timelines and milestones
- Develop robust engagement strategies for care planning that are culturally and linguistically appropriate
- Ensure CAC represents entire service area
- Develop a clear role for tribes in HRS spending
- Ensure aggregate panel advisors will provide accountable and transparent in their decision-making to the CAC
- Develop metrics for statewide housing priority
- Develop a more robust plan for disseminating outcomes of funded projects

Community Engagement – Community Letters of Support

An inventory of the letters of support and the type of entity submitting the letter.

Organization Name	Type
Advantage Dental	Dental Clinics
Aging and People with Disabilities	Public APD Programs
Bay Area Hospital	Hospital
Brookings Harbor School District	k-12 education, social programs
CASA of Coos County	Children's Court Advocates
CASA of Curry County	Children's Court Advocates
City of Bandon-Mayor Mary Schamehorn	Local Government
City of Brookings	Local Government
City of Gold Beach	Local Government
City of Port Orford	Local Government
Coast Community Health Center	FQHC
Coos Bay School District	k-12 education, social programs
Coos County Commissioner-John Sweet	Local Government
Coos County Commissioner-Melissa Cribbins	Local Government
Coos County Community Advisory Council-Member 1	CAC Member
Coos County Community Advisory Council-Member 2	CAC Member
Coos County Community Advisory Council-Member 3	CAC Member
Coos Health and Wellness Public Health	Public Health
Coos Health and Wellness-David Geels	BH
Coquille Indian Tribe	Tribal Government
Curry Community Health-Ben Cannon	Public Health
Curry Community Health-Erin Porter	BH
Curry County Commissioner-Court Boice	Local Government
Curry County Community Advisory Council-Consumer 1	Consumer
Curry County Community Advisory Council-Member 1	CAC Member
Curry County Community Advisory Council-Member 2	CAC Member
Curry County Community Advisory Council-Member 3	CAC Member
Curry County Community Advisory Council-Member 4	CAC Member
Curry Health Network	Hospital, Medical Center, Family Medical
Curry Homeless Coalition	Education, Advocacy, and Supportive Services for People with Housing Needs
Curry Public Library	Public Library
Department of Human Services District 7	Public SSP, CW
Every Child-Coos	Foster child supports
Food Share	Food, Nutrition

North Bend Medical Center	Medical Clinics
North Bend School District	Special Education, ACE Training
Oregon Coast Community Action	Community Action Agency, Food, Education, Housing
Oregon State University Extension Service - Family Health	Family and Community Health Supports
Oregon State University Extension Service- 4H Youth Development and Community Health	Family and Community Health Supports
Organize It! - Char Luther	Community Organizer, Housing
South Coast Education School District	Education Supports
South Coast Family Harbor Relief Nursery	Family and child supports, relief nursery
South Coast Regional Early Learning Hub	Early Learning Hub
South Coast Together	Family, child Adverse Childhood Experiences prevention
The Nancy Devereux Center	Homeless and BH Services
United Way of Southwestern Oregon	Social Support Programs
Wally's House	Child Abuse Intervention Center
Waterfall Community Health Center	Medical Clinic
Youth ERA	Peer-delivered services for transitional age youth 14 - 25

Behavioral Health Policy Assessment

The Behavioral Health team performed an additional review of Applicant responses, in particular, reviewing how Applicant addresses questions regarding: not carving out the Behavioral Health benefit, not putting a "cap" on Behavioral Health (or any area) of services, and ensuring the operation of a Global Budget.

It is the Behavioral Health perspective that if an Applicant is identifying that they would not follow the CCO 2.0 guidelines, via their responses, that a strong consideration for failing the applicant be considered. Otherwise, Behavioral Health highly recommends additional material and declaration of full responsibility for the Behavioral Health benefit before passing the applicant.

Deficiencies: The applicant will delegate a subset of behavioral health services but did not include a plan for how they would coordinate and integrate services.

Recommendations: Applicant needs to include how they will be accountable for the behavioral health benefit if they are delegating a subset of services – this must include care coordination and integration.

Appendix

Scoring Validation

The evaluation process was designed and additional post-hoc analyses were performed to ensure the reliability of the evaluation scores.

Intraclass Correlation: Intra-rater Reliability

Intraclass correlation is performed at the individual (reviewer) level to ensure that each Applicant was reviewed in a consistent manner by the same reviewer throughout the entire evaluation process. The Application Evaluation Plan was designed to reduce the risk that factors other than the response itself could influence how a reviewer applied scoring criteria across multiple Applicants. This included procedures for blinding and staggered Applicant scoring.

1. Applicants were blinded and responses deidentified so that reviewers would not explicitly or implicitly introduce bias into the evaluation process. The exception was Community Engagement as it was infeasible to blind this element of the Application.
2. Furthermore, the order in which Applicants were reviewed was randomized across weeks and within weeks to ensure the independent review of Applicant responses by reviewers. These factors contributed to the consistent and fair evaluation of Applicants throughout the evaluation process.

The blinding and staggered review steps designed into the Application Evaluation Plan, permitted a preemptive accounting for problematic individual intra-rater differences in the Applicant review process.

Interrater Reliability

Interrater reliability is performed at the group level, comparing the reviewers within a team to verify that there was a degree of uniformity in how they scored Applicants. The Interclass Correlation Coefficient (ICC), a widely used measure to examine reliability, was used to assess interrater reliability. ICC below 0.5 indicate poor reliability, values between 0.5 and 0.75 indicate moderate reliability, values between 0.75 and 0.9 indicate good reliability and values 0.9 and above are considered excellent reliability. Analyses were performed in SPSS using a two-way, mixed-effects model for absolute agreement using a 95% confidence level.

Overall Reliability Results

Overwhelmingly, ICC scores indicate moderate to good agreement. Across all Applicants and Teams, 70% of ICC values indicate moderate or better agreement and the ICC scores showed a pattern of normal distribution pattern, where the largest number of ICC rates were in the moderate range, with lower number of values at the low and higher ends of the scale. Below are Applicant level results.

Applicant Results: Interrater Reliability

Each Applicant was reviewed by 12 distinct groups (teams may have multiple sub-teams based on size).

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
3	6	3	0

Low ICC scores may be due to the limited number of reviewers (some as small as 3 reviewers) or the small number of questions reviewed by a group. Team results were also examined at the question level to identify potential discrepancies in scores. These discrepancies in scoring were mitigated at the Team Analysis Meetings.

Team Analysis Meetings

Upon completion of the Applicant scoring process, Teams met to discuss question`s and sections where scores were variable. The purpose of these meetings was to discuss specific Applicant responses and reach a consensus on scoring and the final team recommendation of pass or fail. These discussions mitigated any issues that may have led to poor interrater reliability by giving reviewers the opportunity to discuss and refine their overall assessment of the Applicant. The team pass/fail recommendations were reached after considering and discussing areas of discordant scoring and reaching a team consensus.

Monte Carlo Enrollment Modeling – Full Methodology

Results from CCO 2.0 applicant enrollment scenarios – Monte Carlo simulations help identify which applicants are at risk of not obtaining enough members or too many.

The following memo presents findings from simulated enrollment scenarios intended to reflect the two extremes of a given CCO applicant's membership: minimum enrollment and maximum enrollment. Monte Carlo simulations allow for the variation of multiple factors. Running the simulation thousands of times for each applicant provides a distribution of likelihood. In other words, Monte Carlo simulations use a set of varying parameters to predict the likelihood (in the form of a percent) that:

- An applicant will not receive enough members to meet their self-reported minimums from their pro forma, as well as;
- The likelihood that an applicant will receive too many members, exceeding their maximums as reported in their pro forma.

Some applicants have relatively high risk of receiving either not enough or too many members.

How to read this memo

The analysis is not an assessment of any applicant's proposal, nor should the enclosed information serve as evidence of inefficiency (in the case of not meeting the minimum threshold) or inadequate provider network (in the case of exceeding maximum threshold).

All simulations rely on the same set of core assumptions and parameters. The value of the simulation is not the specific output number, rather the risk level relative to other applicants is informative. As such, OHA should monitor enrollment trends of the applicants labelled high risk to ensure no CCO applicant has to shut down due to insufficient enrollment.

The simulations do not consider any actions that OHA may take. For example, if a CCO's applicant size approaches that CCO's maximum enrollment, the OHA eligibility system will likely close enrollment for that CCO. The analysis below is predicated solely on a range of options for enrollees to switch CCOs, move to open card, or leave open card.

Considerations

The most influential assumption for modeling is that members generally opt to re-enroll into their previous CCO. This "stickiness" factor is common in commercial markets but may not prove to be true for the OHP population. Furthermore, if a significant number of members do not proactively re-enroll and instead OHA distributes enrollment equally across all Successful Applicants in a region, the risks of not meeting the minimum threshold will be largely mitigated because 1) OHA can monitor enrollment relative to the CCO's maximum to ensure the CCO does not receive too many members, and 2) members could be assigned to CCOs without regard to their previous CCO assignment, which nullifies the "stickiness" assumption in the model.

The summary of potential risk for each applicant below is a function of:

- The applicant's self-reported minimum and maximum enrollment,
- The number of OHP members living in the proposed service area,
- The number of Applicants applying for the same service area, and
- The "stickiness" of current OHP members remaining with their current CCO.

The simulations rely on random number generators using the following parameters:

- Members who choose to disenroll from a CCO: The percent of current CCO members who opt to leave their current CCO (when the current CCO is also a CCO 2.0 Applicant)
    - Minimum: 1%
    - Maximum: 35%
    - Mode: 11%

- The percent of members who leave their existing CCO and migrate to a new Applicant
    - The percentage ranges vary depending on the number of Applicants
    - The model allows for some members to disenroll into Open Card because some eligibility categories allow for that.

- The percent of current Open Card members who enroll with a CCO
    - Minimum: 0%
    - Maximum: 40%
    - Mode: 20%

- For those current Open Card members who enroll with a CCO
    - The percent ranges vary depending on the number Applicants

The simulations also rely on:

- Current CCO enrollment, which is based on July 2018 enrollment data. (Enrollment data from March 2019 are not significantly different. See Appendix Table 3.1 and 3.2 for a comparison)
- Current OHP enrollment by county
- Current Open Card enrollment by county
- The presence of an existing CCO applying for similar service region.

The model is structured on enrollment by county. As such, applicants proposing to serve partial counties were challenging to model accurately. Despite this limitation the model allows for stress testing by running two different scenarios for each applicant: 1) remove all partial county service areas and run the model to ensure that even without those extra areas the applicant will not likely exceed their maximum enrollment threshold, and 2) if an applicant intends to serve a partial county, include that entire county when modeling the applicant's enrollment to ensure that even serving the full counties the applicant will meet their minimum threshold. <u>This assumes all current applicants are awarded a contract.</u>

Table 1. Applicant CCOs' self-reported minimum and maximum enrollment thresholds

	As reported on Financial pro forma:		Converted to # of members	
CCO Applicants	**Minimum member months**	**Maximum member months**	**Min**	**Max**
Advanced Health	206,828	269,558	17,236	22,463
All Care CCO	570,600	1,099,157	47,550	91,596
Cascade Health Alliance	156,780	261,300	13,065	21,775
Columbia Pacific	140,161	336,387	11,680	28,032
Eastern Oregon CCO	480,000	750,000	40,000	62,500
Health Share CCO	2,390,981	4,801,200	199,248	400,100
Intercommunity Health Network (IHN)	512,784	854,640	42,732	71,220
Jackson Care Connect	201,712	672,372	16,809	56,031
Marion Polk Coordinated Care	748,533	1,295,514	62,378	107,960
Northwest CCO	225,000	375,000	18,750	31,250
PacificSource Gorge	84,000	206,016	7,000	17,168
PacificSource Central	480,000	790,104	40,000	65,842
PacificSource Lane	120,000	1,179,600	10,000	98,300
PacificSource MarionPolk	120,000	982,920	10,000	81,910
Primary Health of Josephine County	108,000	180,000	9,000	15,000
Trillium Community Health Plans	510,000	5,181,808	42,500	431,817
Umpqua Health Alliance	258,000	429,000	21,500	35,750
West Central CCO	422,400	1,108,800	35,200	92,400
Yamhill Community Care	255,000	375,000	21,250	31,250

Table 2. OHP enrollees by count, July 2018 count of persons

Baker	4,909
Benton	15,301
Clackamas	74,615
Clatsop	11,241
Columbia	11,951
Coos	22,155
Crook	7,170
Curry	7,095
Deschutes	42,865
Douglas	36,419
Gilliam	461
Grant	1,827
Harney	2,457
Hood River	6,950
Jackson	70,113
Jefferson	9,403
Josephine	32,864
Klamath	24,127
Lake	2,335
Lane	103,382
Lincoln	16,005
Linn	38,219
Malheur	12,633
Marion	107,237
Morrow	3,796
Multnomah	206,241
Polk	20,497
Sherman	458
Tillamook	7,828
Umatilla	23,645
Union	7,547
Wallowa	2,056
Wasco	8,758
Washington	107,778
Wheeler	397
Yamhill	26,515

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

The analysis in this memo relies on OHP enrollment data from July 2018. The more recent data from March 2019 is not significantly different from the July 2018 numbers. Total statewide enrollment in CCOs grew by 1.6% from the two time periods.

Table 3.1 CCO enrollees by county – Difference from July 2018 to March 2019

	Number difference	Percent difference
Baker	302	7.98%
Benton	156	1.30%
Clackamas	209	0.35%
Clatsop	154	1.85%
Columbia	64	0.69%
Coos	216	1.26%
Crook	93	1.61%
Curry	151	2.90%
Deschutes	42	0.12%
Douglas	553	1.94%
Gilliam	21	6.25%
Grant	53	3.80%
Harney	94	4.69%
Hood River	127	2.43%
Jackson	736	1.32%
Jefferson	241	4.38%
Josephine	630	2.32%
Klamath	624	3.57%
Lake	123	7.13%
Lane	1,748	2.13%
Lincoln	197	1.70%

Linn	-131	-0.43%
Malheur	755	7.84%
Marion	534	0.65%
Morrow	35	1.29%
Multnomah	2,249	1.38%
Out-of-State	-97	-73.48%
Polk	181	1.15%
Sherman	49	15.91%
Tillamook	172	3.00%
Umatilla	1,015	5.87%
Union	568	9.78%
Unknown	-15	-57.69%
Wallowa	123	7.48%
Wasco	254	3.94%
Washington	708	0.85%
Wheeler	33	11.70%
Yamhill	226	1.14%
Total Enrolled in a CCO	13,193	1.57%

Table 3.2 CCO enrollees – Difference from July 2018 to March 2019

	Number difference	Percent difference
ADVANCED HEALTH	305	1.6%
ALLCARE CCO, INC.	477	1.0%
CASCADE HEALTH ALLIANCE, LLC	588	3.5%
COLUMBIA PACIFIC CCO LLC	397	1.7%
EASTERN OREGON CCO, LLC	3,195	6.8%
HEALTH SHARE OF OREGON	3,037	1.0%
INTERCOMMUNITY HEALTH NETWORK	271	0.5%
JACKSON CARE CONNECT	620	2.1%
PACIFICSOURCE COMMUNITY SOL GORGE	364	3.1%
PACIFICSOURCE COMMUNITY SOL INC	449	0.9%
PRIMARYHEALTH JOSEPHINE CO CCO	276	2.9%
TRILLIUM COMMUNITY HEALTH PLAN	1,730	2.0%
UMPQUA HEALTH ALLIANCE, DCIPA	528	2.0%
WILLAMETTE VALLEY COMM. HEALTH	650	0.7%
YAMHILL COMMUNITY CARE	306	1.3%

Member Allocation Methodology

The methodology used to allocate members in the Enrollment Modeling is described below. This methodology is still being refined for the final matching process.

Provider Type

For each member claims history was reviewed to determine whether that member has seen a Behavioral Health, Primary Care Provider (PCP) or Pediatric provider. For the purpose of this test, the most recent provider(s) visited during the lookback period was used to establish the match.

To prioritize preserving member relationships with Behavioral Health providers, visit codes contained in claims information were analyzed. If no Behavioral Health claims were found, Primary Care Providers, including Pediatricians, were reviewed for potential matching.

Lookback Period

The claims that used to establish the provider match included all submitted encounter data within a lookback period of 15 months. This period was chosen to capture members who receive yearly services and provides some padding for delays in scheduling and billing.

Excluded Claims

Claims related to Emergency Room services, Urgent Care, and Hospital Inpatient services were not included as they do not demonstrate a provider relationship but instead an institutional relationship.

Provider Matching Process

Once the review of claims was complete, and a potential provider match is identified for the member, it was compared to the data provided in the Delivery System Network (DSN) file. This established whether the provider identified is contracted with:

1. One available CCO
2. All available CCOs
3. None of the available CCOs

For members with a provider record matching one available CCO, the member was allocated to that CCO.

Members matching all or none of the available CCOs were moved to a 'Case analysis.' For eligibility purposes, a 'Case' is created when multiple members of the same family are enrolled in OHP. This review determined whether any other member of that person's family is currently assigned to a CCO and assigned them to the same plan. This effort is made to keep naturally grouped members together.

For members with no Case assignment, they were evenly distributed between available CCOs.

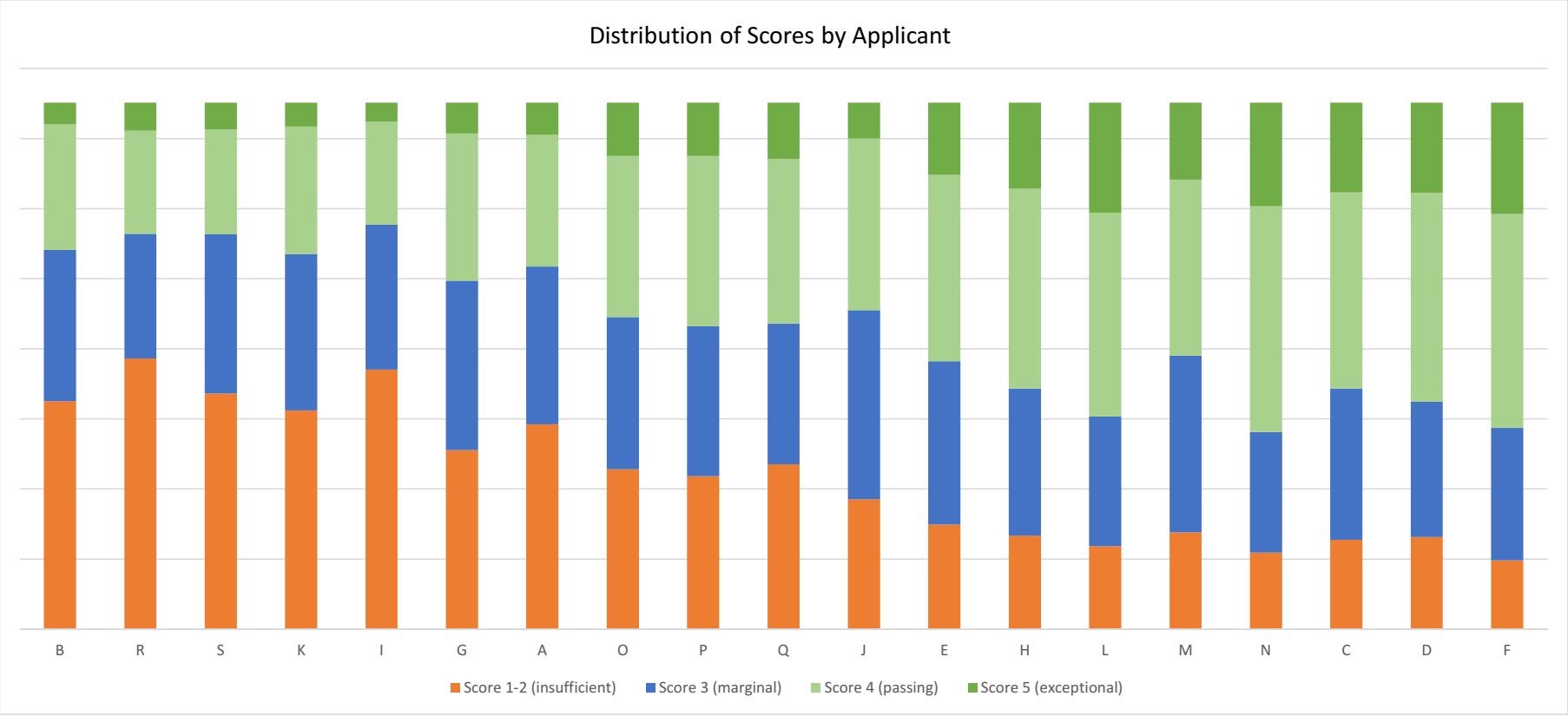
Members with no claims history

If no claims history exists, then the member's current Case was analyzed. If a member of their case has been assigned to a CCO then this member was assigned to that CCO. If their case has no CCO assignments, then the member moved to the even distribution process. With no claims history and no family grouping to maintain, a member should be served equally well by any CCO in the area.

Pass/Fail by Category

APP B	APP R	APP S	APP K	APP I	APP G	APP A	APP O	APP P	APP Q	APP J	APP E	APP H	APP L	APP M	APP N	APP C	APP D	APP F
FIN	FIN	FIN	FIN	FIN	BUS	BUS	FIN	BUS	BUS	BUS	CSD	FIN	FIN	FIN	FIN	FIN	FIN	FIN
BUS	BUS	BUS	BUS	BUS	CC	CC	CC	CSD	CC	CSD	DST	BUS	BUS	BUS	BUS	BUS	BUS	BUS
CC	CC	CC	CC	CSD	CSD	CSD	DST	DST	CSD	FIN	FIN	CC	CC	CC	CC	CC	CC	CC
CSD	CSD	CSD	CSD	DST	CE	DST	BUS	FIN	FIN	CC	BUS	CSD	CSD	CSD	CSD	CSD	CSD	CSD
DST	DST	CE	DST	CE	FIN	FIN	CSD	CC	DST	DST	CC	DST	DST	DST	DST	DST	DST	DST
CE	CE	DST	CE	CC	DST	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE
WCCCO	MPCC	CHA	Yamhill	AllCare	Umpqua	NWCCO	EOCCO	WOAH	IHN	PHJC	JCC	PS-Cent	PS - MP	CPCCO	Trillium	PS - CG	PS - Lane	HSO

FIN - Finance
BUS - Business Administration
CC - Care Coordination and Integration
CE - Community Engagement
CSD - Clinical and Service Delivery
DST - Delivery System Transformation



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

		Total Asset				Total Liability				Total Capital & Surplus			
	Applicants	FY2020 (*)	FY2018	Increase (decrease)	% as FY2020/ FY2018	FY2020 (*)	FY2018	Increase (decrease)	% as FY2020/FY 2018	FY2020 (**)	FY2018	Increase (decrease)	% as FY2020/FY 2018
APP A	NWCCO	25,759,000		n/a	n/a	15,213,000		n/a	n/a	9,100,000		n/a	n/a
APP B	WCCCO	38,492,000		n/a	n/a	22,751,000		n/a	n/a	13,700,000		n/a	n/a
APP C	PSCSG	57,513,111	58,300,174	(787,063)	99%	9,156,093	49,880,909	(40,724,816)	18%	47,103,461	43,585,742	3,517,719	108%
APP D	PSCSL	66,331,257		n/a	n/a	17,161,404		n/a	n/a	47,103,461		n/a	n/a
APP E	JCC	25,873,433	27,255,103	(1,381,670)	95%	12,436,742	12,436,742	-	100%	11,975,466	14,818,361	(2,842,895)	81%
APP F	HealthShare	79,802,457	99,666,104	(19,863,647)	80%	17,536,745	28,282,051	(10,745,306)	62%	57,811,215	71,384,053	(13,572,838)	81%
APP G	Umpqua	35,036,000	34,035,706	1,000,294	103%	20,523,000	28,237,987	(7,714,987)	73%	11,927,000	5,797,720	6,129,280	206%
APP H	PSCSC	100,256,941	58,300,174	41,956,767	172%	44,864,033	49,880,909	(5,016,876)	90%	52,103,461	43,585,742	8,517,719	120%
APP I	AllCare	47,500,528	37,269,099	10,231,429	127%	26,506,000	17,884,488	8,621,512	148%	20,693,818	19,384,611	1,309,207	107%
APP J	Primary	8,336,380	9,589,616	(1,253,236)	87%	4,815,805	7,814,966	(2,999,160)	62%	2,154,581	1,774,650	379,931	121%
APP K	YCCO	40,279,000	36,811,625	3,467,375	109%	18,630,000	17,356,222	1,273,778	107%	17,072,000	19,455,403	(2,383,403)	88%
APP L	PSCSMP	65,066,566		n/a	n/a	11,556,515		n/a	n/a	52,103,461		n/a	n/a
APP M	CPCCO	20,199,419	28,515,654	(8,316,235)	71%	7,557,756	17,571,001	(10,013,245)	43%	11,294,637	10,944,653	349,984	103%
APP N	Trillium	194,498,450	151,943,350	42,555,100	128%	117,938,112	93,087,256	24,850,856	127%	76,953,438	58,856,094	18,097,344	131%
APP O	EOCCO	48,652,000	65,016,133	(16,364,133)	75%	28,745,000	24,007,802	4,737,198	120%	17,225,000	24,007,802	(6,782,802)	72%
APP P	Advanced	12,244,118	13,493,690	(1,249,572)	91%	1,824,637	5,551,012	(3,726,375)	33%	9,816,584	7,942,678	1,873,906	124%
APP Q	IHN	118,510,421	112,250,059	6,260,362	106%	41,805,400	43,805,503	(2,000,103)	95%	73,461,940	68,444,556	5,017,384	107%
APP R	MPCCO	36,280,693	51,241,983	(14,961,290)	71%	20,945,393	30,664,327	(9,718,934)	68%	3,000,000	20,577,656	(17,577,656)	15%
APP S	CHA	35,785,426	35,801,535	(16,109)	100%	19,756,017	22,314,101	(2,558,084)	89%	15,074,456	13,487,435	1,587,021	112%

Note:

* Those numbers are extracted from the BE MM scenario, and represent the financial status at 2020 year-end.

** Deducted 2020's net income (loss) from the reported capital balance for better comparison to FY2018 ending capital.

*** FY2018's Income Statement items are OHP business line only; Premium should include the quality pool revenue and thus Line 6. "Total operating revenues" reported number is used here. Modifications might be needed for certain CCOs to exclude non-OHA funded other health care related revenues (this will be noted in the cell)

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

	1. Allocated to Single CCO in Service Area	2. Member or Member Family Provider Networked to Single CCO in Service Area	3. Allocated Evenly to Subset of CCOs in Service Area	4. Allocated Evenly to All CCOs in Service Area	**Total**	
AllCare CCO, Inc		32,797	5,144	12,766	50,707	
Cascade Health Alliance, LLC	16,419				16,419	
Columbia Pacific CCO, LLC		2,218		7,480	9,698	
Eastern Oregon Coordinated Care Organization, LLC	45,853				45,853	
Health Share of Oregon		157,983	2,374	56,749	217,106	
InterCommunity Health Network	48,278	318		358	48,954	
Jackson Care Connect		2,300	1,656	5,343	9,299	
Marion Polk Coordinated Care		31,174	999	15,273	47,446	
Northwest Coordinated Care Organization LLC		5,233		7,481	12,714	
PacificSource Community Solutions - Central Oregon	44,679				44,679	
PacificSource Community Solutions - Columbia Gorge	11,177				11,177	
PacificSource Community Solutions - Lane		327	1,069	13,200	14,596	
PacificSource Community Solutions - Marion Polk		27,573	1,071	15,023	43,667	
Primary Health		6,808	3,141	11,224	21,173	15,000 max
Trillium Community Health Plan, Inc.		18,559	11,778	70,506	100,843	
Umpqua Health Alliance, LLC	24,121	229	1	486	24,837	
West Central Coordinated Care Organization LLC		240	8,835	13,200	22,275	
Western Oregon Advanced Health, LLC abn Advanced Health	14,959	1,048		1,542	17,549	
Yamhill County Care Organization	19,268	1,242	2,730	2,912	26,152	
Total	224,754	288,049	38,798	233,543	785,144	

1. Allocated to Single CCO in Service Area	The service area the member lives in (Zip Code, County combinations) is serviced by a single CCO. The member is allocated to that CCO.
2. Member or Member Family Provider Networked to Single CCO in Service Area	Either the member or someone in the member's case has a provider who is networked to a single CCO in the service area. The member and others on their case are allocated to that CCO.
3. Allocated Evenly to Subset of CCOs in Service Area	Either the member or someone in the member's case has a provider who is networked to more than one, but not all of the CCOs in the service area. The member and those on their case are allocated together to one of the CCOs, all cases with the same subsets of CCOs are allocated evenly among that subset of CCOs.
4. Allocated Evenly to All CCOs in Service Area	Either the member has no recent provider **OR** their provider is networked to all the CCOs in the servie area **OR** their provider is not networked with any CCO in the service area. The member and those on their case are allocated evenly among all the CCOs in their service area.
Special Populations are excluded from allocation.	About 180,245 members belong to special populations. These include members in ABAD, OAA, Foster Care, Tribal Members (HNA), and Medicaid-Medicare Dual Eligibles. **They are not allocated in the above analysis.**

using data as of 5/22/19

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