RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant I
AllCare CCO, Inc.

CONFIDENTIAL UNTIL 7/9/19

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

- AllCare did not provide PBM details in financial survey as required
- DCBS financial review found that results appear to be reasonable for projections provided.

Service Area Analysis

- AllCare is requesting to serve Curry, Jackson, Josephine, and Douglas counties. There is a service area exception request to serve only part of Douglas County. AllCare received passing scores for this exception request.
- AllCare is one of four applicants in this service area. There is low or no risk that the applicant will fail to meet minimum enrollment or exceed maximum enrollment.

Evaluation Results – Team Recommendations

- Finance – Fail; responses lacking detail and not meeting expectations or requirements.
- Business Administration – Fail; majority of questions were missing info and some were unresponsive. Missing details about infrastructure, SOH-HE data matching, and member transition. These areas would require a significant amount of effort to remedy.
- Care Coordination and Integration – Pass
- Clinical and Service Delivery – Fail
- Delivery System Transformation – Fail; missing information about reporting systems, quality standards and compliance, referrals and prior auth processes, PCPCH system and access analysis.
- Community Engagement – Fail; missing support for CAC development, community engagement, and making transparent and equitable SDOH spending decisions.

Community Letters of Support

- 67 letters of support were received from various provider groups and local entities

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

AllCare's responses to informational questions scored low in Behavioral Health, Cost, Social Determinants of Health, Business Operations, and VBP.

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 22, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

AllCare CCO, Inc.

I have performed a financial evaluation of AllCare CCO ('CCO') based on the materials provided. CCO is part of the AllCare Health, Inc. holding company system, which includes AllCare Health Plan, Inc. CCO will provide services in Jackson County, Josephine County, Douglas County, and Curry County. The results provided appear to be reasonable for projections provided.

The Pro Forma Statutory Balance Sheet that was prepared by the Applicant, projects Best Estimate ('BE') RBC of 237.4%, 244%, 262.9% for year-ending 2020, 2021, 2022, respectively. The applicant would meet the RBC requirements in each year of their minimum enrollment/Claims+0% projections. The applicant would not meet the RBC requirement in 2020 for their maximum enrollment/Claims+0% projection, but would meet the requirement in 2021 & 2022.

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 100% membership, Minimum ('MIN') 96%, and Maximum ('MAX') 185%. The CCO's assumptions and Proforma should be based on BE 100%, MIN 75%, and MAX 125%.

CCO and AllCare Management Services, LLC ('AMS'), entered into a Management and Administrative Service Agreement. AMS will provide management services, claims administration, IT services, enrollment, member services, care coordination, population health, quality, compliance, and provider services. The contract is a PMPM model based upon member enrollment and includes 10% of the quality bonus pool paid annually.

It was noted in the 'Scratch Sheet' tab, "due to economies of scale and membership levels in the MAX MM models, AllCare feels it should lower the administrative charge by $2 to $40.20, $40.28, $40.35 for year 2020, 2021, 2022, respectively. The model does not permit a varying charge for administrative costs by year by model, therefore, we choose to enter the lower administrative charge for all 3 model assumptions BEMM, MINMM and MAXMM as it has an impact on the RBC levels. In making this adjustment across all three models, this results in a difference on the CCO Administrative Costs tab. These differences are $2 for the BE MM and MIN MM models. The minor differences noted in scenarios BE MM and MIN MM are a result of rounding."

		2020	**2021**	**2022**
Maximum MM:		1,099,157	1,102,133	1,102,133
Fixed Administrative Costs	Assumptions Line 9	1,000,000	1,100,000	1,250,000
Variable Administrative Costs	Assumptions Line 10	46,384,435	46,598,194	46,675,344
Total Administrative Costs	calculated	47,384,435	47,698,194	47,925,344
Reported Administrative Costs	P and L Lines 17, 18	45,171,288	45,472,808	45,707,528
Difference (should be 0)	calculated	2,213,147	2,225,386	2,217,816

Verify				
Reported Administrative Costs	P and L Lines 17, 18	45,171,288	45,472,808	45,707,528
Fixed Administrative Costs	Assumptions Line 9	1,000,000	1,100,000	1,250,000
Maximum MM:		1,099,157	1,102,133	1,102,133
Amount charged PMPM		40.19	40.26	40.34

Analyst reviewed the 'CCO Administrative Costs' worksheet and it appears that they charged MAX $40.19, $40.26, and $40.34 PMPM for 2020, 2021, and 2022, respectively. This differs from the 'Company Assumptions' tab #10 "What is the variable administrative costs for CCO Operations on a PMPM basis" and 'Scratch Sheet' tab explanation as stated above. Due to AllCare "feeling it should lower the administrative charge", it does not appear that this is an arms length transaction, fees are fair and reasonable, as required by SSAP 25.

Review of the RBC, the CCO would not meet minimum RBC level under any assumption if claims were 2%, 4% or 6% higher, in 2020 and 2021, but would meet the requirements under the minimum projection in 2022 for a 2% negative deviation. The CCO would also experience excessive net losses if claims are 2% higher under the BE, MIN, and MAX estimates. When the BE assumption is stressed at +2% claims, Net Loss would be ($4.4M), which is 20.8% of C & S. It is important to note that under the MAX assumption, if claims were 6% higher, the CCO would be insolvent with C & S of ($3.7M). (These amounts are no cumulative, so negative or below average results would have further negative impacts.) This variation leaves very little to no room for negative deviations from the projections, and may put the applicant in a Company Action level if they are unable to meet projections, but the projections appear to have some cushion for losses to remain above Company Action level (roughly $3 million for 2020).

The Excel worksheet 'Exhibit 12.3c-(ucaa)form13H MAX MM' - 'Assumptions' tab under Balance Sheet: #5, "includes a capital infusion of $2M in 2020 and $3.5M in 2021 in order to support RBC requirements.

The applicant appears to have sufficient assets to cover their liability obligations without requiring positive cash flow from operations.

Does the CCO meet the RBC and Capital & Surplus requirements?

The CCO only meets the basic capital and surplus and RBC requirements under BE and MIN only. Under the MAX assumption, RBC would fall below 200% to 159.4% in 2020, but would rise above 200% in subsequent years. It is worthy to note that the CCO has implied that under the MAX assumptions, regardless of increase in claims, they would need capital infusions. CCO stated within the application material that they have incorporated a plan to achieve the required RBC by Q3 2021 as necessary, however did not provide the plan.

Recommendations and Additional questions:

- What is the parent company's financial threshold to infuse capital into the CCO? Does this estimate include consideration for lowering Administrative costs when enrollment is at MAX?
- What is the 'Plan' to achieve required RBC under MAX assumption?
- Recommend that the CCO provide the contracted fee PMPM for 2020, 2021, 2022 and based proforma off those contracted variable administrative fees.
- Recommend that all Administrative Service Agreements comply with SSAP 25 as the Agreement should be an arm's length transaction and the fees should be fair and reasonable.
- Recommend that CCO provide Proforma be based on assumptions BE 100%, MIN 75%, and MAX 125%.
- Recommend that the CCO appropriately stress test with consistent variables across BE, MIN, and MAX, to identify the true breaking point of the CCO. The CCO adjusted variable administrative fee PMPM and included capital infusions under the MAX assumptions.

Issues:

- Proforma does not stress at 75% and 125%, it is uncertain what RBC and C & S would be at this level. Applicant did provide what their projected minimum and maximum enrollment levels would be, but that appears to deviate from the RFA requirements.
- Proforma includes adjusted Administrative Fees for MAX to meet RBC, however, review noted that with lowered variable Administrative Fees, the CCO still does not meet the required RBC.
- It is uncertain if this Administrative Service Agreement complies with SSAP 25 as it does not appear to be arms length transactions and fees do not appear to be fair and reasonable.
- CCO states they are unable to meet SAP reporting to NAIC for 2020 and will request an exemption.

Conclusion:

Based on the review of the application, the it is recommended that CCO provide further information, stress testing, and verify information provided is reasonable before making contract decision. The UCAA application contained errors, change of stress testing criteria, miscalculations and/or misinformation and did not include the stress test provisions in the OHA requirements. Most of the stress tests have been completed manually through the review, so there is little to no new information for that, but indicates an incomplete filing.

[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. The focus of this review is the reasonability of projected numbers stated in Applicant's Balance Sheet and P&L pro formas (BE MM scenario) by comparing to the 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**
595,615	563,468	1,099,157	570,600	95%	**Too low**

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$422.41		$436.97	$461.40	-8%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
90%	87%	3%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.36%	3.40%

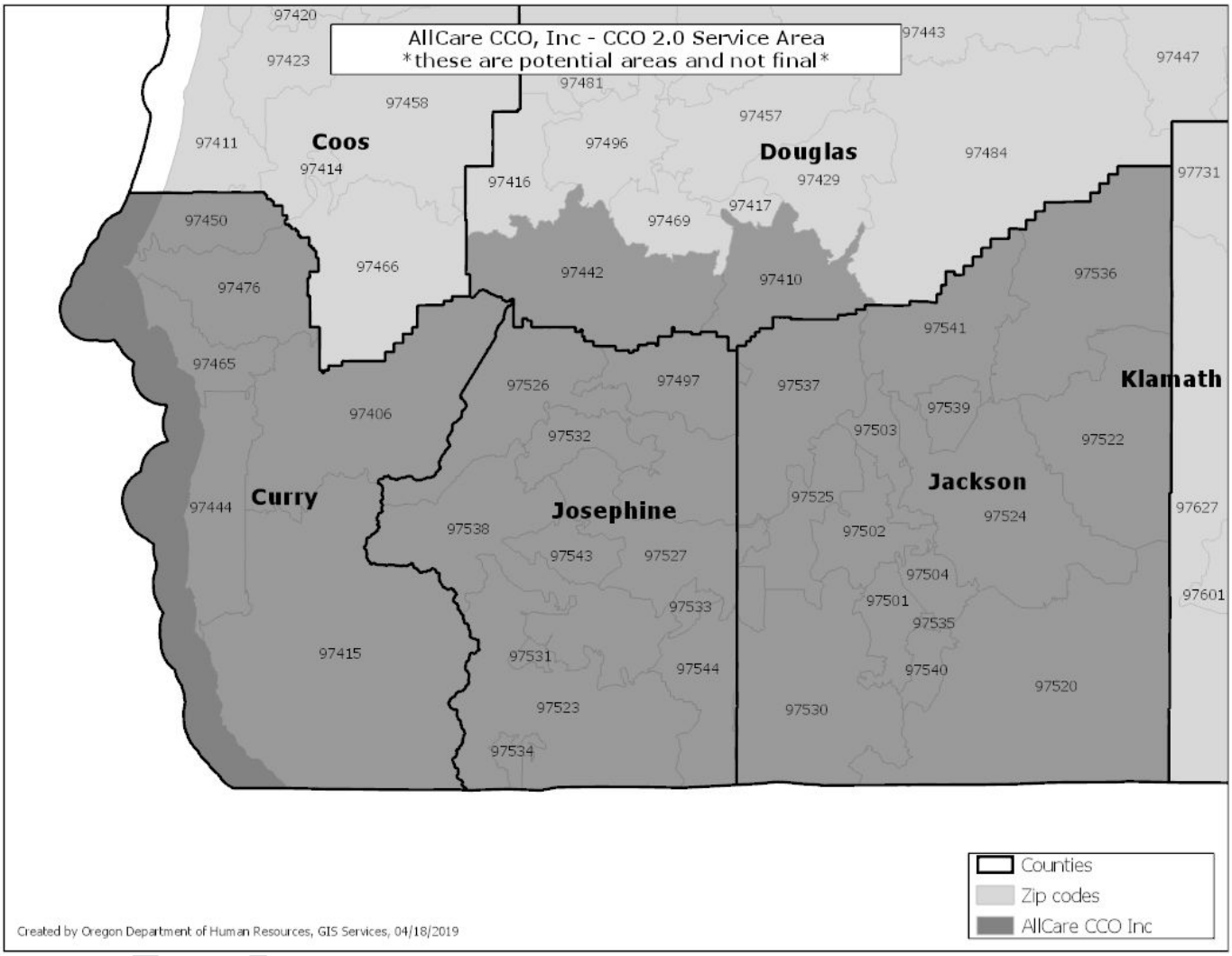
Population Trend	
Applicant Assumption	**OHA Assumption**
0.27%	0.27%

AllCare's enrollment is listed as "too low", but that is primarily because their minimum scenario was only 96% of their best estimate – a higher minimum than any other applicant. ASU's attached estimate is about 95% of ALLC's best estimate. Moreover, if the PHJC application or Jackson County expansion is declined, expected AllCare enrollment would increase.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Curry, Josephine and Jackson counties, and partial Douglas county. The partial county request is aligned with the Applicant's current service area. Three Applicants are requesting to cover the two zip codes in southern Douglas county.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	4	26
Care Coordination and Integration	1	29
Community Engagement	6	9
Clinical and Service Delivery	4	29
Delivery System Transformation	1	11
Finance	0	0

The full text of the Exception Request can be found in the Appendix.

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
Josephine, Jackson, Curry	Douglas	In addition to AllCare, one other applicant proposes to serve Curry, one other applicant proposes to serve Josephine, and two other applicants proposes to serve Jackson. Two other applicants propose to serve the partial Douglas region.	3% chance AllCare may not receive enough members in the proposed areas. If AllCare is limited to only full counties, the chance of not enough members increases to 75%.	No scenarios show enrollment exceeding applicant's maximum	Low risk

Additional Analyses on High Risk Areas

Southwest Oregon

The analysis for southwestern Oregon differs from those above because in this region we must consider the relatively small maximum thresholds for Primary Health of Josephine to ensure there is enough capacity.

Over 110,000 members reside in Curry, Josephine, and Jackson Counties. Three applicants propose to serve different configurations of the three counties.

Applicant	Maximum threshold	Proposes to serve
AllCare	91,596	Curry, Josephine, and Jackson
Primary Health of Josephine	15,000	Josephine and Jackson
Jackson Care Connect	56,031	Jackson

County	Non-open-card population	Open-card population	Total member population
Curry	5,200	1,900	7,100
Josephine	27,400	5,600	33,000
Jackson	56,100	14,000	70,100

Because Primary Health's maximum is only 15,000, OHA must restrict enrollment in that applicant for Josephine and Jackson Counties. Jackson Care Connect could theoretically absorb nearly all non-open-card members in Jackson County and AllCare could absorb all non-open-card members by itself, without Primary Health or Jackson Care Connect.

The sum of all three applicants' maximum thresholds is over 162,000 yet the sum of all members, including open-card, in the three counties is only 110,200. The capacity theoretically exists among the applicants, but OHA should closely monitor enrollment trends, especially because both All Care and Primary Health propose to serve parts of Douglas County, which is not included in the member numbers above.

The table below shows the various scenarios and the impacts for each Applicant.

Member Allocation Projection

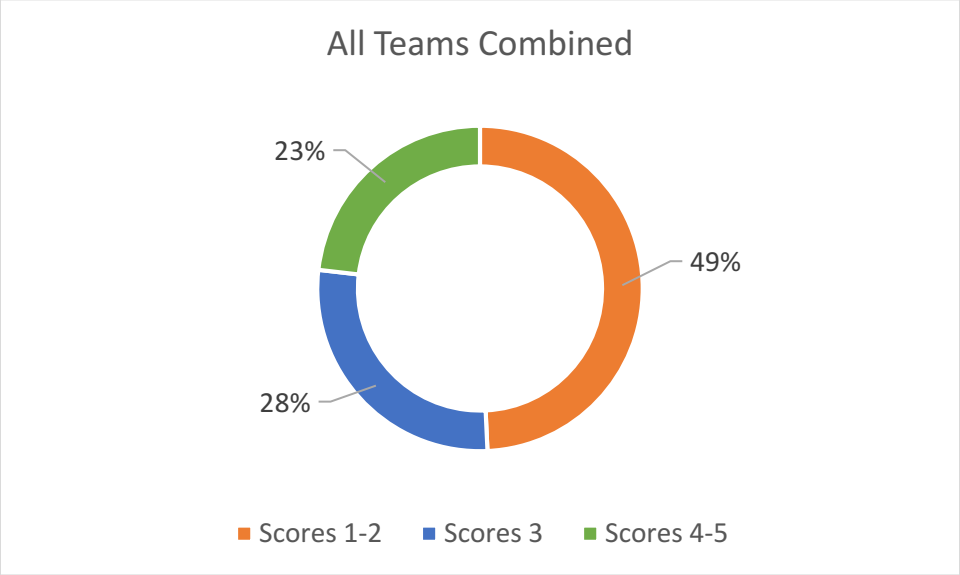
Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, AllCare is likely to receive approximately 50,707 members out of the 47,550 minimum required.

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.

Scenario description	Impact on AllCare	Impact on Primary Health	Impact on Jackson Care Connect	Analysis and Comments
All three applicants awarded	3% chance AllCare may not receive enough members in the proposed areas. If AllCare is limited to only full counties, the chance of not enough members increases to 75%.	Projected enrollment falls within the applicant's parameters	Projected enrollment falls within the applicant's parameters	
AllCare and Primary Health awarded	Projected enrollment falls within the applicant's parameters	100% chance Primary Health receives too many members. However, OHA can monitor this and curtail enrollment as Primary Health's total approaches their max.	Not awarded in this scenario	If Primary Health receives its max (15,000 members), AllCare can absorb all other members in the three counties. However, there are also 21,500 open-card members. AllCare can absorb all but 3,604 open-card members. There will be a capacity constraint if more than 17,896 open-card members opt to join a CCO.
Primary Health of Josephine and Jackson Care Connect awarded	Not awarded in this scenario	Primary Health would be the only CCO serving Josephine County. The 27,400 CCO members would exceed Primary Health's max of 15,000	JCC would have to serve all of Jackson County because Primary Health would be over capacity serving only Josephine. Jackson County's 56,100 members exceeds JCC's max of 56,031. Any open card members moving to CCOs would exacerbate the problem.	Untenable scenario. All CCOs would be over capacity. In addition to Primary Health and JCC being over capacity, Advanced Health would have to serve Coos and Curry Counties alone. Over 29,000 members live in the two counties and that would exceed Advanced Health's max of 22,463.
AllCare and Jackson Care Connect awarded	Projected enrollment falls within the applicant's parameters. AllCare has the capacity to serve all of Josephine County	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters. JCC could theoretically serve nearly all current CCO members in Jackson County.	AllCare and Jackson Care would meet their minimums and would not exceed their maximums.

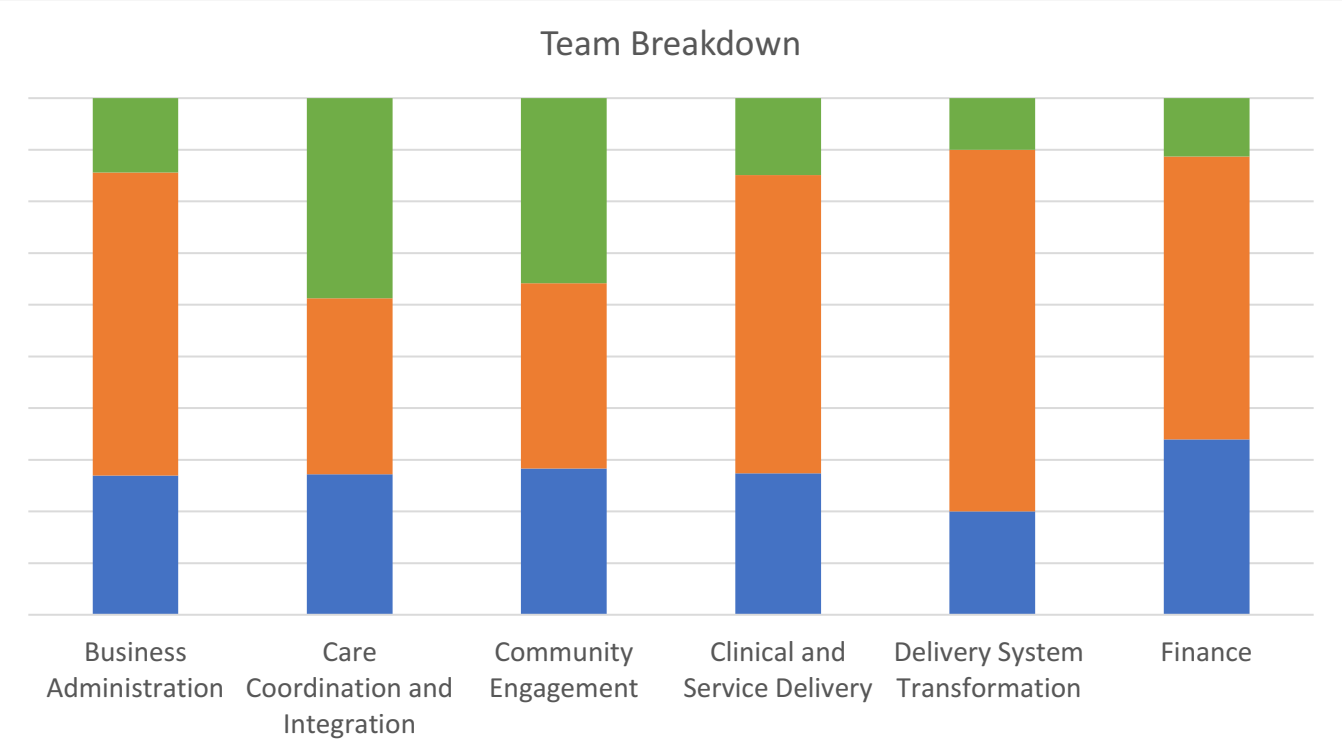
Evaluation Results – Overall Scores

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	FAIL	X		X	
Business Administration	FAIL	X		X	X
Care Coordination and Integration	PASS	X		X	X
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	FAIL	X		X	
Community Engagement	FAIL	X	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**
Behavioral Health	61	60	56
Cost	14	17	3
Social Determinants of Health	47	34	32
Business Operations	224	86	81
Value-Based Payment	24	10	2

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	18	27	12
Behavioral Health	18	22	15
Social Determinants of Health	15	7	11
Value-Based Payment	28	23	5
Business Operations	61	17	19

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
Cost	8	6	4	x		x	
CCO Performance and Operations	7	7	1				
Value-Based Payment	14	5	1	x		x	

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

Deficiency Analysis

Cost

The responses to the cost section were incomplete and lacking detail. There is no process described for tracking services across spectrum of care within care coordination. There is no evidence of providers coordinating with one another, instead showing an overreliance on care coordinators. The cost containment strategies described were not feasible and are exclusively reactive – instead of proactive. The Applicant's description of the behavioral health approach separates BH from physical health, which is not compliant with the requirements.

CCO Performance and Operations

No evaluation plan was provided. Responses were vague, referring to "internal committees" without explaining what these were, and who would be a part of them. HRS strategy lacked detail.

Value-Based Payment

The VBP section had very limited detail. No justification for PCPCH structure or for growth over time was included. No demonstration of risks associated with VBP design, and mitigation strategies described seem unlikely to succeed. Failed to meet 2021 VBP requirements, and there was insufficient demonstration of how future targets would be met.

Team Recommendation: **FAIL**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that AllCare CCO, Inc. be given a "fail" for the financial section. All aspects of the application were underwhelming, lacking detail and did not appear to meet expectations or requirements.

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
Social Determinants of Health	11	10	7	X		X	
Administrative Functions	30	18	15	X		X	X
Health Information Technology	30	9	1	X			
Member Transition	27	8	1	X		X	

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

Deficiency Analysis

Administrative Functions

There were moderate to large amounts of detail missing in the responses from this section. The frequency of monitoring members for Medicare coverage was missing and there were no tools described to perform audits and monitor the encounter data for accuracy. There were no feasible plans or mechanisms for performing systematic planned or ad hoc monitoring for Fraud, Waste and Abuse. Pharmacy administration responses were lacking info on how formulary changes would be communicated, what strategies were being used to make the 24-hour prior authorization processing timeline and how members can access pharmaceutical information. The pharmacy and TPL responses with missing detail **could likely be remedied relatively quickly** however there appears to be large gaps in FWA processes suggesting missing infrastructure.

Health Information Technology

Applicant appeared to have a high EHR adoption rate but there was no discussion of strategies used to address barriers and no plan was included that covered the entire 5-year contract. The EHR roadmap was missing fundamental detail.

The Applicant did not demonstrate the ability to match SDOH-HE data to claims data – an essential component in the VBP creation process and indicates that there may be serious gaps in knowledge of VBP models or HIT.

Member Transition

There were large gaps in information and detail for this section. Biggest gaps were around care coordination and continuity of care, especially for prescriptions. Warm handoff activities were not defined and lacked a contingency plan for members that failed to match to a primary care provider.

Social Determinants of Health

There were many responses that were incomplete. For SDOH, little detail on what technology and methods are used to collect and analyze the SDOH data. They mention that they use MARA scores but provide no definition. There was good detail on language interpretation but all the other sections were missing info. Language access was only explained in terms of missing interpreters and the incorporation of a single survey question is not adequate to address language and cultural appropriateness.

Team Recommendation: **FAIL**

- In general, majority of questions were missing info and some were unresponsive.
- For the administrative functions section, missing details were indicative of missing processes or infrastructure. These many deficiencies combined would require **a significant amount of effort to remedy**.
- The Applicant did not appear to know how to match SDOH-HE data with claims data which is an essential step in formulating VBP models that take those factors into account. This deficiency could be remedied with a **light to moderate amount of effort.**
- There were large amounts of detail missing in the member transition section that indicated gaps in essential process around care coordination and continuity of care. Altogether, these deficiencies would take a **significant amount of effort to remedy.**
- The SDOH-HE section was missing info on SDOH data collection and some responses pointed to an incomplete understanding of language access concepts. These deficiencies would likely take a **significant amount of effort to remedy** as there would need to be education, new or additional technology and processes created.
- Multiple areas requiring significant amount of effort to remedy and the overall quality of the responses led to a team recommendation to FAIL this applicant.

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 Covered Services	3	10	23	X		X	
Care Integration	7	3	11				
Care Coordination	28	23	25	X		X	
Behavioral Health Benefit	5	4	3	X			
Health Information Exchange	16	7	5			X	X

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 plans were understood to be high-level and aspirational. Plans for development of MOUs with CMHPs did not include detailed descriptions of processes by which these activities would occur. Applicant did not describe processes sufficient to assess gaps in workforce capacity.

Behavioral health covered services responses were generally well received, although detail on patient involvement was seen as lacking. Applicant did not provide detail on how barriers to member involvement would be monitored and mitigated. No process was identified to monitor Supported employment services caseload.

Care coordination generally lacked detail or missed required components. Applicant did not address plans for crisis management. Confusion seemed to exist regarding the key concepts of 'rights' and 'choices' regarding person-centered planning. A lack of detail was identified in the following areas:

- Coordination with Medicare Advantage plans
- Plans to work across systems including processes for referrals and continued tracking after screenings have occurred.
- Role of Long Term Care providers in the transformation of models of care.
- Coordination of follow-up activities after oral health screenings across the population
    - Responses were focused on children and pregnant women. A more comprehensive plan is needed.

Team Recommendation: **PASS**

Care integration responses were well received; however, additional detail on information sharing, member participation in treatment planning and overall monitoring of treatment planning is desired. Targeted conversations with applicant may be needed to remedy deficiencies in care coordination, screening and referral processes, and HIE.

Applicant's ability to support Health Information Exchanges (HIE) was not clearly demonstrated. Applicant lacked detail on how to expand hospital event notification and HIE services. Plans to support oral health activities focused on the role of a case management team. No clear path was provided on development of support for Hospital event notifications for behavioral and oral health providers. Applicant failed to demonstrate a complete grasp of HIE and confused that term with VBP. Targeted conversations on provision of hospital notifications to diverse provider types is recommended.

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 Benefit	1	12	20				
Behavioral Health Covered Services	44	32	8				
Service Operations	38	6	2	X		X	
Administrative Functions	37	7	1	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 small to moderate amounts of detail. Applicant does not appear to use grievance system to monitor for correct application of medical necessity. There is very little detail provided on network adequacy – the responses do not separately address physical, behavioral and oral health providers; there is no mention of how specialties are counted nor how an FTE is calculated. These deficiencies are estimated to require **smaller amounts of effort to fix however there are many of them**.

Behavioral Health Benefit

Responses only missing a little detail for this section – no deficiencies noted.

Behavioral Health Covered Services

This section was missing small to moderate amounts of detail and some questions were not addressed at all. The SUD section didn't address data and had limited detail, the care coordination section only contacted members by phone, no other methods used. Member information was sent out by mail but no mention of when this happened. The processes around care coordination are unclear – such as how members are identified for the various levels of care coordination. The Applicant appeared to delegate unengaged members to the PCP. The Wraparound services question was not answered at all and there was no mention of how this service is communicated to members. It appears from their answer that they do not understand why the response rate for Wraparound survey must be 35% or greater. There was no description of monitoring these services at all. Although separately the deficiencies in this section could be remedied with a **small amount of effort**, **the sheer number of deficiencies present would collectively, require a moderate effort to remedy**.

Service Operations

The responses in this section were missing a moderate to large amount of detail. There was limited detail on medically necessary criteria and utilization controls for pharmacy services, there was no detail provided

on hospital services and no plan to cover services or track and monitor services. There was no timeline given for prior authorizations. LTSS responses did not explain on how services would be provided regardless of setting and there was no mention of how care would be transitioned for members receiving these services. The large amount of detail missing from these answers suggested that there are underlying processes and services that are missing as well. These deficiencies are estimated to require a **moderate effort to remedy.**

Team Recommendation: **FAIL**

- The responses from this Applicant were missing small to moderate amounts of detail and some responses were missing entirely.
- Deficiencies identified ranged from small to moderate. The Behavioral Health Covered Services and Service operations sections had deficiencies that were considered to take **moderate amount of effort to remedy**.
- The quality of the responses and multiple sections with moderate level 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
Accountability and Monitoring	12	4	2	X		X	
Delivery Service Transformation	9	2	1	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 set, communicated and enforced with providers and sub-contractors. Lacking description of external program purpose and administration. Lacking sufficient information on complaints, grievances and appeals.

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.

CCO Performance – Applicant failed to provide details describing quality improvement, such as how value and efficiency are calculated and applied to outcomes. Lacking sufficient information about the concrete process to measure, track and evaluate hospital services, specifically by population sub-category (by REAL-D).

Delivery Service Transformation:

Transforming Models of Care – Applicant failed to provide details describing PCPCH such as oversight, tier levels, member assignment by provider type, member and provider outreach, and engagement of potential new PCPCH providers. Lacking sufficient information about monitoring the non-PCPCH model to ensure fidelity. Lacking sufficient information about supports of those with special health care needs, the plan for emphasis on whole person care or how the applicant plans to monitor the non-PCPCH model.

Provision of Covered Services – Applicant failed to provide details describing how data will be used to improve quality of care for members with SPMI. Lacking sufficient detail in supplemental reports and standards, including how data will be used to improve services.

Team Recommendation: **FAIL**

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

Accountability and Monitoring

- Description of reporting systems
- Information about the process for implementation of quality standards
- Plan if providers/subcontractors fail to comply
- Description of how the Applicant's Referrals and Prior Authorization process facilitate continuity and coordination of care
- Information about how the external network (providers, health systems) utilizes applicant's referral and prior authorization system

Delivery Service Transformation

- Details regarding PCPCH system by tier level and member assignment
- Information on PCPCH engagement and outreach to members and providers
- Information about PCPCH oversight
- Access analysis - time and distance standards not sufficient for workforce capacity and community access needs.
- Description of how data will be used to improve quality of care for members with SPMI

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	5	9	16			X	
Community Engagement	2	3	5	X	X		
Social Determinants of Health	3	8	9				
Community Engagement Plan	33	14	13	X		X	

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

Deficiency Analysis

- No information about the process for how members provide input for decision making; point given for historical description of public input related to CHA/CHP
- No mention of how the member voice is elevated or where the board is involved
- Do not address barriers or strategies to community engagement
- No mention of QI
- Doesn't mention partners in partial service area, Douglas County
- No description of CAC structure, requirement, or role, or OHP consumer representatives' CCO board involvement or engagement
- Does not describe a strategy for collaborating with other CACs in the region
- No mention of engagement with tribes
- Included the priorities, but offered no plan or description of how the priorities were or will be identified and vetted; instead, relied on what they've done in developing their CHP, but not future plan for vetting SDOH priorities, which is different; also, included a table that does not answer the question.
- Insufficient detail for how members are involved in care planning at the provider level
- Spending process is an internal process – not clear how it is public, transparent or equitable
- Very weak conflict of interest—"team members must declare conflicts of interest"

Team Recommendation: **FAIL**

- Align CAC representation with the HRS
- Ensure they have sufficient support around CAC development
- CCO needs significant support from OHA around community engagement, including awareness, skillset and capacity for sufficient community engagement
- Develop a robust public, transparent equitable process for SDOH spending decisions
- OHA technical assistance could help

Community Engagement – Community Letters of Support

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

Organization Name	Type
Access Building Community	Community Action Agency
Addictions Recovery Center	BH/SUD
Advantage Dental	Dental
Blue Zones Project, Grants Pass	SDOH-HE Improvement Programs
Boys and Girls Club Rogue Valley	Youth Programs
CAC Member - Audrey Tiberio	CAC Member
CAC Member - Ben Cannon	CAC Member
CAC Member - Edward Smith-Burns	CAC Member
CAC Member - Georgia Nowlin	CAC Member
CAC Member - Michael Weber	CAC Member
CAC Member - Tyler Johnson	CAC Member
Capitol Dental	Dental
CASA Josephine County	Foster Children, Teens
Child Care Resource Network	ESD program, Early Childhood Education
Coastal Community Health Center	FQHC
College Dreams	Education Support
Consumer Credit Counseling Service	Financial Education, Credit Counseling
Curry Community Health	Public Health, Mental Health, Addictions
Curry County Commissioners	Local Government
Curry County Homeless Coalition	Homeless, Housing Services
DHS-SSP District Office	Self-Sufficiency Programs
Eagle Point School District 9	School District
Every Child Oregon	Foster Care Supports
Grants Pass School District 7	School District
Grants Pass Sobering Center	BH/SUD
Grants Pass Treatment Center	Opioid Treatment Program
Hearts With a Mission	Youth Homeless Program
Housing Authority of Jackson County	Housing Program
JOE's Place Ministries	Youth Homeless and Outreach Program
Josephine County Food Bank	Food Bank
Josephine County Library	Public Library
Josephine County Public Health	Public Health
Josephine Housing and Community Development Council	Local Public Housing Authority
Kid Time Children's Museum	Preschool and Discovery Museum

Organization Name	Type
Kid Zone Community Foundation	K12 Physical Education
Kids Clinic	Pediatric Provider, PCPCH
KOBI-TV/NBC5	Media
La Clinica	Safety Net Clinic
Maslow Project	Homeless Programs
National Counsel on Interpreting in Health Care	Award - National Language Access
Oasis Shelter Home	Emergency Shelter, DV and SA
Oregon Coast Community Action	Community Action Agency
Oregon State University Extension Services	Food Education Programs
Pathway Enterprises, Inc.	Adult Ed and Life Skills
Planned Parenthood	Provider
Primary Care Provider - Karen Hoskins	Provider
Provider - Dr. Robert Gentry	Provider, MRIPA Founder
Ready Ride	NEMT
Rebuilding Together	Home Modification for APD
Rogue Community College	Community and Higher Education
Rogue Retreat	Case Management, Housing Programs
Rogue Valley COG, Senior and Disability Services	Deaf & Medical Providers Workgroup
Rogue Valley COG, Senior and Disability Services	APD and AAA
Siskiyou Community Health Center	FQHC, Outreach Programs
South Coast Regional Early Learning Hub	Early Learning Partner
Southern Oregon Child and Family Council	Head Start, Early Head Start
Southern Oregon Early Learning Services	Early Childhood Supports, K-12 Education Social Supports
Southern Oregon Goodwill	Programs and Supports for Working Parents
Southern Oregon Health Equity Coalition	Health Disparities Programs
Southern Oregon OPEC Parenting Hub	Parenting Education Hub
Southern Oregon Success	Trauma-informed practice training
Southwestern Community College	Child Care Resource and Referral Program, Home Visiting, and Parenting Education Collaborative Hub.
Three Rivers School District	School District
UCAN	Community Action Agency
United Way of Jackson County	Community Programs
Willamette Dental Group	Dental

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: Applicant delegates "mental health services" and utilizes a program that "oversees the quality of services between delegated entities." This seems to negate their responsibility. Additionally, Applicant neglects to address substance use disorder piece of behavioral health, only discusses mental health. Applicant describes a behavioral health approach that separates behavioral health from physical health.

Applicant is missing a process and detail on plan for a MOU with the CMHP.

Recommendations: Provide details missing for MOU with CMHP. Require Applicant to provide details and statements articulating ownership of benefit.

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.

Full County Coverage Exception Request – Full Text

Introduction: AllCare is requesting continuation of its current service area that includes all of Jackson, Josephine, and Curry Counties, together with two zip codes in adjacent southern Douglas County. AllCare was asked by the OHA in 2012 to serve Douglas County zip codes 97410 and 97442 which we accepted as part of our contract. This service area reflects the natural transportation corridors and historical health care referral patterns of the resident population who have relied upon Josephine County physical health, behavioral health, and oral health providers to meet their health care needs.

As of March 2019, 470 Douglas County OHP Members were enrolled in AllCare. This represents 1.38% of the total Douglas County OHP population. Due to the low number of Members involved, this does not reflect any effort on AllCare's part to minimize financial risk, nor create any adverse selection such as red-lining of high risk areas.

Instead, continuation of this service area request will preserve long standing provider relationships between the residents of Azalea and Glendale, OR and the provider network in Josephine County. It will ensure timely access to needed services for southern Douglas County residents who would otherwise have to drive to Roseburg or farther to receive the care they need. During winter, this presents a safety problem due to transportation corridors between Roseberg and Glendale and Azalea that encompass mountainous terrain that is often unsafe due to snow and ice. Access, continuity of care, and safety are the primary reasons for maintaining AllCare CCO's service area boundaries.

(1) Serving Less than full County will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:

Community engagement, governance, and accountability: OHP residents of Azalea and Glendale OR, Douglas County, are eligible to participate in AllCare's governance structure involving the Josephine County CAC and the AllCare Board. This includes eligibility to participate as a Board and/or CAC representative, access to open public meetings program, and community engagement in the programs we fund throughout the service area to improve individual and community health.

Behavioral Health integration and access: Our OHP residents from Azalea and Glendale, OR have long been served by our behavioral health contractor, Options for Southern Oregon, whose corporate offices and clinics are located in Grants Pass, Josephine County, OR. Options offers mental health crisis management as well as screening, assessment, and treatment for the full range of behavioral health diagnoses. This includes integration of behavioral health clinical personnel in the Women's Health Center in Grants Pass, providing braided maternity and behavioral health services for integrated pre-natal and post-natal care. Options also operates a fully integrated physical health presence within one of its behavioral health clinics in Grants Pass serving those with Severe and Persistent Mental Illness which is available to our Douglas County OHP members who might otherwise have little or no access to such services. This is a Tier 5 PCPCH Clinic. Our Douglas County members would not have convenient or timely access to such programs if they were excluded from our service area.

Social Determinants of Health and Health Equity: Our OHP residents from Azalea and Glendale, OR, also benefit from our community-based programs funded through our SDoH and HE initiatives. This includes our investments in supportive housing, health equity training of over 4,000 providers, volunteers, and peer supports within 81 organizations across Southern Oregon who serve our OHP members across the continuum of care, and over 175 projects in support of early childhood development, nutrition, non-emergent medical transportation, parenting classes and economic development/workforce capacity initiatives.

Value-Based Payments and cost containment: AllCare was an early adoptor of VBP models and currently deploys seven models including primary care, pediatrics, maternity, behavioral health, oral health, certain specialties, and facilities (hospitals and skilled nursing). OHP Members residing in Azalea and Glendale benefit from our VBP models which incentivize providers across the continuum of care to support the triple aim designed to improve individual health, improve community health, and reduce costs by eliminating unnecessary duplication of services through greater care coordination across care settings.

Financial viability: AllCare offers a financially viable alternative for care delivery compared to higher cost options available elsewhere in Douglas County due to shorter driving times, easier access to pharmacies, and easier access to provider clinics and hospital services.

(2) Serving less than the full County provides greater benefit to OHP members, Providers, and the Community than serving the full County*:*

The benefits of serving southern Douglas County through AllCare's provider network in Josephine County include the following:

The population in southern Douglas County is insufficient to economically support the full array of primary, specialty and hospital services at the local level and would require inconvenient transportation options to access other Douglas County resources compared to services available in Grants Pass, only 10-15 minutes away.

Southern Douglas County OHA Members have long-standing health care provider relationships that precede the CCO model of care, dating back to the 1980s and 1990s. Interruption of those provider relationships will disrupt the continuity of care, launch the transitions of care process to switch CCOs, and potentially create unintended outcomes that could negatively impact quality of care such as reduced access to pharmacies, peer supports, traditional health services, oral health, and inpatient care settings; and

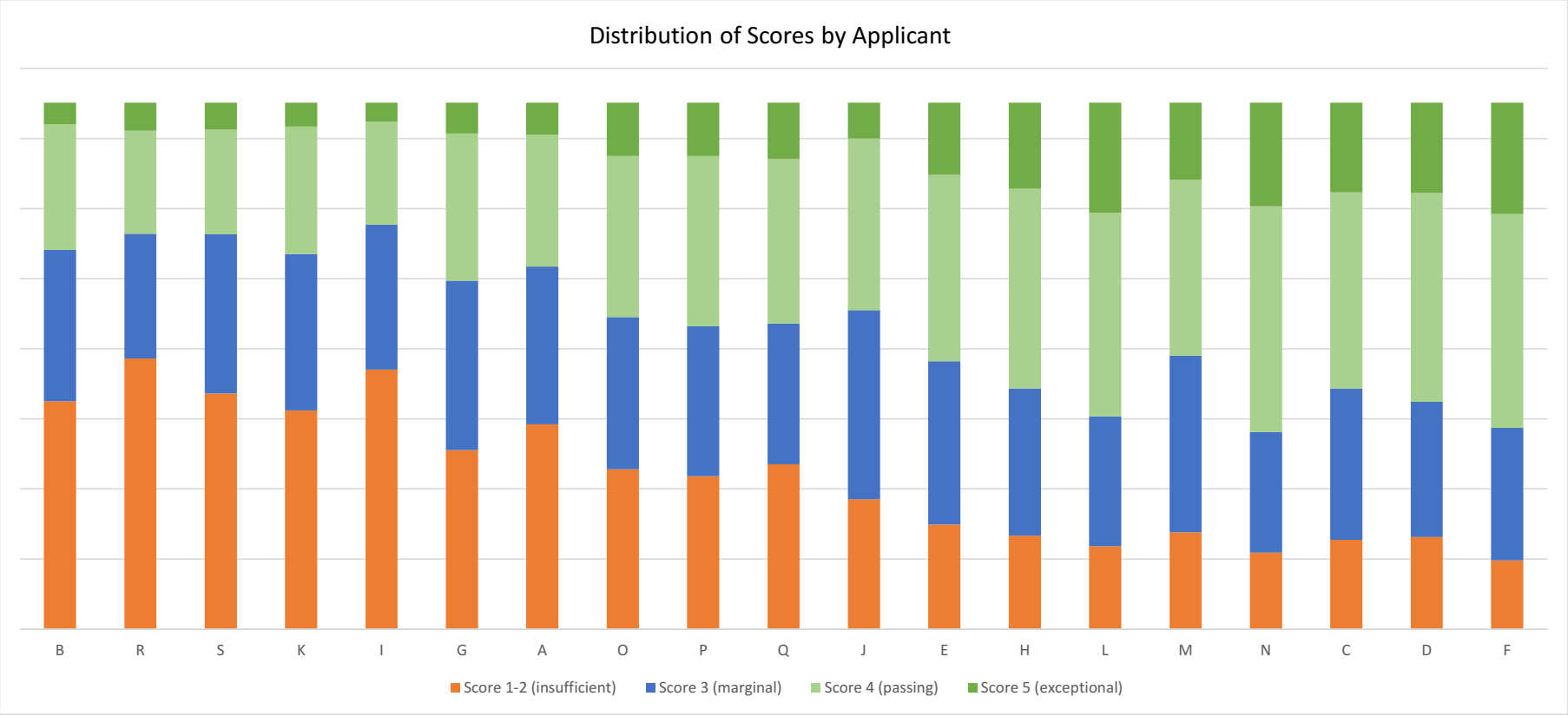
(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-ling high risk areas*:*

As stated above, AllCare CCO was asked by the OHA in 2012 to add two southern Douglas County zip codes to our service areas and we would very much like to continue to serve this population. There is no effort on our part to minimize our financial risk nor is there any intent to create adverse selection. This is a rational approach for all involved and should be continued under the CCO 2.0 contract between AllCare CCO and the Oregon Health Authority.

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

CONFIDENTIAL UNTIL 7/9/2019