RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant M
Columbia Pacific CCO, LLC

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

- ASU noted that CPCCO subcapitates claims to risk accepting entities (RAEs). If the RAEs go insolvent, there may not be enough C&S to cover the members' benefits.
- DCBS financial review found that the pro forma financials appear positive, and there is a little margin for error if the Company's projections are higher than actual results. Cumulative results below their projections would be problematic and compound the issue.

Service Area Analysis

- CPCCO is requesting to cover the entirety of Clatsop, Columbia, and Tillamook counties. There is no service area exception request.
- CPCCO is one of two applicants for this service area. There is low or no risk that CPCCO will be below the enrollment minimum or exceed the enrollment maximum.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Pass
- Care Coordination and Integration – Pass
- Clinical and Service Delivery – Pass
- Delivery System Transformation – Pass
- Community Engagement – Pass

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

CPCCO's responses to informational questions scored high in all five categories – Behavioral Health, Cost, Social Determinants of Health, Business Operations and VBP.

Financial Analysis

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Division of Financial Regulation

M E M O R A N D U M

May 30, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Columbia Pacific CCO, LLC (CPCCO)

I have performed a review of Columbia Pacific CCO that includes pro forma financial information, audited financials, Articles of Incorporation, and biographical affidavits.

CPCCO appears to meet OHA's RBC, Liquidity, and Premium to Surplus Leverage Ratio requirements (as defined by the checklist) per the Pro Forma Statements generated under the Best Enrollment Estimates (Ideal). These Ideal ratio estimates are based on net income projections for the 2020 – 2022 where no annual net losses are expected.

This expectation appears unrealistic because the immediate prior history for CareOregon, Inc. (Parent Company) have shown significant net operating losses for the prior two years (2016-17) per their audited consolidated financial statements. Also, while the CPCCO individually was profitable in 2016 by the end of 2017 a small net loss was reported.

In addition, the analyst notes that if you increase the claims cost estimate just 2% for those scenarios calculated net losses are generated for every situation and if you increase the claims cost estimate 4% the RBC ratio generated from the Ideal estimates drop below 200% for years 2020 – 2022. However, the capital surplus balances for these entities is substantial and the analyst would not expect immediate insolvency as a concern given the worst case scenario that was tested.

The answers to many important qualitative issues such as the terms, interrelationships and who have administrative and/or management services contracts with CPCCO are missing due to incomplete attachments to the application.

For example, descriptions of how costs are determined/allocated under these service contracts and the experience level of those assigned to prepare required financial filings and ratio calculations are missing.

Detailed statements indicating whether exemption requests can be expected from SAP/NAIC filing requirements, descriptions of the current/future reinsurance program(s), and past/future expected sources of capital (if needed) are also missing. These are all important qualitative issues (as defined by the checklist) that need to be addressed at some point in the near future to ensure OHA requirements are met.

No information was provided about the amount of risk that the providers would receive in the capitated agreements. The pro forma financials for CPCCO report $0 liability for unpaid claims $161 million in annual premium revenue. The scope of my review was limited to CPCCO and did not include any of the other providers that have the liability for the unpaid claims and the unpaid claims expense that is associated with roughly $161 million in premium revenue on the books of CPCCO.

The pro forma balance sheet for the best estimate of enrollment projects RBC of 274%, 294% and 314% the end of 2020, 2021, and 2022, respectively. The Company performed various stress tests on their projections, and if claims costs are 2% higher than projected, the RBC under the best and minimum enrollment scenarios would be above 200%, but below 200% for 2020 in the maximum enrollment, rising above 200% in 2021 and 2022. Under a 4% increase, the RBC would be below 200% in the best scenario and 2020 and 2021 in the maximum enrollment, but above 200% in the minimum enrollment. Negative deviations would impact their projections, but it appears that they would have sufficient capital if costs are 2% higher, but would be troubled under their best and maximum enrollment numbers if costs are 4% higher.

A capital infusion/contribution(s) could be used to improve surplus or 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, and there is a little 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.

The audited financials for CPCCO were reviewed and no material concern was noted, via the consolidated statements of CareOregon, Inc.. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in the years from 2015 and 2016, but had a small net loss in 2017 of $474,090. They reported net income of $4.4 million in 2015 and $487,439 in 2016. Total net worth was $5.6 million in 2014 and changed to $10.9 million in 2017. DFR calculated a ratio of total current assets to total current liabilities of 129.0%, in 2017.

This is below the considered “ideal benchmark” of 200%, and below the current health insurance market average, which was 175.4% at 12/31/2018, but they still have more assets than liabilities, so they are not dependent upon positive cash flow to maintain their current liabilities.

CPCCO paid $13.9 million in 2017 for administrative services to CareOregon, Inc..

A small deviation to claims expense that is not expected would require a capital infusion in order to maintain adequate liquidity. A 2% negative deviation to total hospital and medical expenses would not put RBC under 200% for all enrollment scenarios.

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

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

Questions for OHA to address:

- OHA should get further clarification of the administrative and managements services, costs and allocation methods as part of the review process.
- OHA should get clarification on capital support.

[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**
280,320	127,915	336,387	140,161	46%	**Too low**

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$568.65		$577.68	$570.43	0%

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

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.41%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.27%	0.26%

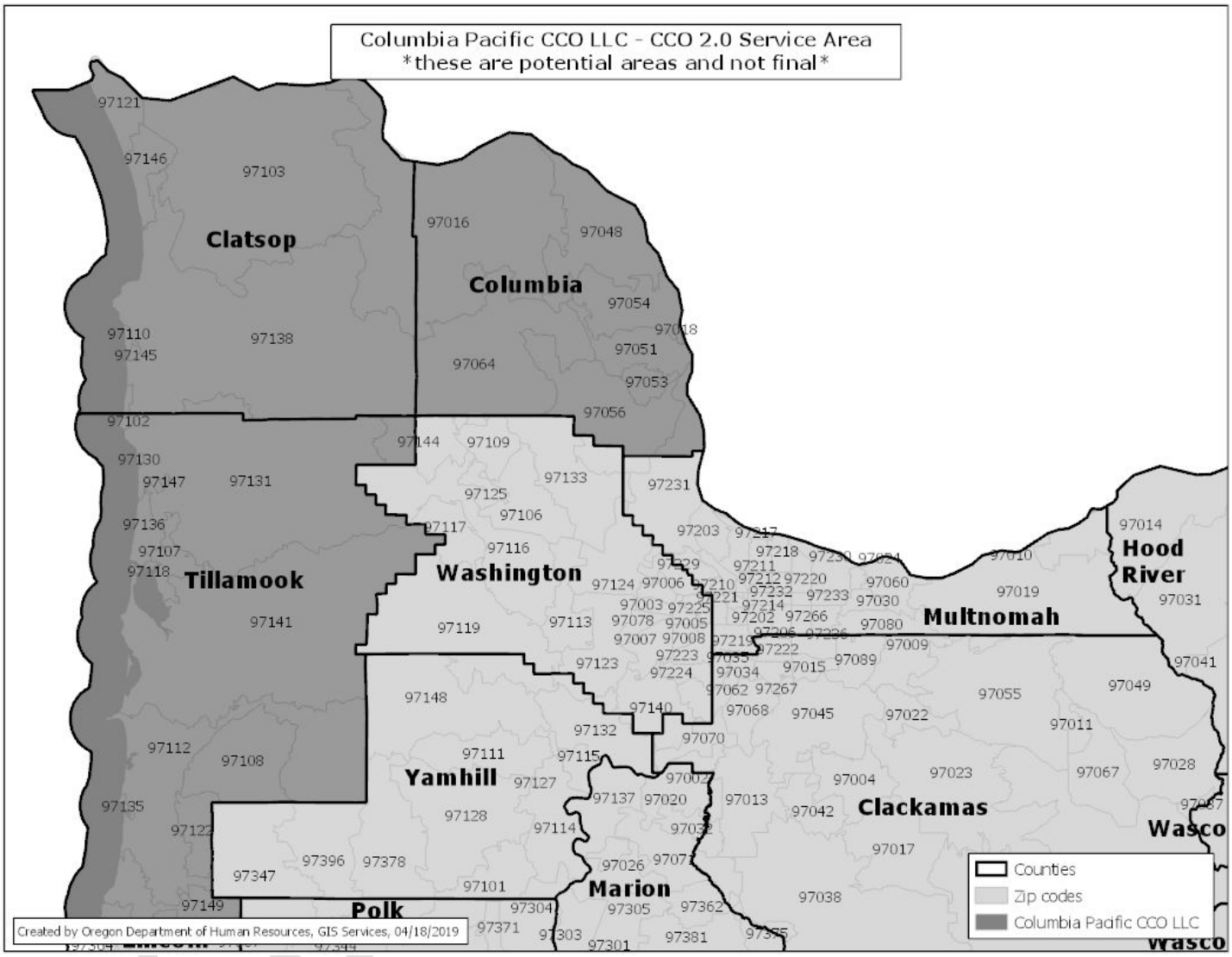
CPCCO is one of many CCOs that subcapitate substantially all of their claims to risk accepting entities (RAEs). If the RAEs go insolvent, these CCOs might not have enough C&S to cover the members' benefits even though the risk was technically transferred to the RAEs.

- 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 Clatsop, Columbia, and Tillamook 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
Clatsop, Columbia, and Tillamook	-	Columbia Pacific's service area mirrors Northwest CCO's proposed service area. Yamhill proposes to serve part of Tillamook	No scenarios show enrollment below applicant's minimum	No scenarios show enrollment exceeding applicant's maximum	Low risk

Additional Analyses on High Risk Areas

Northwest Coast

The Monte Carlo modeling, which assumes a significant share of members choose their current CCO, shows that Northwest CCO will not receive enough members to meet the applicant's minimum. Additional analysis is required to assess the likelihood of Northwest CCO not receiving enough members if very few members opt to keep their current CCO and OHA distributes members evenly based on the CCOs available to each member.

Approximately 31,000 members live in Clatsop, Columbia and Tillamook counties. Assume that Yamhill CCO would not serve any parts of Tillamook County. If no members actively enrolled in any CCO, OHA would distribute members evenly between Northwest CCO and Columbia Pacific CCO. Each CCO would receive 15,500 members. Northwest CCO's self-reported minimum threshold is 18,750. From the data available, the only way Northwest CCO obtains enough members is if **at least 3,250** more members choose Northwest CCO than they choose Columbia Pacific CCO.

There are 7,400 members in the three counties who are in open-card. If these members choose open-card again, that reduces the number of members available to the applicants to 23,600. For Northwest CCO to remain viable, it would need **nearly 7,000** more members than Columbia Pacific CCO.

The fact that Yamhill CCO proposes to serve parts of Tillamook County exacerbates the likelihood that Northwest CCO may not obtain enough members to meet their minimum threshold. The scenarios below assume that Yamhill CCO does not serve any parts of Tillamook County.

Scenario description	Impact on Columbia Pacific CCO	Impact on Northwest CCO
Both applicants serve northwest coast.	Projected enrollment falls within the applicant's parameters	100% chance Northwest CCO does not meet their minimum threshold.
Only Columbia Pacific CCO serves northwest coast	Projected enrollment falls within the applicant's parameters	Not awarded in this scenario
Only Northwest CCO serves northwest coast	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters

CPCCO and NWCCO enrollment assumptions are mutually exclusive against their low-end viability assumptions (i.e. their low-end viability assumptions indicate they cannot exist in tandem).

- Recommend OHA select one of these two applicants and deny the other.
- Suggest OHA follow up on DCBS comments regarding $0 liability reported by CPCCO for unpaid claims.

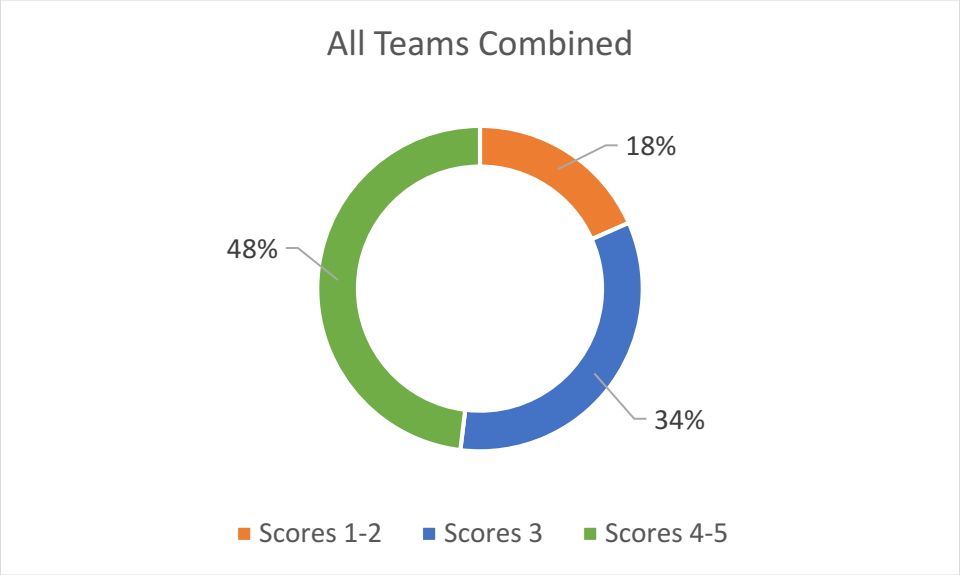
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Columbia Pacific is likely to receive approximately 9,698 members out of the 11,680 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.

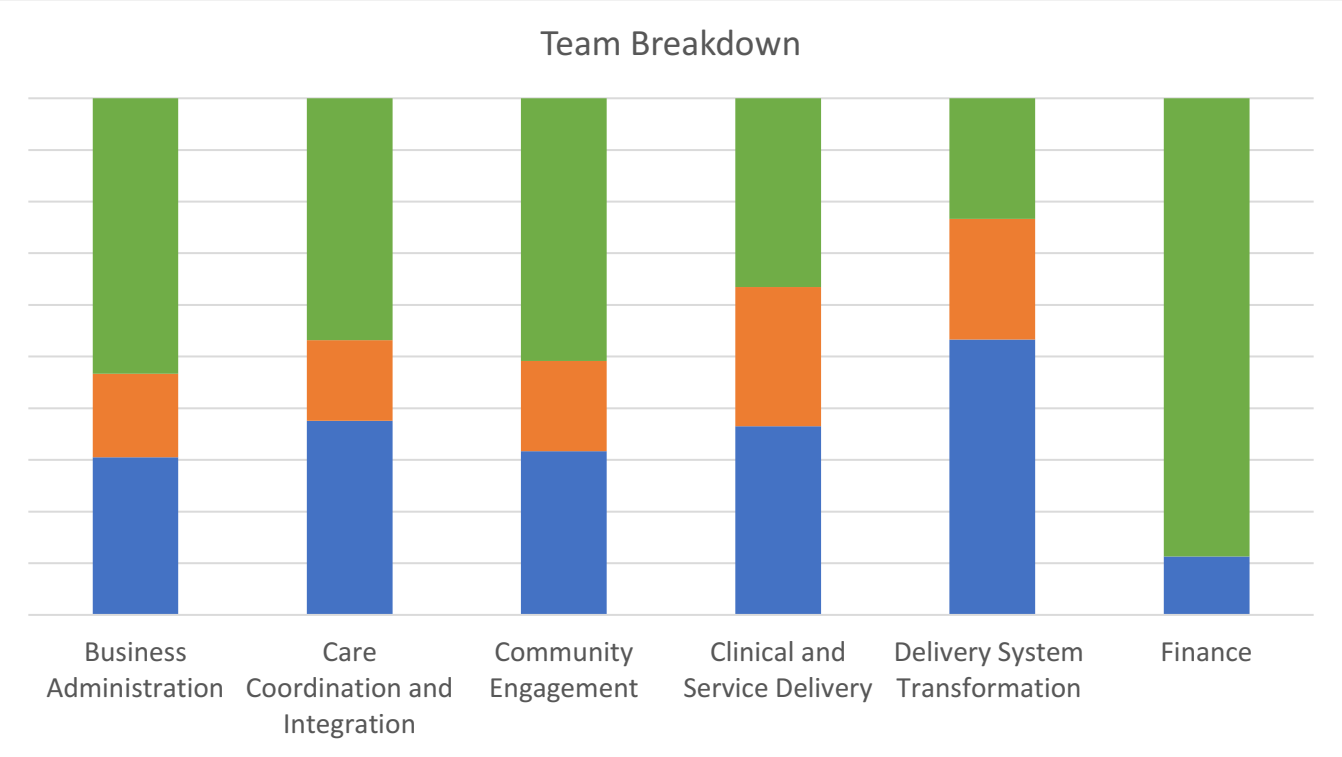
Evaluation Results – Overall Scores

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	PASS	X		X	
Care Coordination and Integration	PASS	X	X	X	
Clinical and Service Delivery	PASS	X		X	
Delivery System Transformation	PASS	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
Cost	0	6	28
Value-Based Payment	0	7	29
Social Determinants of Health	17	34	62
Business Operations	81	143	167
Behavioral Health	40	62	75

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
Social Determinants of Health	3	8	22
Cost	8	16	33
Business Operations	27	26	44
Behavioral Health	14	20	21
Value-Based Payment	11	25	20

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	1	14				
Cost	0	4	14				

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

Deficiency Analysis

Value-Based Payment
No deficiencies noted

CCO Performance and Operations
No deficiencies noted

Cost
No deficiencies noted

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Columbia Pacific CCO, LLC be given a “pass” for the financial section. There were no financial concerns or deficiencies.

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	1	12	27	X			
Administrative Functions	14	14	35	X			
Social Determinants of Health	3	10	15			X	
Member Transition	9	15	12	X			

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

Deficiency Analysis

Administrative Functions

Some answers in this section were light on detail such as encounter data was missing the frequency of validation, pharmacy section no example of a public facing website that did not require a log-in or password and that included information in languages other than Spanish and English. The description of Applicant's governance is missing how oversight and monitoring works for key committees. These deficiencies would be relatively easy to remedy. The TPL section contained very little detail – missing info on TPL data source, how is TPL verified, and a description of how TPL data is monitored and frequency of monitoring. If TPL processes are missing entirely, this would require a **moderate amount of effort** to remedy.

Health Information Technology

Some answers in this section were light on detail such as, missing plans for HIT/VBP work, for years 3 to 5, description of how SDOH would be used in VBP models could use more detail, and mitigation of VBP barriers description did not really address mitigation strategies. All deficiencies noted would **require little effort to address adequately**.

Member Transition

The responses in this section repeatedly mentioned that they were relying on OHA involvement and delegating many activities to the Applicant parent company. Overall, answers were light on detail, especially for activities around transferring a member to another CCO. The Applicant was missing info entirely on warm handoff and other transition activities and contingency plans for members who failed to match to PHPCP. If the missing detail and information is due to Applicant's incomplete understanding of how parent company will perform the transition activities, then **deficiencies would be easy to remedy**. If transition processes are truly absent, these deficiencies would take a **small to moderate amount of time to correct.**

Social Determinants of Health

For the SDOH-HE section, there were no strategies listed for how this data would be collected and no info on how SDOH-HE providers' applications for funds would be tracked. The Health Equity section was missing info on how new clinics would be assessed, how training would be monitored, whether there were alternative formats for material other than other languages and missing detail on their communication strategies with public and partners. These deficiencies would take a **small amount of effort to address**.

Team Recommendation: **PASS**

- Majority of answers were responsive but light on detail. Clear majority of deficiencies could be **remedied relatively quickly.** The TPL and Member transition deficiencies could take **moderate amount of effort** to resolve.
- Recommendation that Applicant provide detailed info on their TPL processes and receive education/support as needed.
- Recommendation that Applicant provided detailed description of their processes involved in transferring members to another CCO, what warm handoff activities they are planning and what their contingency plans are for members who do not match to a PCPCH.

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
Health Information Exchange	0	8	20				
Care Integration	4	4	13				
Behavioral Health Covered Services	6	9	21	X			
Care Coordination	14	38	24		X	X	
Behavioral Health Benefit	3	6	3				

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 failed to address how gaps in covered services would be mitigated. Limited detail was provided by the applicant on how provision of covered services, and access to those services, would be addressed. Reviewers were concerned with the milestones provided for development of MOU with CMHP as well as overall workforce capacity. The CMHP described by the applicant was not understood to be local and presents a 'people' problem.

Care coordination responses failed to address plans for coordination among dual eligible and Medicare Advantage plans. Generally a lack of detail was noted on the applicant's plan to coordinate with social services. Platforms for coordination were identified but not processes. No plans were provided for coordination with other agencies. The Applicant provided limited detail on plans to engage and follow up with both members and providers. Plans for transitions to some settings, and prioritization processes were not addressed. Applicant failed to provide a description for preventive oral health services for specific populations. Plans for member engagement are not innovative and the Applicant has no strategy for reaching new members within 30 days.

Team Recommendation: **PASS**

Behavioral health covered services responses were generally well received. However, the Applicant failed to provide detailed information about housing for SPMI population.

Care integration responses were generally well received; however, additional detail on urgent or emergency oral health services as well as plans for handling of special needs populations are desired.

Applicant's ability to support Health Information Exchanges (HIE) was unclear in from both financial and technical perspectives.

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	4	12	17	X			
Service Operations	13	15	18				
Behavioral Health Covered Services	26	30	28	X		X	
Administrative Functions	13	19	13			X	

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

Deficiency Analysis

Administrative Functions

Heavy focus on PCPs but no other discussion of other specialties including how and when are they moving from analysis to improvements. There is no clear decision-making pathway. Applicant lists reliance on personal relationships as a barrier but no suggestions of how to fix this. There was no distinction between physical and oral health providers when calculating network adequacy. Oral health providers were called out which is a plus. Applicant used the term "Patient Centered medical home" which is not a term used in Medicaid. The deficiencies noted in this section are **relatively easily remedied**.

Behavioral Health Benefit

The Applicant states that they will work with providers to ensure there are no barriers but there is no description of how. There is no detail on access to in-home services. The deficiencies noted in this section are **relatively easily remedied.**

Behavioral Health Covered Services

The responses in this section were largely responsive but were missing some detail. Care coordination section only mentions attempts to contact member by phone -there should be additional methods. Member notification has too many steps to access care coordination. The Applicant did not provide ADA accessible application as their images could not be opened with alt+text. There were duplicate answers in different places which looked like copy-paste errors. There was no detail on how Applicant would provide culturally and linguistically competent services. Very little detail on what monitoring of services would look like. For the peer delivered services, there was limited detail. And Applicant should provide more info on staffing. For dyadic services, there was no info on how they will maintain this treatment model and how to communicate these services. A response on the SUD services was missing. The responses to the LTSS services questions need a lot more detail.

Service Operations

No description of the frequency and method of monitoring of utilization. Lacking detail on communicating pharmacy benefit information to members.

Team Recommendation: **PASS**

The deficiencies identified could be remedied with **relatively little effort**.

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	2	8	2			X	X
Accountability and Monitoring	5	8	5	X		X	

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

Deficiency Analysis

Accountability and Monitoring:

Quality Improvement Program – The Applicant failed to provide detail about referral and pre-authorizations specific to BH, Oral and PH services.

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 about how programs are administered and their purpose. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

CCO Performance – Lacking sufficient information about tracking hospital services by REAL-D categories.

Delivery Service Transformation:

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as members services, tier levels, oversight, and engagement of members and 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.

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

Team Recommendation: **PASS**

Overall, the responses provided by this applicant are sufficient to receive a passing score. The following items are identified for follow up at Readiness Review:

Accountability and Monitoring:

- Provide details about prior auths and referrals
- Provide information about a corrective process if the providers/contractors fail to comply with the quality standards

Delivery Service Transformation:

- Provide details about PCPCH system by tier level
- Provide details about oversight of PCPCH system
- Provide details about processes to improve care for SPMI population

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
Social Determinants of Health	3	4	13				
Community Engagement Plan	11	19	30	X		X	
Governance and Operations	5	10	15				
Community Engagement	2	5	3	X		X	

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

Deficiency Analysis

- No descriptions of projects for the Community Engagement Plan, and the plan for engagement was too high level and Applicant did not submit their CHA/CHP
- The publicly funded providers mentioned in the application are not included in the CEP, which is unexpected.
- Member engagement should involve more than just CAC members, no description of how all members will be engaged and how exclusionary practices will be addressed especially for those with languages barriers
- Tribes and better inclusion of culturally specific organizations are needed. Applicant should understand their role as a leader vs just collaborating with CACs for other CCOs; there should be county government representation on the CAC.
- Communication between member and board needs to be clarified, and between the board and the CAC, when board decisions are being communicated.
- Quality Improvement was not addressed, need more detail on the member role
- Applicant population - Insufficient detail on how Applicant defines its population and unclear how improved understanding of the community will lead to better alignment
- Insufficient to vet these priorities only through the CHP process; unclear if the SDOH-HE award of funding will be a transparent and equitable process and if project outcomes will be broadly shared and how SDOH funding will mesh with other funding that is currently happening.
- More clarity needed on how HRS will align with CHP priorities
- Community engagement –experience or capacity for engaging the community to address disparities, especially racial disparities is missing

Team Recommendation: **PASS**

The deficiencies noted above are considered to take a moderate amount of effort to remedy.

- Recommendation to receive TA and guidance from OHA
- Develop a better plan for how they'll align with their CAC demographics
- Identify improved strategies for elevating the member voice
- Develop a plan for engaging tribes and culturally specific organizations across all community engagement initiatives
- Ensure plan for consistent use of qualified and certified interpreters
- Ensure CAC alignment with ORS
- Develop a better plan for reporting governance decisions made on CAC recommendations back to the CAC
- Develop a plan for engaging the community to address disparities, especially racial disparities
- Develop an equitable and transparent process for SDOH-HE funding, with a clear plan for evaluation and sharing of outcomes

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 Care Organizations
Capitol Dental	Dental Care Organizations
CASA for Children	Social Services
Clatsop Community Action	Housing/Food Access/Early Childhood
Coastal/Clatskanie Health Center/Yakima Valley Farm Workers	Clinical Provider
Columbia County Commissioners	Local Government
Columbia Health Services	Clinical Provider
Columbia Pacific Food Bank	Housing/Food Access/Early Childhood
Columbia River Fire and Rescue	County Services
Community Action Team	Housing/Food Access/Early Childhood
Department of Human Services District #1	County Services
Food Roots	Housing/Food Access/Early Childhood
Helping Hands Reentry Outreach Centers	Housing/Food Access/Early Childhood
Legacy Health System	Clinical Provider
Linguava	Language Access/Equity
Northwest Oregon Housing Authority	Housing/Food Access/Early Childhood
Northwest Regional Educational Services District	Education
OHSU – Scappoose	Clinical Provider
Passport to Languages	Language Access/Equity
Providence Medical Group	Clinical Provider
Providence Seaside Hospital	Clinical Provider
The Rinehart Clinic	Clinical Provider
Tillamook County Board of Commissioners	Local Government
Tillamook County Community Health Centers	Clinical Provider
Tillamook County Transportation District	Transportation
Tillamook County Women's Resource Center	Social Services
Tillamook School District #9	Education
Way to Wellville	National Health Improvement Project
Willamette Dental	Dental Care Organizations

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 does not sufficiently detail the Local Behavioral Health Plan with the CMHP. Based on the description, is does not seem to be local. There is a lack of detail and processes to show how covered services will be addressed and accessed.

Recommendations: Submit a Local Plan that is detailed and reflective of the region.

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
4	6	2	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.

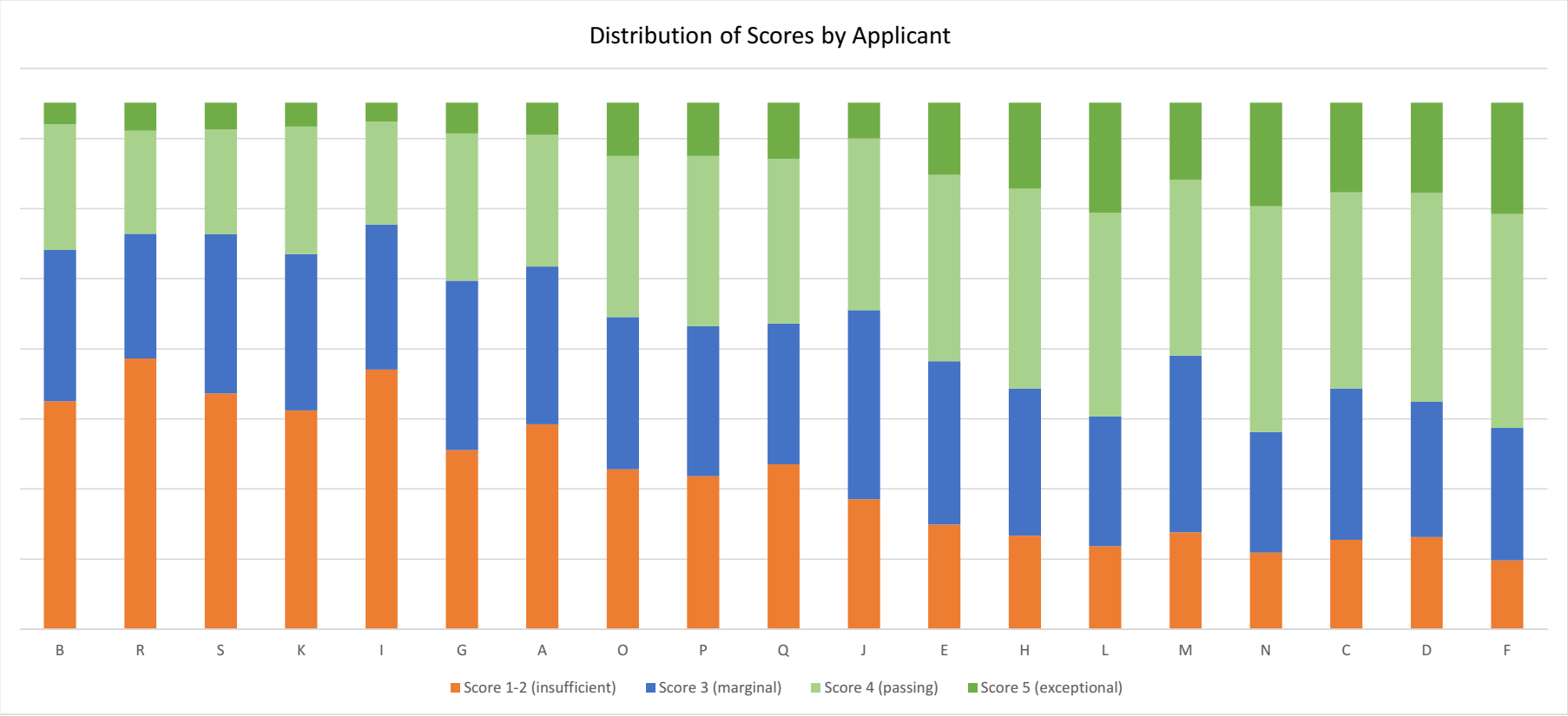
Members with no claims history

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

CONFIDENTIAL UNTIL 7/9/2019