RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant O
Eastern Oregon Coordinated Care Organization, 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

- DCBS financial review found that the pro forma financials appear to be reasonable for projections provided but leave little financial protection from any negative deviations in their results.
- ASU raised concerns about capital funding and multiple CCOs under Moda.

Service Area Analysis

- EOCCO is requesting to cover the entirety of Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, and Malheur counties. There are no service area exception requests.
- EOCCO is the only applicant for this service area.

Evaluation Results – Team Recommendations

- Finance – Fail; concerns around cost containment, care coordination and behavioral health integration.
- Business Administration – Pass
- Care Coordination and Integration – Fail; lacked detail on planned processes for the provision of covered services, workforce gaps, and relationships with tribal populations.
- Clinical and Service Delivery – Pass
- Delivery System Transformation – Fail; lacking information about quality standards, data collection, referrals and PAs, and PCPCH oversight.
- Community Engagement – Pass

Community Letters of Support

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

Evaluation Results: Policy Alignment

The responses from EOCCO show strong alignment with four of the policy objectives – Behavioral Health, Cost, Social Determinants of Health, and VBP. The responses showed weak alignment with Business Operations.

Evaluation Results: Informational Assessment

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

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Division of Financial Regulation

M E M O R A N D U M

May 29, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: CCO2.0 Financial Review
EOCCO=West Central CCO

I have performed a financial evaluation of Eastern Oregon CCO (EOCCO) application for their Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler Counties operations based on the materials provided. OCCOO is an existing CCO, operating in the above counties prior to 01/01/2020.

As part of the Oregon Dental Group holding company system, which includes health insurers, Oregon Dental Service (NAIC=54941) and Moda Health Plan, Inc. (NAIC-47098), EOCCO may have access to additional parental resources.

The audited financials for EOCCO were reviewed and no material concern was noted. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in all three of the years from 2015 through 2017 and reported net income between a $11.4 million in 2016 and a high of $15.6 million in 2015. Totals net worth was $26.0 million in 2014 and changed to $13.5 million in 2017, due mainly to $52 million in dividends paid to their owners in 2016 ($35.1 million) and 2017 ($17.5 million).

EOCCO paid $26.7 million in 2017 for administrative services, paid to Moda, Inc.

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

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

PROFORMA REVIEW

The proforma results provided appear to be reasonable for projections provided, but leave little financial protection from any negative deviations in their results.

Complete review could not be conducted given the lack of scenario data provided as noted in review conclusions below. Only Claims +0%, all enrollment scenarios provided complete scenario data.

ENROLLMENT:
The CCO provided the membership percentage assumptions for Best Estimate ('BE') 100% (600,000 Member Months), Minimum ('MIN') 80% (480,000 Member Months), and Maximum ('MAX') 125% (750,000 Member Months).

RBC:
The applicant is under-funded at the start as beginning operations with an estimated 161.6% RBC to start 2020. RBC, prepared by the Applicant, projects Best Estimate ('BE') RBC of 186.8%, 210.0%, and 233.37% for year-ending 2020, 2021, and 2022, respectively. They would meet the minimum RBC percentages in 2021 and 2022. They follow a similar pattern for their minimum enrollment estimate/Claims +0%, with 2020 RBC of 194.9%, then 2021 and 2022 exceeding 200%. They follow a similar pattern for their maximum enrollment estimate/Claims +0%, with 2020 RBC of 198.5%, then 2021 and 2022 exceeding 200%.

Applicant would need to earn $4,086,502 in income in the first year to end the year with a 200% RBC. Note that Company is projecting only $2,682,092 in income the first year thus ending the year with a projected 1st year RBC of only 186.8%. This is before any negative deviance in expected claims is even considered which then negatively magnifies the RBC deficiency throughout the year and affecting following year's RBC results. Applicant experiences a net loss after only 0.9% negative deviation in expected claims.

The applicant would not meet the RBC requirements in any year across all enrollment projections for Claims +2%, +4% projections. RBC calculations was not provided by Applicant for any of the +6% scenarios.

The company is dependent upon profitable results from operations to meet the requirements, and there is little margin for negative deviations without broaching the minimum RBC requirement of 200%.

To breach the 200% RBC threshold, Claims would need to:
decrease at least -0.47% for Expected Membership/Claims +0% scenario;
decrease at least -0.19% for Minimum Membership/Claims +0% scenario;
decrease at most +0.05% for Maximum Membership/Claims +0% scenario;

Data was not provided for any of the +2%, +4% nor +6% scenarios.

MINIMUM CAPITAL AND SURPLUS:
The CCO met the basic capital and surplus requirements under all scenarios presented. Claims +6% was not presented.

NET INCOME:
To breach the Net Loss threshold of $0, claims would need to increase roughly:
0.90% for Expected Membership scenario;
0.28% for Minimum Membership scenario;
1.40% for Maximum Membership scenario.

This is a very small cushion for financial protection for any negative deviations, especially as they are dependent upon net income and positive financial results from operations to meet the required RBC percentage.

LIQUIDITY:
The applicant appears to have sufficient assets to cover their liability obligations on scenarios where data was provided. Applicant maintained liquidity ratio roughly:
169+% for Expected Membership & Claims +0% scenario;
173+% for Minimum Membership & Claims +0% scenario;
174+% for Maximum Membership & Claims +0% scenario;
Data was not provided for any of the +2%, +4% nor +6% scenarios.

To breach the 100% liquidity benchmark, the claims cost have to rise to:
6+% for Expected Membership scenario;
7+% for Minimum Membership scenario;
7+% for Maximum Membership scenario.

PREMIUM TO SURPLUS:
The Applicant's Premium to Surplus ratio is:
13.8-16.7:1 for Expected Membership & Claims +0% scenario;
15.4-15.6:1 for Minimum Membership & Claims +0% scenario;
11.8-15.7:1 for Maximum Membership & Claims +0% scenario;
Data was not provided for any of the +2%, +4% nor +6% scenarios.

Mitigating the above concerns is the fact that the Applicant appears to have parental resources available for further capitalization as needed. The assets available, though,

are limited, and with three CCO applicants within the organization, the resources may be more strained and limited.

As funding from other owners was yet to be determined, it is unclear if beginning C&S ($17.225M) was to be the total C&S to be later allocated between the multiple owners or if that was to be ODSCH's contribution and the other owners were to contribute "additional funds – yet to be determined."

The second situation would alleviate the starting RBC issues noted above but analysis was performed based on the first situation, as that was all the information provided. Any additional funds contributed by the other owners would only improve the overall analysis of the Applicant.

Analyst made the assumption that the beginning capital of $17.225M would be allocated to the current ownership percentages.

Any additional funds contributed by the owners would only improve the overall analysis of the Applicant.

Applicant increased their beginning C&S to $16.25M for their Minimum Enrollment Scenarios, skewing ratio analysis on these scenarios.

Applicant increased their beginning C&S to $21M for their Maximum Enrollment Scenarios, skewing ratio analysis on these scenarios.

It would be prudent to ensure that EOCCO, NWCCO and WCCCO are setup as separate legal entities and are not combining their assets and C&S in a single entity, while breaking out the premiums and claims cost by geographic contract. Doing so would show that each CCO may have sufficient assets for a location, but may not have enough when combined into the actual single entity that is bearing the risk.

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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**
600,000	562,090	750,000	480,000	94%	600,000

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$534.55		$552.73	$545.67	-2%

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

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.28%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.00%	0.26%

In-depth review of financial risks associated with three CCOs under Moda

Admin load % and profit margin assumption

In the FY2020 projection under the BE MM scenario, the three CCOs assumed the same admin load at 9.1% and profit margin at 0.8%.

The admin load 9.1% is consistent with EOCCO's FY2018 financial result and thus deemed reasonable.

The profit margin 0.8% is significantly lower than EOCCO's FY2018 profit margin 3.7%. Further, per the prior years' financial reporting history, EOCCO's profit margins are: 4.9% for 2017, 3.9% for 2016, 6.0% for 2015, 9.3% for 2014, and 0.8% for 2013. Based on this historical data, the projected profit margin for 2020 seems too conservative.

Risk: the risk noted by DCBS might be alleviated if the profitability is underestimated by the applicants.

Recommendation: Revisit the proforma data to adjust the operating expense

DCBS's review comment regarding strained/limited parental resource for further capitalization

DCBS's review summary memos for NWCCO, WCCCO and EOCCO all state that "Mitigating the above concerns is the fact that the Applicant appears to have parental resources available for further capitalization as needed. The assets available, though, are limited, and with three CCO applicants within the organization, the resources may be more strained and limited than if done under a single application."

Per review of the submitted organization charts, OHA financial analyst noted that EOCCO has multiple equity shareholders and Moda only holds 29% stake of EOCCO. The other significant stakeholder is GOBHI, which also holds 29%.

Moda currently holds 100% stake in both NWCCO and WCCCO as they are newly founded, however, other interested or expected equity partners might contribute upon start-up or in the future. Among those interested parties, only GOBHI for NWCCO would be a common shareholder as for EOCCO, otherwise all the other interested equity partners are different and thus DCBS's concern about strained and limited resources from parent company would be alleviated.

Capital & Surplus for EOCCO

DCBS's analysis shows EOCCO's beginning capital is not enough to meet the RBC requirement. At 2018 year-end, EOCCO has a C&S balance of $24m, however, it only plans to contribute $17m as the starting capital at the beginning of 2020 under the BE MM scenario.

EOCCO plans to distribute $6.5m plus whatever net income it will make in FY2019 as dividends to the shareholders before the CCO 2.0 contract starts.

Risk: Aggressive dividend distribution plan will put EOCCO at a less solid financial situation.

Recommendation: Recommend EOCCO to keep more capital funding to meet the RBC requirement before distributing dividend to its shareholders.

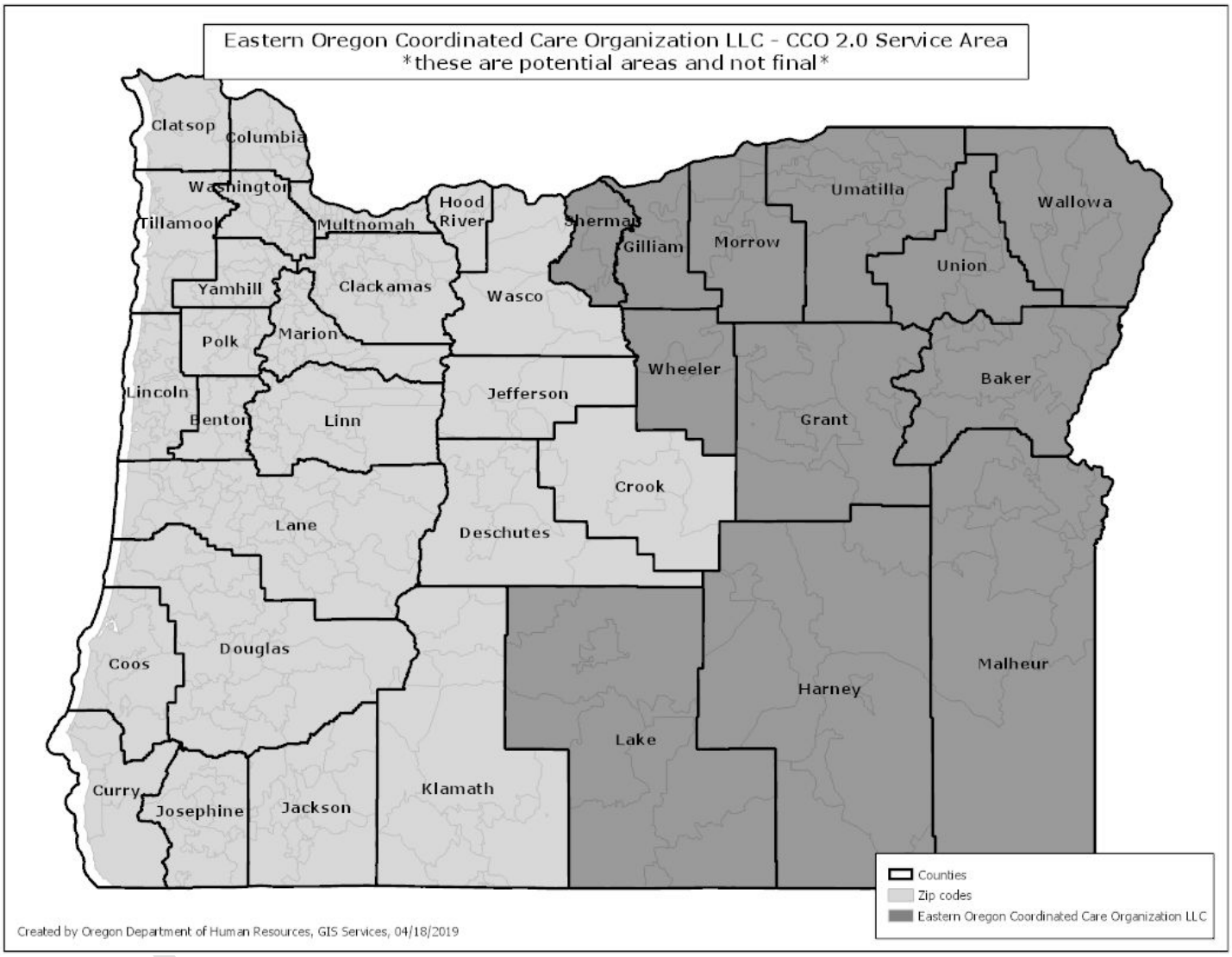
EOCCO has a pattern of paying dividends to shareholders, yet shows less than 200% RBC as of 1/1/2020.

- Suggest OHA require minimum retained capital of $22 million as of 1/1/2020 (estimated 200% RBC ratio). Nonpayment of dividends in 2019 will be deemed sufficient to satisfy this requirement, in case 2019 P&L is sharply negative.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Sherman, Gilliam, Morrow, Umatilla, Union, Wallowa, Wheeler, Grant, Baker, Lake, Harney, and Malheur 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.

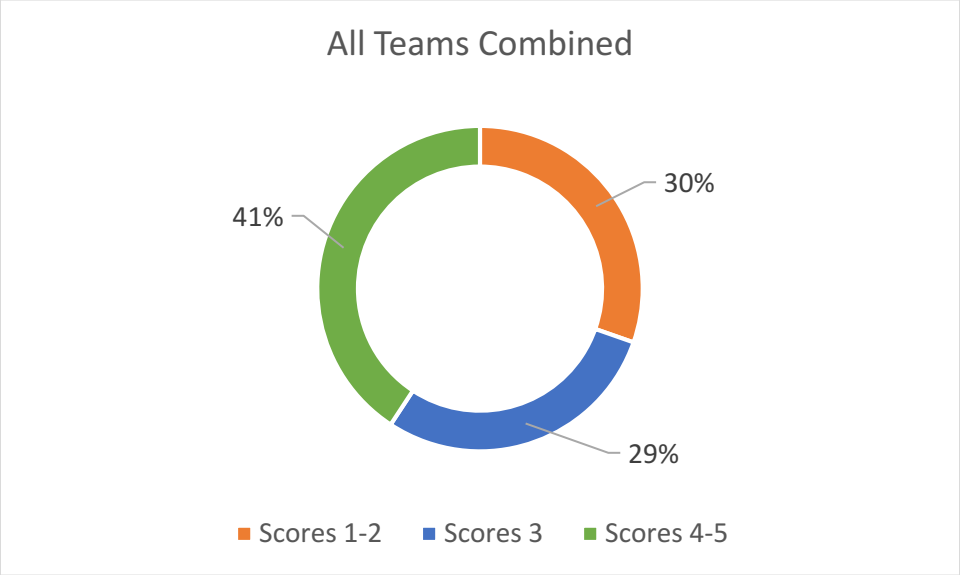
Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler	-	No modeling performed. EOCCO would be the only CCO serving the eastern half of the state. A significant number of Open Card members would have to join the applicant, or a significant number of current members would have to leave in order for the applicant's enrollment to fall outside of their min-max range.			

Member Allocation Projection

No member allocation tests performed. EOCCO would be the only CCO serving these counties.

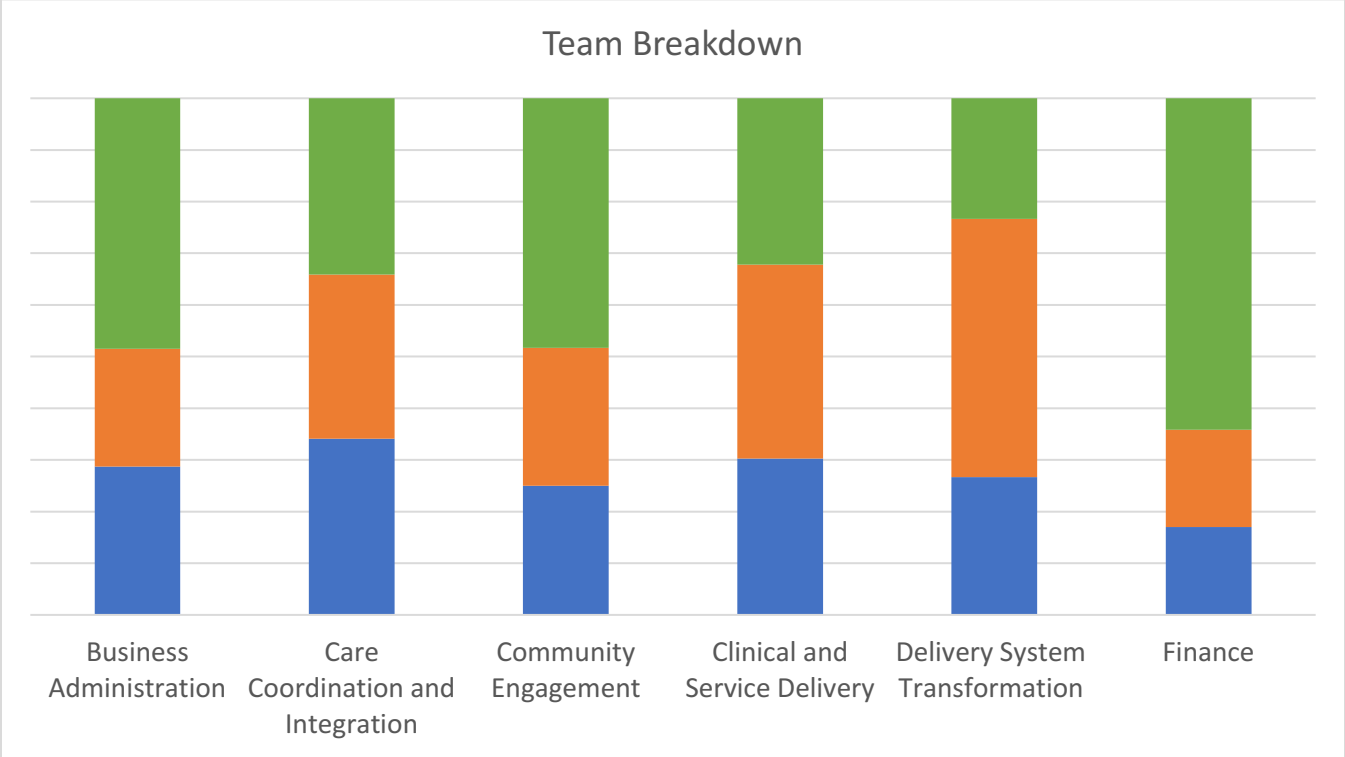
Evaluation Results – Overall Scores

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

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	4	9	23
Social Determinants of Health	21	27	65
Behavioral Health	43	54	80
Cost	9	11	14
Business Operations	151	116	124

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	4	5	24
Cost	11	15	31
Business Operations	27	24	46
Value-Based Payment	20	10	26
Behavioral Health	8	22	25

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	2	18	X		X	
CCO Performance and Operations	4	3	8	X		X	
Cost	6	4	8	X		X	

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

Deficiency Analysis

Value-Based Payment

No major concerns outside of lack of detail.

CCO Performance and Operations

EOCCO did not have a clear strategy for connecting payment or HRS spending to quality.

Cost

Responses related to addressing cost containment focused on fraud and abuse prevention. Inadequate information was provided regarding care coordination and tracking of services. Unclear how Applicant intends to connect payments to quality. Responses indicate they may not be adhering to requirements regarding limiting of behavioral health spending, specifically around separating funding for behavioral, oral and physical health services.

Team Recommendation: **FAIL**

The recommendation was largely driven by very substantial concerns related to Applicant's ability to achieve cost containment and care coordination requirements. Deficiencies and gaps felt more fundamental to their ability to meet 2.0 expectations. Did not demonstrate an ability to successfully adhere to CCO 2.0 requirements for care coordination, cost containment, and behavioral health integration.

Overall, EOCCO addressed the financial aspect of the application well, but the financial team believes that the concerns around cost containment and care coordination were significant. These items would **require significant resources** to correct.

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
Administrative Functions	6	14	43	X			
Social Determinants of Health	4	5	19				
Health Information Technology	13	16	11	X			
Member Transition	15	13	8	X			

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

Deficiency Analysis

Administrative Functions

Responses in this section generally contained adequate level of detail. The pharmacy section was lacking info on the public facing website, the Fraud, Waste and Abuse response did not mention essential processes of data matching or claims review and the encounter data section there was missing information on how encounter data review processes, what tools they use to monitor and validate the information. There was very little data provided on the subcontractors who are performing major pieces of work, and how they are monitored. Also missing a description of Applicant's board operations and processes. All deficiencies appear to require **smaller amount of effort to remedy**. The encounter data processes would take **more effort to address** if they are not already in place.

Health Information Technology

Responses in this section were mostly responsive but lacked detail. There were some components missing such as the HIT plan did not include overall 5 year plans. For the E.H.R adoption, the response was over-focused on metrics, not enough detail provided. Reviewers questions whether the Applicant understood what types of information were needed for this section. The deficiencies in this section would take **relatively little effort to address**.

Member Transition

The responses in this section in general lacked detail. Large amount of detail was missing on how Applicant will coordinate with other CCOs during the transition process, plan for ensuring continuity of care for all components mentioned, what warm hand off activities are planned, how providers to coordinate with will

be identified, and how members will be engaged in this process. The data reception plan is too high level to evaluate. The deficiencies noted require **moderate amount of effort to adequately address**.

Social Determinants of Health

The responses in this section was somewhat responsive but lacking detail. There was no mention of policies to translate policies into other languages. They only talk about diversity at lower levels of the organization and point to an equal opportunity policy, but more information is needed. Some of their policies on language translation appear to violate OHA rules and there appears to be confusion around how to implement culturally and linguistically appropriate polices. The deficiencies noted **could be remedied relatively quickly**.

Team Recommendation: **PASS**

- The responses from this Applicant were largely responsive but tended to lack detail and sometimes large amounts of detail.
- Recommendation that the Applicant submit detailed information around their encounter claim validation processes.
- Recommendation that the Applicant submit detailed information on plans for E.H.R adoption and detailed roadmaps for HIT/VBP implementation.
- Recommendation that the Applicant provide detailed information on these processes for transferring and receiving members from other CCOs.
- Recommendation that the Applicant submit detailed information on their language translation policies and receive education on how to translate cultural and linguistically appropriate concepts into policy.

Care Coordination and Integration

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	0	1	11				
Behavioral Health Covered Services	0	14	22	X			
Health Information Exchange	3	16	9				X
Care Coordination	37	25	14			X	
Care Integration	15	3	3	X			

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

Deficiency Analysis

Care coordination responses failed to address planned support for existing PCPCH systems as well as plans to coordinate for oral health. The Applicant failed to include in their responses multiple specific populations including tribes, families and oral health providers. Plans to conduct transition of care were viewed as extremely weak. It was unclear from the responses provided how the Applicant educates providers on interactions with social services.

Significant concerns were raised around existing relationships and processes for care coordination.

Care integration responses were brief and non-responsive. The Applicant provided little detail on how their network of providers for members with special health care needs is formed and how coordination will happen between different elements of the system. Due to their unresponsive nature it was difficult for reviewers to determine which elements could improve with a work plan.

Team Recommendation: **FAIL**

Applicant's responses on behavioral health benefit were well received by reviewers but lacked detail on planned processes for the provision of covered services. Additionally, it was noted that the Applicant failed to address workforce gaps, as well as strategies to mitigate those gaps. No detail was provided on relationships with tribal populations.

Behavioral health covered services responses were generally well received. However, a significant percent of reviewers worried that planned care coordination efforts for these services fell below stated standards.

Applicant's ability to support Health Information Exchanges (HIE) was mostly clear but focused on planned implementation of a population health management tool: not deployment and use of an HIE. The Applicant needs to identify concrete steps to ensure access to HIE and hospital event notifications. No future plans were provided for engagement of oral health providers in HIE solutions. Shortcomings in this section are technological in nature and **will require a heavy-lift**.

Clinical and Service Delivery

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Covered Services	27	28	29			X	
Behavioral Health Benefit	12	10	11	X			
Administrative Functions	18	15	12	X			
Service Operations	21	10	15			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 mostly responsive and only missing a small amount of detail. For the network adequacy responses, there was no explanation of how FTE is calculated which makes it difficult to interpret the data provided and, providers were mentioned specifically (physical, behavioral and oral health) in the response on wait time, as requested. It also appears as if only primary care providers were addressed in the oral health section. Detail was lacking on strategies to address network adequacy issues. In the grievance and appeals section, there was not enough detail on how this data could enact improvements. All deficiencies identified could be addressed with a **small amount of effort**.

Behavioral Health Benefit

The responses in this section were largely responsive but missing some detail. Especially the questions around billing system barriers lacked details on to deal with these barriers in relation to Dual eligible members. These deficiencies is estimated to require **minimal effort to remedy**.

Behavioral Health Covered Services

The responses in this section were largely responsive but missing some detail. For the care coordination response, there was no indication of how Applicant will reach out to members with no utilization in first 6 months. There was a process for identifying care coordination needs for high needs populations, but no timelines. There was no process for outreach other than they are mailed a packet - would be good if alternative methods were also available. For the SPMI section, there was no process for identifying members who decline ACT services and Applicant doesn't provide details on how they would address barriers to ACT services, how they would track ACT services across providers or how they are educating providers on the availability of these services. For Wraparound services, it is unclear how these services are communicated to members and no information on how these services are monitored. For the utilization

rates, there was no detail on ensuring capacity. The deficiencies noted are estimated to require a **small amount of effort to address**.

Service Operations

The responses in this section were mostly responsive but missing some detail. For the utilization management questions, more detail is needed on frequency and methodology. For hospital services, strategies to address readmission are missing as well as the process for tracking readmission. For the LTSS questions, answers were copied and pasted multiple times – it appears as if Applicant has a gap in understanding these services. To access care coordination services, a member would need education and access to a phone/computer. This process should be more member friendly. The deficiencies noted in this section could be addressed with a **small amount of effort**.

Team Recommendation: **PASS**

- Overall, the responses were mostly responsive but missing some detail.
- Recommendation that Applicant provide detailed answers to the LTSS questions. It is possible that the Applicant could benefit from education on LTSS services.
- Recommended that the Applicant revise their process to access care coordination services so that it is more member-friendly (does not require that the member know how to read and have access to a phone/computer).
- Recommendation that the Applicant provide detailed answers to the questions regarding ACT services.
- The deficiencies noted were all estimated to require **small amounts of effort to remedy**.
- The quality of the responses and deficiencies that required smaller amounts of effort to remedy led to a team recommendation of PASS.

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	4	3	5	X			
Accountability and Monitoring	11	5	2	X		X	

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

Deficiency Analysis

Accountability and Monitoring:

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

Quality Improvement Program – Applicant failed to provide details describing capacity to collect electronic and other forms of data, such as staffing, policies, and procedures. Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination.

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

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing plan for improving the quality of services and outcomes. Lacking sufficient information on plan for collecting data by population sub-category (by REALD).

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as sites, tier levels, oversight, and member outreach.

Team Recommendation: **FAIL**

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

Accountability and Monitoring:

- Information on how quality standards communicated with providers.
- Description of experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data.
- Information about how referrals and prior authorizations are requested and how this process facilitates the continuity and coordination of care.

Delivery Service Transformation:

- PCPCH details by tier level
- Description of oversight of PCPCH system

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	2	2	16	X			
Community Engagement Plan	12	19	29			X	
Governance and Operations	12	7	11				
Community Engagement	6	2	2			X	

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

Deficiency Analysis

- The Regional Health Equity Collaborative is missing from the Community Engagement Plan
- Mechanism for CAC input in CCO decision making is insufficient (i.e., one RCAC member on CCO board, representing all 12 CACs). No strategy for aligning CAC population with demographics and unsure if CAC representation complies with ORS. No description of how the CAC membership selection consistent with the ORS, requiring equal numbers of county representatives. Process for Board accountability to the CAC is needed.
- Does not provide information on non-CAC member engagement, only mechanism for ongoing communication of the member voice is through the complaint and grievance system.
- No plan for engagement of tribes, no plan for how the board will engage with OHP consumer representatives.
- SDOH-HE process doesn't include how priorities are vetted in the community beyond the CHP development process
- The process for CBIs decision-making is not clear, including the role of the CAC and tribes in in how decisions are made, or how entities may apply; the answer seems primarily focused on flexible services.

Team Recommendation: **PASS**

- Recommendation to receive TA and guidance from OHA
- Ensure partnerships are developed with tribes and local Regional Health Equity Coalitions
- Ensure robust plan for engaging OHP members beyond the CACs
- Develop plan for how the community members, providers and service-delivery partners inform CCO decision making
- Develop culturally and linguistically appropriate mechanisms for recruiting and engaging CAC members from diverse populations and ensure the CAC composition aligns with ORS
- Need to more clearly identify how they will engage members in care planning beyond member onboarding
- Strengthen strategies for accountability and transparency from the board to the CAC
- Develop a more robust plan to engage the community for addressing disparities, especially racial disparities
- Develop a plan for how CBI decisions are made, include the role of CACs

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 Clinic
Asher Community Health Center	Medical Clinic
Bake County Local Community Advisory Council	CAC
Baker County Community Connection	Community Action Agency, AAA, Housing authority, You program agency
Blue Mountain Hospital District	Hospital, Medical Clinic
Building Health Families	Family education and support programs
CHI St. Anthony Hospital	Hospital
Condon Child Care	Early Education and Child Care
DHS APD District 9	Public Aging and Disability Services
DHS Office - Burns	Public Self-Sufficiency and Child Welfare Program
Domestic Violence Services, Inc	DV and SA Programs
Eastern Oregon Healthy Living Alliance	Regional Community Health Improvement Plan
Eastern Oregon IPA	Medical Clinic
Eastern Oregon IPA - Michelle Aguirre Community Health Worker	Provider
Elgin Health Center, LLC	Medical Clinic, PCPCH
Gilliam County - Amy Nation, Juvenile Director	Juvenile Services
GOBHI	BH - GOBHI
Good Shepherd Health Care System	Hospital, Medical Clinic
Grande Ronde Hospital	Hospital, Medical Clinic
Grant County Community Advisory Council	CAC
Grant County ESD	Education Services, Disability Services
Harney County Community Advisory Council	CAC
Harney County Senior and Community Services Center	Senior Services
Harney District Hospital	Hospital, Medical Clinic
Hermiston Family Medicine and Urgent Care	Family Medicine, Urgent Care
High Country Health and Wellness Center/Harney County Health Department	Public Health, Medical Clinic
Lake County Commissioner	County Government
Lake County Public Health	Public Health
Lake County Public Health	Public Health
Lake District Wellness Center	BH, SUD
Lake Health District	Hospital, Medical Clinic, BH, Home Health, Public Health
Lifeways	BH, SUD
Malheur County Community Advisory Council	CAC
Malheur County Court	County Court System

Community Letters of Support

Organization Name	Type
Malheur County Juvenile Department	Juvenile Services
Malheur Education Service District	Education Services, Disability Services
Malheur Memorial Health Center	Medical Clinic
Mid-Columbia Center for Living	Mental Health, Addiction, IDD, and Crisis services
Morrow County Health Department	Public Health
Morrow County Health Department	Public Health
Morrow County Health Department	Public Health
Morrow County Health District	Hospital, Medical Clinic, Paramedic Services
Murray's Drug Inc.	Pharmacy
NAMI Oregon	BH
Northeast Oregon Area Health Education Center	Workforce Development, Education
ODS Community Dental	Dental Clinic
OHP Member - GOBHI	OHP Member
OHSU - Rural Practice-Based Research Network	Research, Education, Coaching
Oregon Child Development Coalition	Child care and early education programs
Oregon Food Bank	Food Bank, Education
Oregon Infant Mental Health Association	Early Childhood Development
OSU Center for Health Innovation	Workforce Development
OSU Extension Office, Sherman County	SNAP, 4-H Youth Development and Healthy Living
OSU Extension Office, Umatilla and Morrow Counties	SNAP, 4-H Youth Development and Healthy Living
OSU Extension Service Lake County	SNAP, 4-H Youth Development and Healthy Living
Passport to Languages, Inc.	Interpreter
Pediatric Specialists of Pendleton	Pediatric Medical Clinic
Pendleton Primary Care Clinic	Medical Clinic, PCPCH
Praxis Medical Group	Medical Clinic
Sherman County Juvenile Director	Juvenile Services
Sherman County Local Community Advisory Council	CAC
Snake River Pediatrics	Medical Clinic, PCPCH
St. Alphonsus Medical Center	Hospital, Medical Clinic
St. Anthony Hospital - Amanda Waterland, CHW – Case Management	Hospital Case Management
St. Luke's, Eastern Oregon Medical Associates	Medical Clinic
Stark Medical Group	Medical Clinic
Symmetry Care	BH - GOBHI
Tillamook Family Counseling Center - Frank Hanna-Williams	BH - GOBHI
Umatilla County Public Health	Public Health
Union County CARE Program	Community Resource Center

Valley Family Health Care	Health Centers, Dental Clinics, Outreach
Wallowa Local Community Advisory Council	CAC
Wallowa Memorial Hospital	Hospital
Wallowa Valley Center for Wellness	BH, DD, Crisis, SUD
Wheeler County Local Community Advisory Council	CAC
Winding Waters Health Center	Medical, Dental, BH Clinic

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 delegates the behavioral health benefit, including key areas that the CCO must be responsible for: administrative responsibilities, utilization management, contracting with an adequate behavioral health provider network and development and implementation of various forms of value-based payment (VBP) models with their network of providers. It is not clear from the application if they are adhering to requirements not to limit behavioral health spending and the applicant indicated segregated funding physical, oral and behavioral health.

Recommendations: This applicant has some critical deficiencies and does not seem to understand the key principles of CCO 2.0. The applicant would need to submit a plan to ensure that they are accountable for the behavioral health benefit for members and that they are operating under a global budget.

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	7	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.

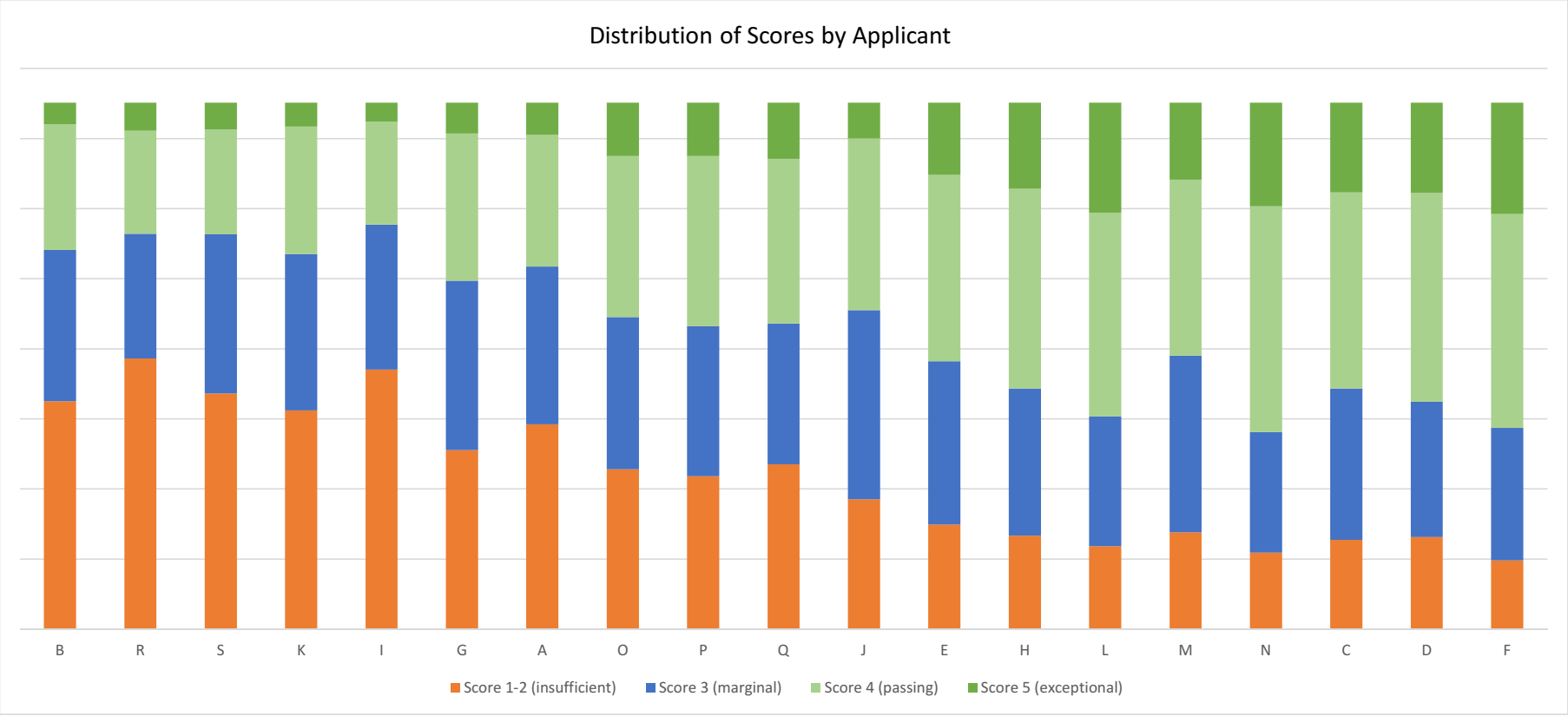
Members with no claims history

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

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