RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant R
Marion Polk Coordinated Care, Inc.

CONFIDENTIAL UNTIL 7/9/19

Evaluation Overview

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

Criteria Development

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

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

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

Passing Score

Team Analysis

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

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

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

Evaluation Results: Policy Alignment

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

Evaluation Results: Informational Assessment

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

Ex:

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

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

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

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

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

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

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

Executive Summary

Financial Analysis

- MPCC is a newly formed CCO, however, it is based on the current CCO Willamette Valley Community Health, thus the two CCOs will be comparable.
- DCBS financial review found that the results provided appear to be reasonable for the projections provided but recommended further review of additional information. Profitability was unfavorable and surplus decreased to insolvency in most cases where a stress test was applied.
- ASU noted that MPCC's profitability projections are overly optimistic, and low RBC level is not meeting 200%

Service Area Analysis

- MPCC is requesting to cover the entirety of Polk and Marion counties, and partial Linn, Yamhill, Benton, and Clackamas counties.
- There is a service area exception request for partial Linn, Yamhill, Benton, and Clackamas counties. MPCC failed in all six categories.
- MPCC is one of two applicants for Marion and Polk Counties, and one of several applicants in the partial counties requested. There is moderate risk that MPCCs enrollment will be below the minimum threshold, and no risk that they will exceed the maximum threshold.

Evaluation Results – Team Recommendations

- Finance – Fail; responses did not demonstrate and understanding of CCO goals and requirements.
- Business Administration – Fail; responses are lacking detail. Lack on infrastructure to support administrative procedures, HIT, EHR, VBP, and member transition.
- Care Coordination and Integration – Fail; failed to acknowledge CCOs roles and responsibilities in working with Medicaid Advantage Plans, LTCC, out-of-network providers and Children's System of Care partners.
- Clinical and Service Delivery – Fail; answers are vague and missing detail
- Delivery System Transformation – Fail; responses do not contain a data plan, measuring quality performance. Lacking details about PCPCH program and management of SPMI services.
- Community Engagement – Fail; missing significant details about community engagement plan for all communities in service area. Significant technical assistance/guidance from OHA needed.

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

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

Financial Analysis

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Division of Financial Regulation

M E M O R A N D U M

May 24, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Marion Polk Coordinated Care Organization

I have performed a financial evaluation of the Marion Polk CCO material that was provided to me and there are several issues worthy of note. The results provided appear to be reasonable for the projections provided.

The Pro Forma Statutory Balance Sheet that was prepared by the Applicant for their best guess of enrollment projects RBC of 126.7%, 187.2%, and 209.4% at the end of 2020, 2021, and 2022, respectively.

The Applicant would qualify for a Regulatory Action Event in the first two years of operation, if their projections are met.

A 2% negative deviation in their claims expenses would result in the company being insolvent in the first half of 2021. The potential results appear positive, but there is little to no margin for error if their projections are higher than actual results. And cumulative results below the projections would be problematic and compound the issue.

Under their maximum enrollment scenario, the RBC would not meet the requirements for 2020, but would meet the requirements for 2021 and 2022. The applicant did not include any stress testing, but manual calculations under this scenario indicate that at a 2% negative deviation in their claims expense in 2020 would place the company in a “mandatory control level” event and would not be able to operate under the planned provisions for CCOs. The company would be in a company action level if they are able to meet their projections for 2020, but have a 2% negative deviation in 2021.

The company would be above Company Action level if they meet the projections in 2020 and 2021, but have a 2% negative deviation in their claims expenses in 2022. The potential results appear positive, but there is little to no margin for error if their projections are higher than actual results. And cumulative results below the projections would be problematic and compound the issue.

Under their minimum enrollment scenario, the RBC would not meet the requirements for 2020 and 2021, but would meet the requirements for 2022. The applicant did not include any stress testing, but manual calculations under this scenario indicate that at a 2% negative deviation in their claims expense in 2020 would place the company in a "mandatory control level" event and would not be able to operate under the planned provisions for CCOs.

The company would be in a company action level if they are able to meet their projections for 2020, but have a 2% negative deviation in 2021. The company would be above Company Action level if they meet the projections in 2020 and 2021, but have a 2% negative deviation in their claims expenses in 2022. The potential results appear positive, but there is little to no margin for error if their projections are higher than actual results. And cumulative results below the projections would be problematic and compound the issue.

The Applicant's response to question 6.C.1.c mentions that all three organizations were integral in the management of financial risk with Marion Polk Community Health Plan from 2001 thru 2012 and with WVCH from 2012 to present. I performed a review of the 5 year profile from 2008 through 2012 for Marion Polk Community Health Plan Advantage (NAIC 12310) on the NAIC/ISITE database and I noted a substantial decline to the Company's financial position. Capital and surplus was $7.83 million at 12/31/2008 and decreased in each of the four subsequent years to $5.66 million at 12/31/2011.

The underwriting loss was $78 thousand, $689 thousand, $923 thousand, and $2.0 million at year-end 2008, 2009, 2010, and 2011, respectively. Net income of $209 thousand was reported at year-end 2008 and a net loss of $412 thousand, $602 thousand, and $1.45 million was reported in 2009, 2010, and 2011, respectively. Marion Polk Community Health Plan Advantage also experienced a decline in liquidity from 2008 through 2011. Marion Polk Community Health Plan Advantage's financial position improved in 2012 because the Company stopped writing premium.

The applicant would not have sufficient cash on hand to meet all liability obligations in 2020, without positive cash flow from operations. The results for 2021 and 2020 project they have sufficient cash and liquid assets to meet their liability obligations, under the best of scenarios. Negative deviations from their projects may create liquidity issues that would prevent the ability to meet their obligations, but with the amount of cash noted in the applications, it would appear that it would take some rather large negative cash flows ($15 million in 2020, $22 million in 2021 and $26 million in 202)2 to create a position in which there is no ability to meet their obligation. (Those amounts would be cumulative over the years). Positive results in cash flow would allow for all claims to be paid with sufficient cushion.

No information was provided that would indicate additional sources of capital or cash infusions for liquidity needs, if the need arises.

DCBS has previously worked with the proposed management and does not see any known issues, outside of stating that they would have issues completing SAP based financial statements, while having their CFO complete SAP based financial statements for two licensed insurers.

There is an error in the Applicant's 2% stress test for 100% enrollment that results in the negative impact of the 2% stress test not being included in the capital and surplus for the second and third year of the test.

The Applicant appears to calculate the negative impact that the 2% would have on profitability at 12/31/2020 but it appears that 1/1/2021 surplus was not decreased to reflect the 2% stress test on profitability in the prior year. This results in the Applicant overstating the capital and surplus in "C&S after test #1" by $8,623,576 in 2021; the same amount that the 2% stress should have reduced surplus at the end of 2020. This error reoccurs in 2022.

I recalculated capital and surplus to correct the error and found that applying the 2% stress test to 100% of expected membership results in the CCO being financially insolvent in the first half of 2021.

I did not proceed with evaluating the 4% and 6% stress test at 100% of enrollment or evaluating the 2%, 4%, and 6% stress test on 75% and 125% of enrollment because the point of financial insolvency was located in the above paragraph.

The remaining stress tests should be reviewed for the error mentioned in the above paragraph before performing any evaluation of the data.

[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) for Willamette Valley Community Health. *Note: MPCC is a new formed CCO, however, it is based on the current CCO Willamette Valley Community Health, thus the two CCO will be comparable.*

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**
907,349	751,287	1,295,514	748,533	83%	907,349

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$461.16		$475.21	$467.13	-1%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
91%	90%	1%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.44%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.36%	0.32%

Profit margin

MPCC projected a profit margin of 2.9% for FY2020 under the BE scenario. However, its predecessor WVCH's financial history indicated a much lower profit margin in the past: 0.3% for FY2018, -1.6% for FY2017, 1.5 for FY2016.

Risk: MPCC profitability projections are overly optimistic

Recommendation: Request MPCC provide additional information to substantiate its assumption that its profitability would significantly improve from prior years into FY2020

Capital and Surplus

MPCC's projected RBC level is under 200% at the end of 2020 and 2021, and barely above 200% at the end of 2022 as its low starting C&S level at the beginning of 2020.

However, OHA financial analyst noted that its predecessor WVCH's C&S balance was around $20.6M at end of FY2018, compared to its projected 2020 starting capital of $3M.

Risk: Low RBC level not meeting 200%

Recommendation: Require MPCC to increase the starting capital contribution.

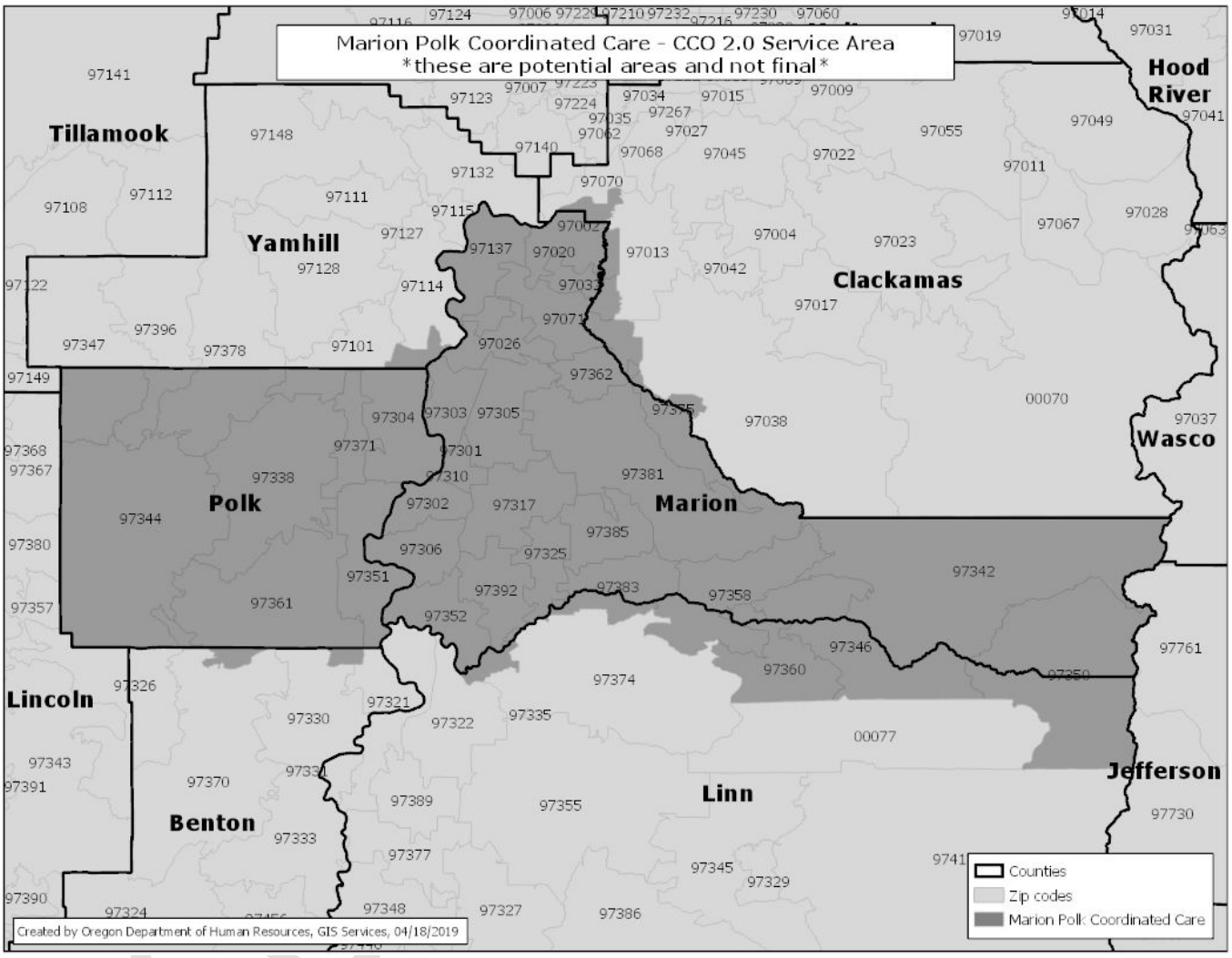
MPCC capital contribution at 1/1/2020 is $3 M of surplus notes, which are subordinated borrowed funds. Resulting 1/1/2020 RBC is approximately 25%. MPCC aggressively assumes 2.9% margin in 2020 as part of reaching higher RBC levels. WVCH C&S (which involves common shareholders) is over $20 M at 12/31/2018. WVCH restricted reserves are $5.1 M as of 12/31/2018. MPCC assumes 900,000 MM enrollment, as compared with 1,200,000 for WVCH.

- Recommend OHA require additional capital as of 1/1/2020 start date. Ideal capital level is $24 million (approximately 200% RBC), but lower levels could be considered.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Polk and Marion counties, and partial Linn, Yamhill, Benton, and Clackamas counties.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	30	0
Care Coordination and Integration	29	1
Community Engagement	15	0
Clinical and Service Delivery	28	5
Delivery System Transformation	12	0
Finance	18	5

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

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

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

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario
Benton, Linn, Clackamas, and Yamhill	Pacific Source - Marion Polk and Yamhill propose to serve Marion and Polk. Marion Polk Coordinated Care's partial counties are also proposed to be served by IHN, Trillium, and Health Share.	28% chance Marion Polk Coordinated Care would not receive enough members.	No scenarios show enrollment exceeding applicant's maximum	Medium risk

If Marion Polk Coordinated Care is not allowed to serve any partial counties, there is a 100% chance they will not receive enough members to meet their minimum.

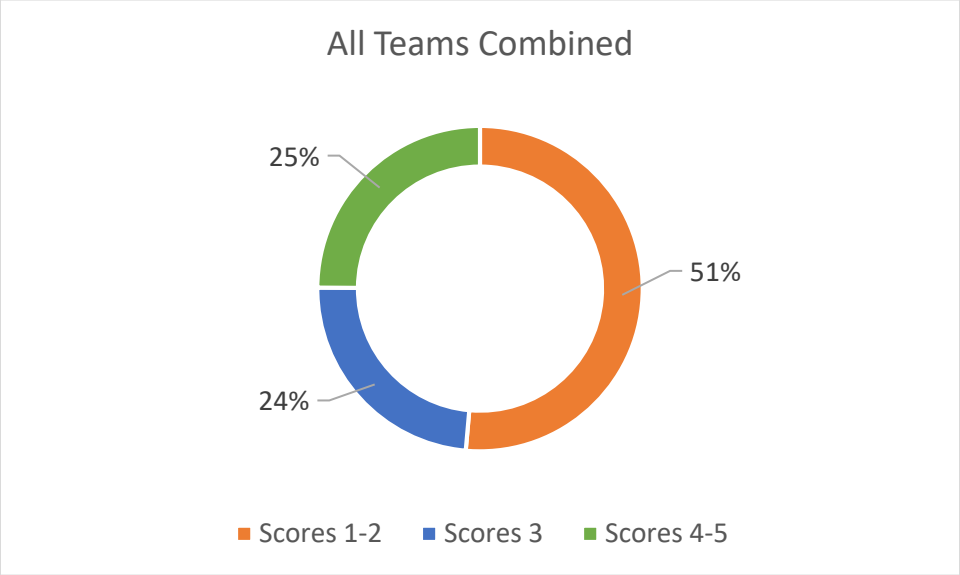
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Marion Polk Coordinated Care is likely to receive approximately 47,446 members out of the 62,378 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.

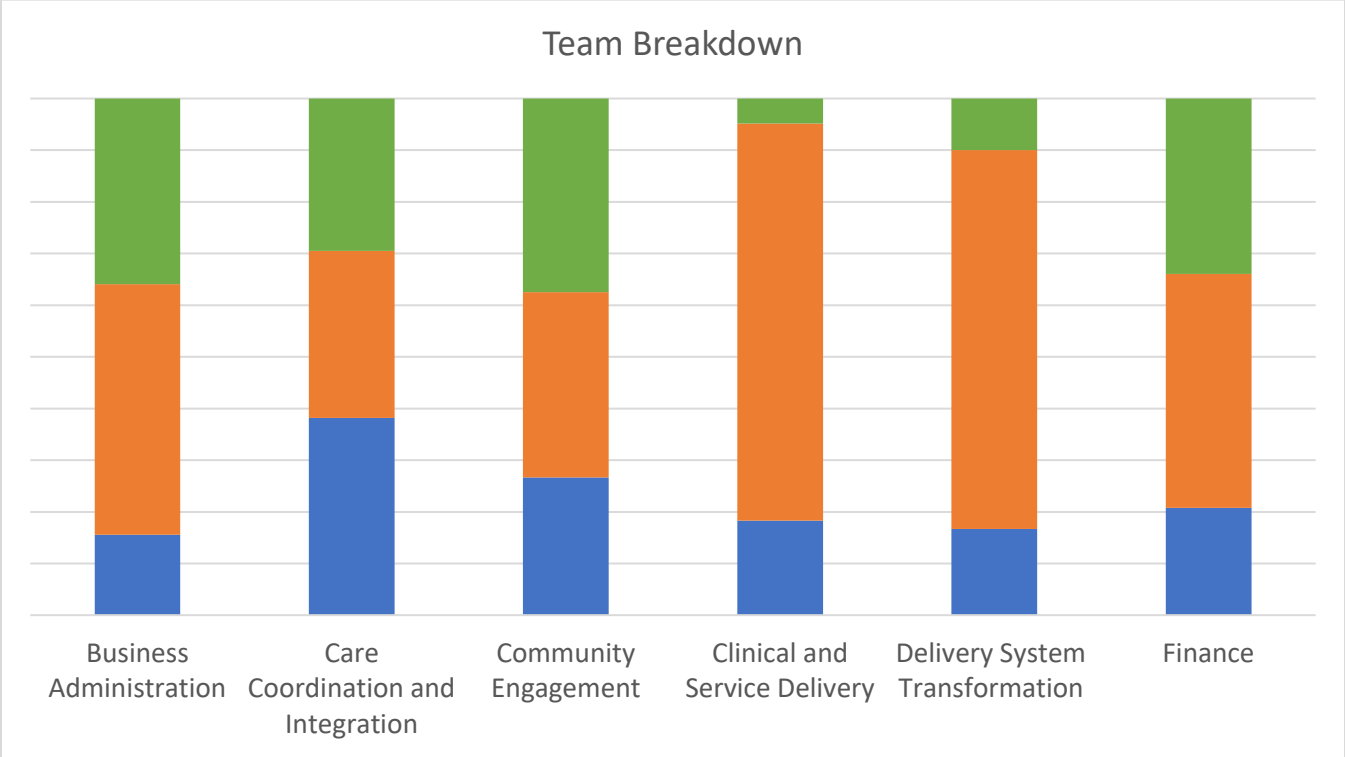
Evaluation Results – Overall Scores

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	FAIL	X		X	
Business Administration	FAIL	X	X	X	X
Care Coordination and Integration	FAIL	X	X	X	X
Clinical and Service Delivery	FAIL	X	X	X	X
Delivery System Transformation	FAIL	X		X	X
Community Engagement	FAIL	X	X	X	

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Social Determinants of Health	44	25	44
Value-Based Payment	15	8	13
Business Operations	184	108	99
Cost	21	5	8
Behavioral Health	122	32	23

Evaluation Results: Informational Assessment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	19	17	21
Value-Based Payment	24	9	23
Social Determinants of Health	15	9	9
Business Operations	47	21	29
Behavioral Health	29	17	9

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	5	6	9	X		X	
Cost	9	1	8	X		X	
CCO Performance and Operations	10	4	1	X		X	

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

Deficiency Analysis

Value-Based Payment – As a whole, the value-based payment aspect of Marion Polk's application is satisfactory. However, there is limited detail to sufficiently address PCPCH spending requirements, no increases discussed, and no explanation of rate development process and theory.

Cost – The cost aspect of this application is lacking in several ways;

1. The financial section lacks detail or is incomplete throughout
2. Responses did not always address the question asked
3. There was no plan provided for integrating behavioral health financing
4. Did not demonstrate how applicant would ensure quality is not compromised in cost containment efforts
5. Procedures are focused around care coordination, without focus on client outcomes
6. Inadequate explanation as to how goals and tasks will be accomplished
7. Growth plan did not indicate a proactive understanding of cost containment

CCO Performance and Operations – There was no detail on plans to use HRS to accomplish any strategic goal identified by the RFA questions. Additionally, while there were up-front evaluations of HRS proposals, no plan was presented to enable evaluation of HRS activities.

Team Recommendation: **FAIL**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Marion Polk Coordinated Care, Inc. be given a "fail" for the financial section. Responses were generally poor, not demonstrating understanding of expectations to which CCOs will be held. Poor explanations were provided for how Marion Polk would accomplish goals.

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
Member Transition	12	4	20				
Social Determinants of Health	13	5	10				
Administrative Functions	32	10	21	X	X	X	X
Health Information Technology	24	7	9	X	X	X	X

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

Deficiency Analysis

Administrative Functions

In general, there was a lack of detail across all responses in this section. For pharmacy section, they did not address how pharmacy benefit would be communicated to members and didn't indicate how prior authorization requests could be made. For FWA, there was no indication of systematic audits or monitoring, no mention of preemptive FWA efforts such as claims edit and detail lacking on general auditing processes. There was also no plan for holding subcontractors accountable for FWA. For TPL, there was no info provided on how data is received, what the data sources would be and how Applicant will verify Medicare coverage. Responses about Applicant governance did not address board operative procedures or approval process. The encounter data validation responses lacked detail – no tools were listed to ensure timeliness, accuracy and only semi-annual claims validation was considered insufficient, although the manual chart review with RN was a plus. Responses indicate that there is currently a lack of people, processes, technology and other infrastructure to support important administrative procedures. These deficiencies would collectively take a **large amount of effort to correct**.

Health Information Technology

For E.H.R adoption, no description of current status, no roadmaps, methods, milestones, and they don't plan on tracking E.H.R use outside their existing system. For HIT/VBP section, they did not provide any info on population health, didn't address useful insights that could be developed, response was limited to REAL-D populations but didn't address any other special member population in their area. There were no plans for years 1-5 and no methods mentioned to match SDOH-HE data with claims data. Also, no HIT tools were specified which suggests that Applicant has some larger gaps in this area. The deficiencies in this area would take a **large amount of effort to correct**.

Member Transition

The responses in this area were lacking detail. The transferring responses were better than the coordination, receiving and transition activities responses. There were no plans to identify members needing additional support, no indication of how they will establish relationship with providers and others for purposes of care coordination and no indication of how they will ensure continuity of care during the transition process in relation to prior authorizations, case management, etc. Applicant stated that validation of information would happen but didn't indicate how. The deficiencies in this area would take a **large amount of effort to correct**.

Social Determinants of Health

For health equity responses. No way to assess fluency or quality of language services. They use complains as primary method to improve services – this is a reactive instead of a proactive approach. There is no info on who will be providing health equity training or monitoring it, what methods will be used and training offered for managers but not employees. Also there is no mention of auxiliary aids for those with hearing, seeing issues and no plans for implementing an organizational health equity plan. Deficiencies in this section **could be remedied relatively quickly**.

Team Recommendation: **FAIL**

- In general the response from this Applicant were lacking detail.
- Responses indicate that there is currently a lack of people, processes, technology and other infrastructure to support important administrative procedures. These deficiencies would take a **large amount of effort collectively, to correct.**
- Responses for the HIT section indicate that there is currently a lack of knowledge, process, technology and/or other infrastructure to support E.H.R adoption and HIT/VBP implementation. These deficiencies would take a **large amount of effort to address adequately.**
- The deficiencies in the member transition section are widespread and would take a **large amount of effort to correct.**
- The general quality of the answers and multiple section requiring large amounts of effort to remedy, led to a team recommendation of FAIL.

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	3	1	8				
Care Coordination	19	35	22	X	X	X	
Health Information Exchange	8	14	6	X			X
Care Integration	7	8	6	X		X	
Behavioral Health Covered Services	19	8	9	X	X	X	

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

Deficiency Analysis

Applicant's responses on behavioral health benefits were generally well received. Reviewers noted a lack of detail for trainings, strategies and outreach associated with workforce pipelines. No outreach strategies were provided for tribal populations.

Behavioral health covered services responses failed to include any information on patient involvement in planning, or the applicant's role in the System of Care. The absence of this information lead reviewers to conclude that the Applicant would need to execute a heavy-lift to become a functional care coordination partner. Poor responses were provided for care coordination with Medicare Advantage plans for dual eligible populations, out of network care, transitions and discharges, and follow up activities. Children's System of Care responses lacked strategies and showed little awareness of systems and partner organizations currently in place. Overall limited detail was provided on plans for outreach to members; reviewers notes that 'mail' is not a feasible outreach strategy.

Care coordination responses failed to provide information on coordination with Long Term Care providers as well as Intensive and Critical Care. The Applicant provided limited detail on planned processes for working with Medicaid Advantage plans and dual eligible populations and provided little detail on plans for patient and family engagement. Reviewers felt that the applicant did not fully understand requirements around member rights. The Applicant's responses relied heavily on activities performed by primary care providers and did not sufficiently acknowledge a CCOs role in coordinating access for members including generating referrals for oral health.

Care integration responses included no description of agreements between hospitals and providers. No detail was provided on a planned role of primary care. Responses acknowledge that partnerships will be developed but not enough detail is provided. Applicant provided little information on how Care Integration

efforts would impact tribal members; reviewers noted that even if there are not tribes in the area tribal members could live in the service area.

Applicant's ability to support Health Information Exchanges (HIE) was not demonstrated. Little information was provided on how the Applicant would increase access to HIE among providers. Responses by the applicant were poorly written. As an example, the Applicant outlined work with behavioral health providers instead of oral health providers in one section. Reviewers were concerned with the quality of responses provided.

Team Recommendation: **FAIL**

Overall, reviewers felt that the deficiencies identified **could not be easily remedied**. Efforts needed to become a functional partner in care coordination across provider types, as well as care systems were too large to be accomplished in the needed timeframe. The Applicant consistently failed to acknowledge CCOs roles and responsibilities in working with Medicaid Advantage Plans, LTCC, out-of-network providers and Children's System of Care partners. While the planned service area for this applicant does not include tribes, reviewers were concerned that this Applicant failed to acknowledge that tribal members may still live in the service area and may still become their members. The poor quality of the responses did not demonstrate how the Applicant would achieve the goals of CCO 2.0

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
Administrative Functions	31	10	4	X		X	
Behavioral Health Covered Services	65	17	2	X	X	X	
Behavioral Health Benefit	26	6	1	X		X	
Service Operations	38	5	3	X		X	

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

Deficiency Analysis

Administrative Functions

The responses in this section were very high-level, sometime not responsive at all, and it was difficult at times to track what response belonged to each question as Applicant would often combine responses. For the network adequacy section, no detail provided on how FTE is calculated or how network provider deficiencies are monitored. The Applicant does not use the grievance and appeal data to improve their network. The answers in this section are sufficiently vague and enough detail is missing to raise questions of credibility and suggest deficiencies that would require **a large amount of effort to remedy**.

Behavioral Health Benefit

The responses in this section were missing a lot of detail. Applicant didn't address barriers adequately for any of the populations – just stated they could figure it out and failed to note the Duals population. There were no plans for how to manage warm handoffs and to address BH barriers, there were no plans other than having BH providers located in PH clinics. The responses in this section raised questions of credibility and suggest deficiencies that would require a **large amount of effort to remedy**.

Behavioral Health Covered Services

The responses in this section were missing a lot of detail. Some answers were incomplete, and some were missing entirely. Applicant did sometimes mention plans to put a plan together in the future. For the care coordination questions, no feasible processes were identified. Applicant also failed to mention how they will communicate with members. The responses in this section raised questions of credibility and suggest deficiencies that would require a **large amount of effort to remedy**.

Service Operations

The responses in this section were missing a lot of detail. The pharmacy responses were the best but they were missing how the Applicant would communicate with members about pharmacy benefit. There was

missing detail on how Applicant would establish medical necessity and no plans to arrange for out-of-area services when needed. Information on contractual relationships with hospitals was either missing or too vague. There were no timelines for prior authorization, no data sources for monitoring and no discussion of high-risk or targeted populations. The LTSS responses were poor or incomplete and the four best practice models were not addressed. The responses in this section raised questions of credibility and suggest deficiencies that would require a **large amount of effort to remedy**.

Team Recommendation: **FAIL**

- The answers in these sections are sufficiently vague and enough detail is missing to raise questions of credibility and suggest deficiencies that would require a **large amount of effort to remedy**.
- The quality of the responses and the **large amount of effort** needed to correct deficiencies noted, led to a team recommendation of FAIL.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Accountability and Monitoring	12	4	2	X		X	X
Delivery Service Transformation	10	1	1	X		X	

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Overall, response provides limited information. Applicant failed to describe a system and process to track performance and quality expectations. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

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

CCO Performance – Applicant failed to describe a process to measure, track and evaluate Hospital services. Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REALD).

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data collection and incorporation into quality improvement activities. Lacking sufficient information about plan to improve quality of services and outcomes, including collecting and analyzing data by sub-categories (by REALD). Lacking sufficient information on utilization of existing resources, including services specific to SPMI.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as tier levels, provider types, oversight, and engagement of potential new PCPCH providers.

Team Recommendation: **FAIL**

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

Accountability and Monitoring

- Insufficient details for overall response
- Lack of details on quality standards and performance measures
- Missing explanation of how applicant's process' facilitates continuity and coordination of care
- Lacking information about specific electronic or other data systems to support quality performance
- Missing a plan for how data will be used to improve care

Delivery Service Transformation

- Lack of details of PCPCH sites
- Applicant's response lacking on oversight of PCPCH system
- Missing description of effective use and engagement of safety net providers
- Missing data sources and methods to collect data on SPMI population
- Lack of details and plan to improve quality of services and outcomes for SMPI 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
Community Engagement Plan	23	11	26	X	X	X	
Community Engagement	3	3	4	X	X	X	
Social Determinants of Health	5	7	8	X			
Governance and Operations	12	11	7	X		X	

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

Deficiency Analysis

- Did not provide a description of projects in the Community Engagement Plan, just one-word descriptions ("housing" or "mental health")
- Two of the three priorities aren't SDOH-HE priorities, as defined by OHA
- Two of the three metrics—cost containment and health outcomes—aren't relevant to Quality Improvement of the CEP and no mention of member engagement in Quality Improvement.
- Only identifies barriers to access to care, but no strategies to access barriers to community engagement
- CAC is sole source of input from members (vs non-CAC members); no description of how OHP consumers will be engaged and no detail on how input informs CCO decision making
- Insufficient detail about governance structure's accountability to the CAC or for reporting governance decisions on CAC recommendations back to the CAC
- Doesn't mention how population is defined or how it will align CAC membership with its population – missing engagement and collaboration with partial service areas
- No mention of engaging with tribes
- Insufficient detail in how HRS spending aligns with CHP priorities
- With regard to care planning, no mention of the following: culture and language considerations, including plain language; education on preventive services; strategies to address navigation around care coordination; and information on how to engage with the CAC
- Didn't describe how input from publicly funded providers was in the application, or any agreements in partial counties
- Doesn't reflect on experience/capacity to engage community members to address disparities (programs included are focused on health care providers)
- Limited detail on recruitment for SPMI population or those receiving LTC services
- Funding process isn't transparent or equitable and no detail on how outcomes will be shared

Team Recommendation: **FAIL**

- Significant technical assistance/guidance from OHA needed
- Include full service area—including partial counties—in community engagement processes and ensure agreements with partial counties are established
- Develop a plan to mitigate barriers to engagement, which includes allocation of resources
- Develop details on now non-CAC members are involved in decision making
- Develop a quality involvement plan for the community engagement plan
- Develop clear strategies for identifying population and aligning CAC with the population; must include culturally specific strategies and tribal engagement
- Develop mechanism for board accountability to the CAC that includes a transparent process for sharing board decisions back to the CAC
- Develop a plan for member engagement in QI activities
- Develop a strategy for including cultural and language considerations, including plain language, care planning
- Develop robust HRS process that includes how entities may apply, how applicant will align CBI spending with CHP priorities, and how tribes are included
- Develop a transparent and equitable funding process, that includes evaluating and sharing outcomes
- More clearly define housing metrics

Community Engagement – Community Letters of Support

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

Organization Name	Type
Boys and Girls Club of Salem	Children, Youth Services, Medical and Dental Clinics, BH, education support
Bridgeway	BH, SUD
Capitol Dental Care	Dental Clinics
CASA of Marion County	Foster Children, legal support
Cascade ID and Infusion	Provider, Specialty Infusion Medication
CHAOS	Medical, BH Clinics
Community Action	Community Action Agency
Family Promise	Homeless and Low Income Family Services
Habitat for Humanity	Housing
Liberty House	Child abuse/neglect assessment, counseling and support for children and families
Love INC of North Marion County	Community Assistance Services, Collaboration
Marion-Polk County Medical Society	Provider Association - Medical Society
Marion-Polk Food Share	Food, Education, Nutrition
New Perspectives	BH, SUD
North Marion Services Team	Community Assistance Services, Collaboration
Northwest Family Services	Family and Child support for victims of crime, DV
OHP Plan Member	OHP Plan Member
Options	BH, SUD
Polk County Commissioners	Local Mental Health Authority, Local Public Health Authority
Renaissance Recovery Resources	BH, SUD
Salem Fire Department	Paramedic, Emergency Response
Salem Free Clinics	Medical, Dental, BH Clinics
Salem Police Department	Local Law Enforcement, Emergency medical and mental health assistance
Salem Keizer Collaboration	P-12 Education and Supports
Union Gospel Mission	Homeless Services, Outreach, Education
WVP Health Authority	Provider Association - IPA
Salvation Army of Marion and Polk Counties	Social Services, Homelessness, Housing

Behavioral Health Policy Assessment

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

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

Deficiencies: Applicant is not including behavioral health in the global budget. They do not indicate a plan to accomplish integrated behavioral health financing

Recommendations: Require applicant to submit a plan for including behavioral health in the 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
2	6	4	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

Members with no claims history

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

Full County Coverage Exception Request

Marion Polk Coordinated Care, Inc. (MPCC) is requesting to serve less than the full county for Yamhill, Linn, Benton and Clackamas. The zip codes requested are the result of contiguous zip codes that cross the Marion and Polk county boarders. The members in these zip codes are imbedded in the Marion and Polk communities and have established relationships with providers in Marion and Polk counties.

The coverage exception request is in no way designed to minimize financial risk and does not create adverse selection. The request is to allow the members in these services areas to maintain the existing relationships with community partners and providers.

Service Area Request Table:

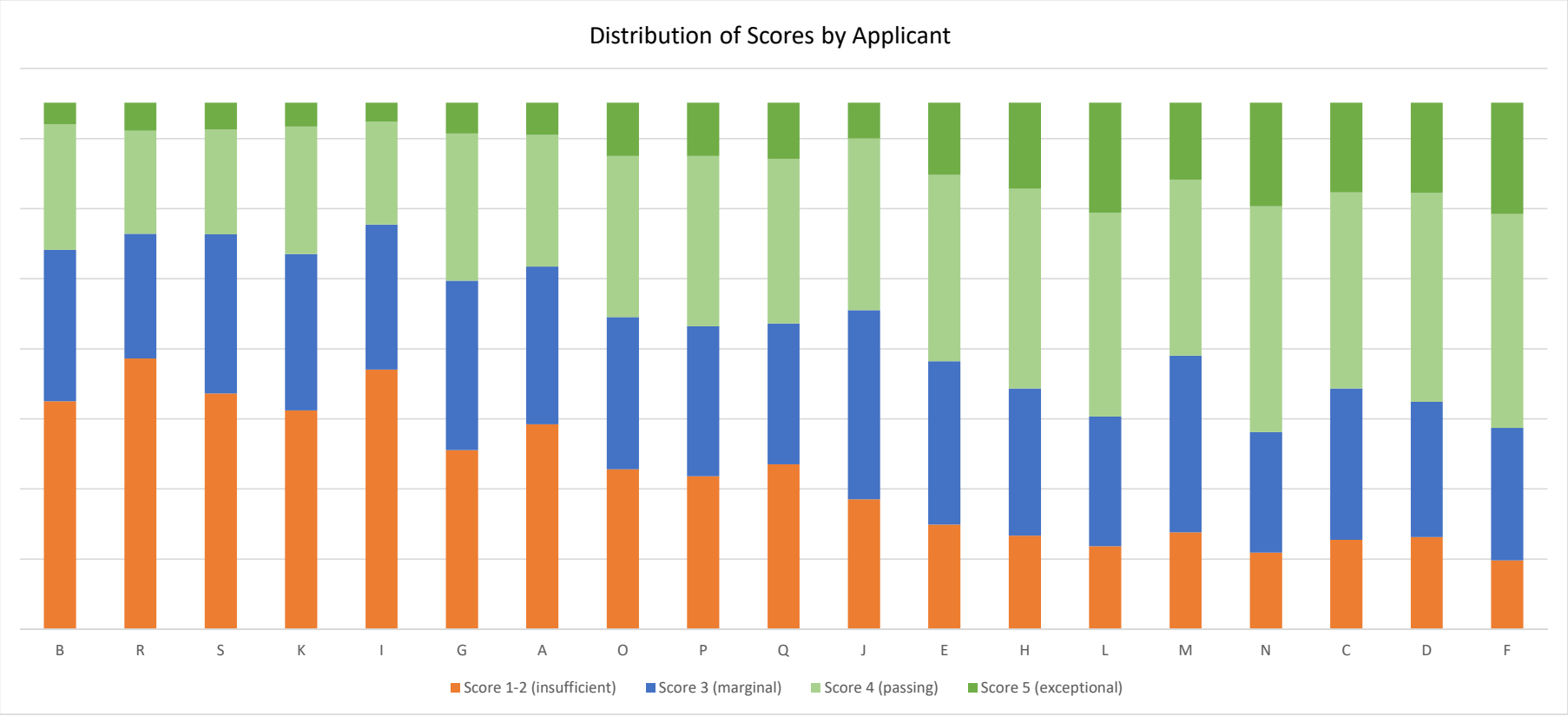
County	Zip Code
Marion County	All
Polk County	All
Linn County	97346, 97350, 97352, 97358, 97360, 97383
Clackamas County	97002, 97032, 97071, 97362, 97375
Yamhill County	97304
Benton County	97361

[End of document]

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