RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant A
Northwest 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

- NWCCO seeks an exemption from SAP and NAIC reporting for 2020 in order to allow sufficient time for hiring and training personnel.
- DCBS performed the financial evaluation and found results to be reasonable for projections provided; however, there is little financial protection from any negative deviations in their results.
- ASU raised concerns about capital funding and multiple CCOs under Moda.

Service Area Analysis

- NWCCO is requesting to serve Clatsop, Columbia and Tillamook counties, with no service area exception requests.
- High risk that NWCCO will not meet minimum enrollment required if two CCOs are awarded in this service area.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Fail; responses were limited, incomplete or not responsive. Requires significant effort to correct deficiencies.
- Care Coordination and Integration – Fail; no description of provider network adequacy and no plan for HIE technologies.
- Clinical and Service Delivery – Fail; responses lacking in detail regarding administrative functions, SPMI and LTC services. Requires significant effort to correct deficiencies.
- Delivery System Transformation – Fail; responses missing significant details about monitoring and accountability, PCPCH and SPMI services.
- Community Engagement – Pass

Community Letters of Support

- 29 letters total from various provider groups
- Multiple letters describe support for GOBHI or EOCCO, rather than identifying NWCCO

Evaluation Results: Policy Alignment

The responses from NWCCO show strong alignment with policy objectives in VBP, Social Determinants of Health, and Behavioral Health; and weak alignment with Cost and Business Operations objectives.

Evaluation Results: Informational Assessment

NWCCO's responses to informational questions scored higher in VBP, Social Determinants of Health, and Behavioral Health; and scored lower in Cost and Business Operations objectives.

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
NWCCO=NorthWest CCO

I have performed a financial evaluation of NorthWest CCO (NWCCO) application for their Clatsop, Columbia, &Tillamook Counties operations based on the materials provided. NWCCO is a newly formed CCO and would begin operations 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), NWCCO may have access to additional parental resources.

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

The 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% (330,000 Member Months), Minimum ('MIN') 75% (225,000 Member Months), and Maximum ('MAX') 125% (375,000 Member Months).

Concerns surrounding Applicant's membership assumptions were communicated by OHA in:

*Applicant assumed Applicant would get 100% of the Counties' populations even though there was a CCO currently operating in those counties.
*The enrollment level needed to ensure sustainability of the Applicant.

Such concerns seem warranted given the review below.

RBC:

The applicant is under-funded at the start as beginning operations with an estimated 153% RBC to start 2020. RBC, prepared by the Applicant, projects Best Estimate ('BE')/Claims +0% RBC of 177.8%, 202.0%, and 224.9% 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 maximum enrollment/Claims+0% estimate, with 2020 RBC of 188%, then 2021 and 2022 exceeding 200%. Under their minimum enrollment/Claims+0% estimate, they will have 204% RBC in 2020, meeting the benchmark, but will then decline to 202% in 2021 and 200% in 2022.

The applicant would not meet the RBC requirements in each year of their minimum and maximum enrollment projections, and all Claims +2%, +4% projections, and combined enrollment/claims deviation 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 increase roughly:
at most +0.89% for Expected Membership & Claims +0% scenario;
at most +0.15% for Minimum Membership & Claims +0% scenario;
at most +1.88% 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.

NET INCOME:

To breach the Net Loss threshold of $0, claims would need to increase roughly:
0.9% for Expected Membership scenario;
0.03% for Minimum Membership scenario;
1.21% 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.

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.

LIQUIDITY:
The applicant appears to have sufficient assets to cover their liability obligations without requiring positive cash flow from operations on scenarios where data was provided.
Applicant maintained liquidity ratio roughly:
250+% for Expected Membership & Claims +0% scenario;
560+% for Minimum Membership & Claims +0% scenario;
190+% 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;
14.2-15.0:1 for Minimum Membership & Claims +0% scenario;
12.3-15.8:1 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 than if done under a single application.

As funding from other owners was yet to be determined, it is unclear if beginning C&S ($9.1M) 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.

Applicant increased their beginning C&S to $11.4M 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.

ASU Analysis of Financial Assumptions

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

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

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**
300,000	149,645	375,000	225,000	50%	**Too low**

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$575.58	$570.43	$585.45	$570.43	1%

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

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 and 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.

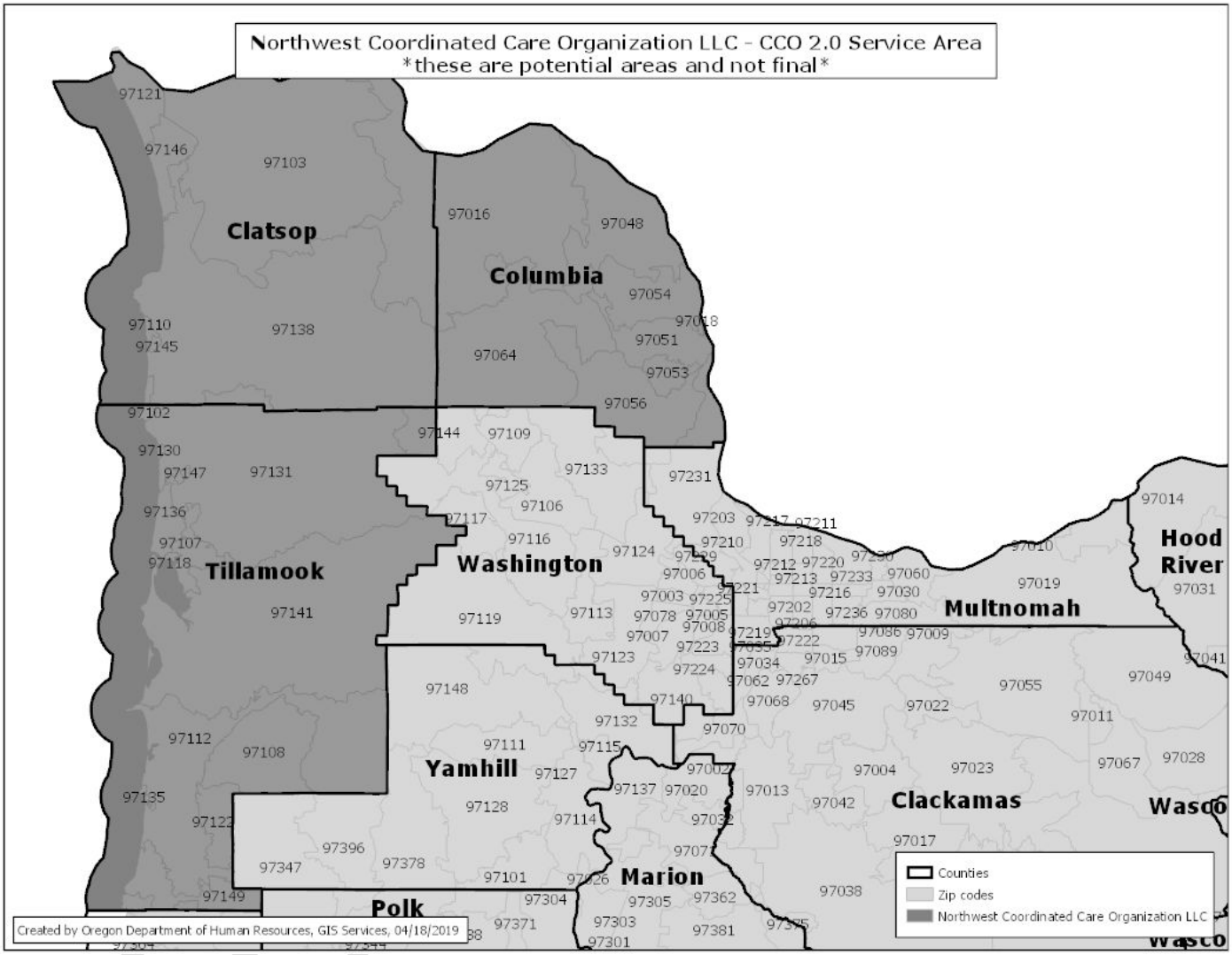
Risk: Aggressive dividend distribution plan will put EOCCO at a less solid financial situation.

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

Service Area Analysis

Requested Service Area

Applicant is requesting to serve the entirety of Tillamook, Clatsop, and Columbia counties.



Full County Coverage Exception Request

Not applicable.

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

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

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Clatsop, Columbia and Tillamook	-	Northwest CCO's service region mirrors Columbia Pacific's proposed service area. Yamhill CCO proposes to serve part of Tillamook.	100% chance Northwest CCO does not receive enough members.	No scenarios show enrollment exceeding applicant's maximum	High risk

If two CCOs are awarded in this service area, there's a 100% chance Northwest CCO does not receive enough members.

Even excluding Yamhill CCO from serving parts of Tillamook, none of the simulated scenarios show Northwest CCO meeting their minimum.

Additional Analyses on High Risk Areas

Northwest Coast

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

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

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

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

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

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

- Recommend OHA select one of these two applicants and deny the other.
- Suggest OHA consider requiring additional capital from NWCCO, if approved, to address DCBS concerns about multiple CCOs financed by MODA.

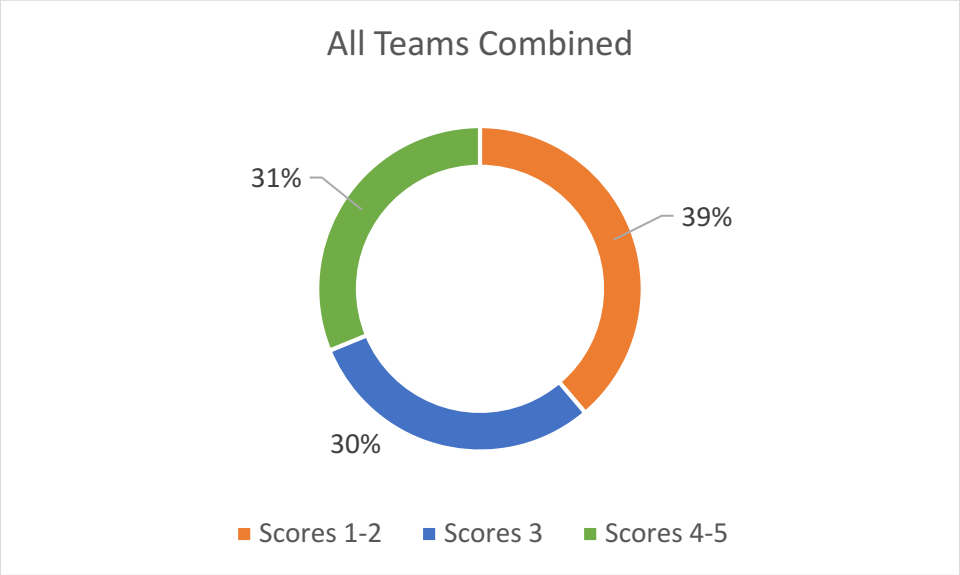
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, NWCCO is likely to receive approximately 12,714 members out of 18,750 minimum required.

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

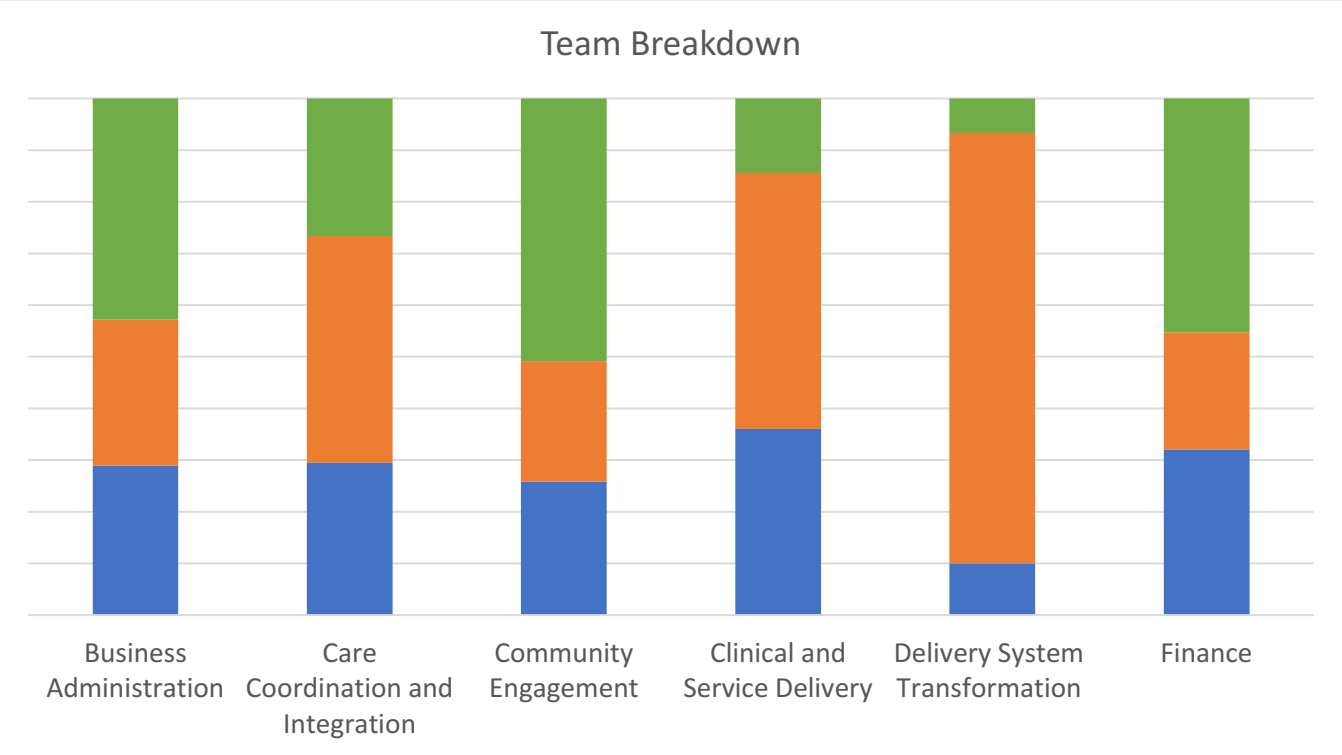
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

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

Evaluation Results: Policy Alignment

Scores for all responses were regrouped 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	8	7	21
Social Determinants of Health	16	32	65
Behavioral Health	55	62	60
Cost	11	13	10
Business Operations	201	111	78

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.

Policy Areas	**1-2**	**3**	**4-5**
Cost	12	15	30
Behavioral Health	11	19	25
Social Determinants of Health	12	7	14
Value-Based Payment	22	15	19
Business Operations	46	27	24

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	1	7	12	X		X	
CCO Performance and Operations	4	6	5	X		X	
Cost	7	4	7	X		X	

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

Deficiency Analysis

Value-Based Payment
There were relatively few weaknesses regarding value-based payment. The chief concern was that there was no real rationale for the PCPCH payment structure.

CCO Performance and Operations
The performance and operations aspect of NWCCO's application was lacking detail and explanation for their evaluation process for HRS & Social Determinants of Health investments. Additionally, NWCCO does not have a SDOH plan beyond health-related services. It is unclear if Applicant has a strategy for how HRS & SDOH contribute to improving community health. Overall, NWCCO had more good answers than bad, but by a very small margin.

Cost
The cost aspect of NWCCO's operations were relatively weak, but the finance team believes implementing improvements **would be a feasible task**. The applicant left some doubt as to whether they have the capacity to implement meaningful cost containment strategies. The strategies that were mentioned were presented without adequate explanation, not explaining why a strategy was chosen or how it will advance their overall goals. There was no connection between behavioral health services and cost, and little explanation of how behavioral health services could play a role in cost containment. Lastly, there was no mention of how social supports could be integrated to contain costs.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Northwest Coordinated Care Organization, LLC be given a "pass" for the financial section. There are areas that would benefit from process improvement to meet CCO 2.0 requirements, and the applicant did leave some doubt as to whether they are able to implement meaningful cost containment strategies moving forward, but the team believes NWCCO will be able to make these suggested improvements.

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	11	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

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

Deficiency Analysis

Administrative Functions

Responses to this section were high level and limited. Specifically, there is very limited information about plans to monitor for fraud, waste and abuse (FWA) – it appears as if there is only 1 employee handling all FWA issues; there is no information on how they will identify FWA and conduct audits on a regular basis; there is no discussion of tools they will use to perform audits and no description of auditing resources available. Limited detail regarding plans for the providing pharmacy information via the required public facing website. The information provided on TPL was largely responsive but was located in the wrong section. Description of the processes to validate encounter claims is very limited and timelines were not provided. Lacking info on the governance structure – how board members are elected or appointed, major operational procedures and processes missing as well as plans for key committees' composition and functions.

Social Determinants of Health & Health Equity

In general, plans for organizational and provider network practices that ensured the provision of culturally and linguistically appropriate services were lacking. Specifically, there was a lack of information on recruitment and retention of diverse personnel and leadership. There appears to be no language access plan for members to access services and there was no plan for continuing education for staff, on health equity. For SDOH-HE, there is no discussion of how REAL-D data would be used in internal SDOH-HE processes. Individually, the deficiencies above **could be remedied quickly**.

Health Information Technology

Very limited responses and some components were not addressed at all. Overall the Applicant failed to address EHR adoption; the roadmap to adoption did not have any targets or timelines or milestones; all three provider types (physical health, behavioral and oral health) were discussed together which indicates that the Applicant is not aware of provider-specific challenges in EHR adoption; provider HIT training is

missing – they only indicate training for their own staff; HIT plans for years 1-5 were not included and there is not enough detail in the narrative provided to determine if their high-level plans are feasible.

Member Transition

Limited, incomplete and missing responses in this section: no description of the info that they will need to transmit for outgoing members and lacking detail on what types of data would need to be shared, in general; very limited detail on how they will coordinate with other CCOs – what coordination will look like and how this relationship will be maintained; limited detail on the continuity-of-care processes and how it will be maintained during transition; no definition or activities described for warm handoffs indicating a lack of understanding.

Team Recommendation: **FAIL**

- In general, responses were limited, incomplete or not responsive.
- Lack of information on governance structure, on how board members are elected or appointed, what the major operational procedures and processes are, and plans for key committees' composition and functions.
- The FWA unit appeared largely non-existent and only very limited, high-level plans were presented for how to address FWA responsibilities and no tools and resources were mentioned that would be used to reach this goal. The creation of a FWA unit and all monitoring and auditing processes, would take a **significant effort to correct.**
- The high-level and very limited responses to HIT and E.H.R adoption questions, in addition to responses that indicate the Applicant is thinking of HIT only in terms of their own system, the lack of provider-specific considerations and lack of plans for years 1-5, indicated that HIT and E.H.R adoption were concepts the Applicant was either not familiar with or did not have adequate time to address. The creation of an HIT plan and E.H.R adoption plan and system implementation would take a **significant effort to correct.**
- Very limited detail on plans for transferring or receiving members, transition activities or coordinating with other CCOs. The responses demonstrate an incomplete understanding of basic healthcare concepts such as warm hand-offs and how to maintain continuity-of-care during a transition. The creation of a transition and receiving plan, with associated coordination processes and transition activities would take a **significant effort to correct.**

This Applicant's responses were limited, incomplete and sometimes missing entirely. The limited responses to questions inquiring about basic healthcare practices tends to suggest a limited understanding or lack of effort. The identification of multiple items needing **significant effort to correct**, and the overall quality of the responses provided, pointed to a FAIL recommendation.

Care Coordination and Integration

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	1	3	8				
Behavioral Health Covered Services	4	8	24	X			
Health Information Exchange	12	12	4	X		X	X
Care Coordination	43	24	9	X		X	
Care Integration	16	4	1	X		X	

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

Deficiency Analysis

Applicant failed to provide detailed processes for behavioral health benefits and behavioral health covered services. Specific deficiency was noted in the lack of process for training and person-centered planning; discharge planning; and member engagement during the transition process.

Care coordination activities have been identified as underdeveloped. Applicant failed to provide a response on coordination with Medicare and demonstrated significant lack of understanding on differences in care coordination for members with special needs (LTSS, 1915i, etc.). Beyond these issues the applicant provided limited responses on:

- How they will form relationships with DHS – this is a **heavier lift** to resolve
- How crisis management will be conducted
- Descriptions of care coordination model, especially oral health

Team Recommendation: **FAIL**

Care integration responses included no description of how the provider network was developed to address needs, or how this applicant determined network adequacy.

Applicant's ability to support Health Information Exchanges (HIE) were generic and did not commit to any specific path or solution. Very little information was provided in this section of the application. No plan or direction was identified for pursuit and support of HIE technologies.

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	30	38	16			X	
Behavioral Health Benefit	12	12	9	X			
Service Operations	30	12	4				
Administrative Functions	31	13	1	X		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 were lacking detail and did not differentiate between physical, behavioral and oral health providers. Responses indicate that Applicant does not use the grievance system to monitor issues. There was no monitoring of subcontracted activities described. The deficiencies noted indicate a lower level understanding of how to establish network adequacy and utilize grievance and appeal data and would require a **light amount of effort** to establish new methods and processes.

Behavioral Health Benefit

The responses in this section were lacking detail. Applicant didn't identify barriers or process to address them; didn't describe how they would address barriers, didn't appear to understand the purpose of the information or how they would make adjustments based on that information. The deficiencies noted suggest the Applicant may not fully grasp the barriers that exist in their system. An analysis of the barriers in their system could be accomplished with a **small amount of effort**.

Behavioral Health Covered Services

Responses in this section were missing detail. Responses did not address how Applicant would reach out to members with no utilization or how they would reach out to members in general. Reviewers were not sure Applicant understood who their population was. Outreach to SPMI population involved sending a member packet which can be considered insufficient and inappropriate. The deficiencies in this area indicate the Applicant has a limited understanding of Medicaid services, especially SPMI services, and how those services should be care coordinated. The deficiencies in this section are estimated to take a **moderate to large amount of effort** to rectify.

Service Operations

Responses in this section were missing detail. There was no discussion of access to care or medication verification; no clear process for activities; no strategies; did not speak to providing services to members in LTC; cut and pasted responses to multiple questions. The responses provided indicate that the Applicant has challenges understanding its service operations, especially hospital and LTC services. The deficiencies in this section could be addressed with a **significant amount of effort**.

Team Recommendation: **FAIL**

- The Applicant's responses were in general, lacking in detail.
- The deficiencies noted in the Administrative Functions section, indicate a lower level understanding of how to establish network adequacy and utilize grievance and appeal data and would require a **light amount of effort** to establish new methods and processes.
- The deficiencies in the Behavioral Health Covered Benefit section indicate the Applicant has a limited understanding of Medicaid services, especially SPMI services, and how those services should be care coordinated. The deficiencies in this section are estimated to take a **moderate to large amount of effort to rectify.**
- The responses provided indicate that the Applicant has challenges understanding its service operations, especially hospital and LTC services. **The deficiencies in this section could be addressed with a significant amount of effort.**
- The general quality of the responses and the presence of multiple areas requiring moderate to large amounts of effort to address 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	15	2	1	X			
Delivery System Transformation	10	1	1				

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

Deficiency Analysis

Accountability and Monitoring

In general, limited or no information was provided about key areas of this topic: purpose of the program, measurement system, and existing or planned reporting system. There is limited to no information the specific electronic or any other data system that the Applicant will use to collect data to assess performance benchmarks or how the data will be used to incentivize improvements in care and adequately measure that quality of care is being provided.

The applicant did not sufficiently describe who administers the programs. Applicant did not provide information about the system that provides data to share among all stakeholders. Lacking information about the Applicant's Referrals and Prior Authorization process and how it facilitates continuity and coordination of care. Limited description about how to measure, track and evaluate the quality of care including the clinical care, ED utilization, or how the value is calculated.

Applicant did not provide enough information about the corrective action plan – how providers are graded, and what happen the providers/contractors fail to comply with the quality standards or how the providers are being graded.

Delivery System Transformation

In general, very short, incomplete and very limited description of PCPCH delivery system. The applicant does not currently use PCPCH. They do mention working to contract with PCPCHs and that they are providing financial incentives; however, the response lacks information provided about member engagement, outreach and the methods that will be used for potential/new safety net providers to become PCPCH.

For BH and SPMI services, the applicant's analysis is based on claims data rather than prevalence, so analysis is therefore not comprehensive. There is no response specific to SPMI, instead the applicant's response is very broad and speaks to data collection in general. Does not address actual need.

Team Recommendation: **FAIL**

- Lacking information about accountability and monitoring.
- Missing technology platforms for use in measurement and quality.
- Missing significant details about performance system, corrective action plans and processes
- Missing processes for subcontractors
- No information about how gaps are identified
- Inadequate information about the PCPCH system of care. Insufficient description of applicant's plans underway for PCPCH relationships.

Lacking response for covered populations, specifically SPMI. Lack of detail or a feasible plan.

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	1	4	15			X	
Community Engagement Plan	11	16	33	X		X	
Community Engagement	4	4	2		X	X	
Governance and Operations	12	7	11		X	X	

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

Deficiency Analysis

- Did not explicitly state how public providers were included or how input used in application development.
- Means to build relationships not very detailed and not well thought out for each unique organization or agency.
- Means for community input into CCO decisions beyond CAC or RCAC not addressed.
- Not clear that member voice sufficiently elevated thorough the CAC or RCAC. No clear member engagement in care planning beyond member handbook and some health fairs.
- Not enough details on experience or capacity to address health disparities. No mention of explicit steps to establish agreements with county government.
- No details on how will partner with other CCOs.
- Did not fully address how HRS aligned with CHP priorities. Did not differentiate between flexible services and community benefit initiatives of HRS.
- Conflict of interest policy is weak and does not clearly state how process for funding is transparent.

Team Recommendation: **PASS**

- Provide more information about how will build relationships within community, as well as elicit community input outside of CAC. Could take input more frequently.
- Provide more details about member-centric activities and how will elevate member voice, especially with CAC engagement with governance.
- Demonstrate improved understanding of existing relationships in community based on potential shared service area with another CCO.
- Generally, needed more focus on race and ethnicity, diversity, with emphasis on clear strategies to engage.
- Community engagement plan generally inadequate, but unclear if due to no clear strategy detailed or not planning for a good strategy. Recommend TA and guidance from OHA to overcome.
- Greater detail on governance relationships with CAC and how CAC will meet statute.
- Greater detail on prior experience addressing disparities and capacity to do so moving forward, including how data will inform the work.

Community Engagement – Community Letters of Support

An inventory of the letters of support, the type of entity submitting the letter, and the alignment with the Applicant's Community Engagement Plan tables

Organization Name	Type	Notes
Adventist Health	Hospital, Medical Clinics	
Albertina Kerr	Children's BH, crisis, residential placement	Describes support for Applicant's Affiliated entity
Clatsop Behavioral Healthcare	BH, SUD	Letter submitted identifies EOCCO, not Applicant
Columbia Community Mental Health	BH, SUD, DD, Medical	Letter submitted identifies EOCCO, not Applicant
Columbia Memorial Hospital	Hospital	
DHS District One - CW and SSP	Public Child Welfare, Self-Sufficiency Programs	Describes support for Applicant's Affiliated entity
Early Assessment and Support Alliance Center for Excellence	BH, early psychosis intervention	
GOBHI Board of Directors	BH, SUD	Describes support for Applicant's Affiliated entity
OHP Member	OHP Member, BH	Describes support for Applicant's Affiliated entity
Kate Allen, Community Development Services	Affordable Housing Professional	Describes support for Applicant's Affiliated entity
N.Winters	Retired Provider, LPC	Describes support for Applicant's Affiliated entity
National Alliance on Mental Health - NAMI	BH, SUD	Describes support for Applicant's Affiliated entity
North Coast Recovery Foundation	Partial Hospitalization, Intensive Outpatient and DUII, MAT, housing	Describes support for Applicant's Affiliated entity
Northwest Housing Authority	Local Housing Authority, SUD housing, low-income housing	Describes support for Applicant's Affiliated entity
NW Early Learning Hub _GOBHI	Early Learning Hub	Describes support for Applicant's Affiliated entity
ODS Community Dental	Dental Clinics	
Oregon Family Support Network - OFSN	Child, Family BH support specialists, crisis wraparound	

Community Letters of Support

Organization Name	Type	Notes
Oregon Food Bank	Food, Education, Nutrition	
Oregon Infant MH Assoc	Early Childhood Development	
Oregon Recovers	SUD Provider Association	Describes support for Applicant's Affiliated entity
Oregon Rural Practice-based Research Network - ORPRN	Rural Health research, partnerships, coaching, education	
OSU Center for Health Innovation	Workforce Development	
R. Stemper	Construction Project Manager, housing	Describes support for Applicant's Affiliated entity
Rinehart Clinic & Pharmacy	Medical Clinic and Pharmacy	
Senator Johnson	Elected Official	
OSU College of Public Health	Center for Children and Families, Oregon Parenting Education Collaborative	Describes support for Applicant's Affiliated entity
Trillium Family Services	BH, Children and Families	
Yakima Valley Farmworkers	FQHC	
Youth ERA	Peer-delivered services for transitional age youth 14 - 25	Describes support for Applicant's Affiliated entity

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 response indicates delegating full responsibility of the behavioral health benefit. Their global budget strategy is not clear in the response. Applicant bases behavioral health needs estimates on utilization, rather than prevalence. Applicant did not explain the role of behavioral health practices/services in cost containment.

Applicant does not have a strategy for integration of the behavioral health benefit or services. Applicant provides philosophical perspective but does not outline a plan for seamless service - does not demonstrate services will be *integrated only co-located*. Applicant lacks a strategy to integrate services and articulates acceptance that smaller communities may not do so. Lacking a strategy for these communities, the applicant accepts a lack of integration in its service areas. Additionally, the applicant describes a current pilot project that integrates physical and behavioral health but does not build on learning from the existing pilot.

Recommendations: Applicant to take full responsibility for behavioral health benefit. Applicant to describe strategic plan to facilitate and ensure seamlessly integrated services. Applicant to develop strategy for service integration in all communities.

Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
4	7	1	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

Lincoln	197	1.70%
Linn	-131	-0.43%
Malheur	755	7.84%
Marion	534	0.65%
Morrow	35	1.29%
Multnomah	2,249	1.38%
Out-of-State	-97	-73.48%
Polk	181	1.15%
Sherman	49	15.91%
Tillamook	172	3.00%
Umatilla	1,015	5.87%
Union	568	9.78%
Unknown	-15	-57.69%
Wallowa	123	7.48%
Wasco	254	3.94%
Washington	708	0.85%
Wheeler	33	11.70%
Yamhill	226	1.14%
Total Enrolled in a CCO	13,193	1.57%

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

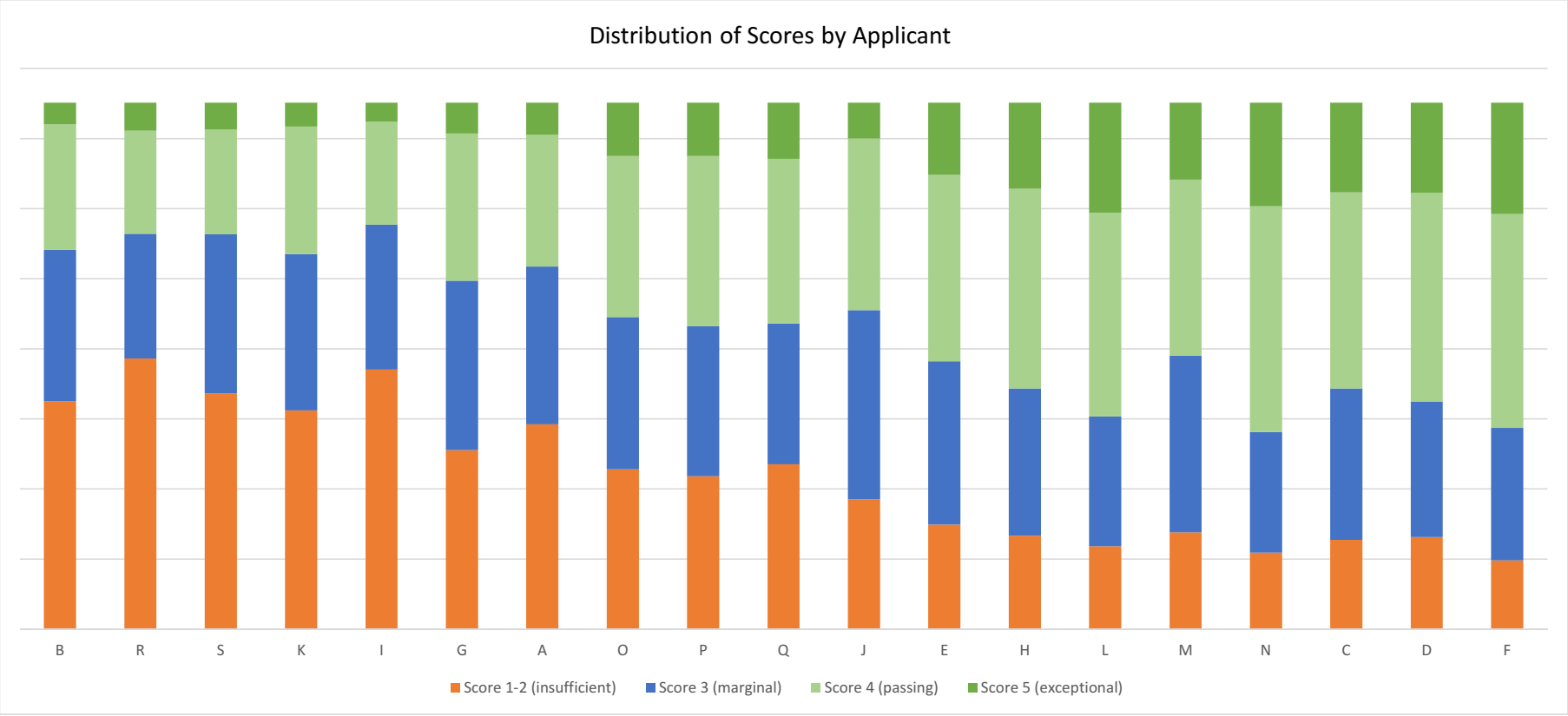
Members with no claims history

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

Pass/Fail by Category

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

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



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

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

Note:

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

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

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

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

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

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

using data as of 5/22/19

CONFIDENTIAL UNTIL 7/9/2019