RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant C
PacificSource Community Solutions – Columbia Gorge

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

CONFIDENTIAL

CONFIDENTIAL UNTIL 7/9/19

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

CONFIDENTIAL UNTIL 7/9/19

CONFIDENTIAL

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.

CONFIDENTIAL

Executive Summary

Financial Analysis

- PSCS – CG is an existing CCO division of PSCSCCO. All four PSCS divisions are potentially sharing resources. The resource allocation method is unclear.
- DCBS performed the financial evaluation and found results to be reasonable for projections provided.
- ASU raised concerns about capital funding and multiple CCOs under PSCS, specifically that C&S could be redundantly recorded across these four applications.

Service Area Analysis

- PSCS – CG is requesting to serve Hood River and Wasco counties, with no service area exception request.
- PSCS – CG is the only applicant in this service area. High likelihood that enrollment falls within the proposed min-max range.

Evaluation Results – Team Recommendations

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

Community Letters of Support

- 20 letters of support from a variety of providers and local entities

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

PSCS – CG's responses to informational questions scored high across all informational questions - VBP, Social Determinants of Health, Behavioral Health, Cost and Business Operations.

CONFIDENTIAL

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 28, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: Oregon Health Authority CCO 2.0 – DFR Financial Review

PacificSource Community Solutions (PSCS) – Columbia Gorge CCO

I have performed a review of PacificSource Community Solutions – Columbia Gorge, that includes pro forma financial information, audited financials, Articles of Incorporation, biographical affidavits, and corporate narratives related to operations and holding company transactions and affiliations.

PacificSource Community Solutions – Columbia Gorge is one of four separate CCOs managed by the PacificSource group of companies, and more specifically, PacificSource Community Solutions, a successful CCO. PacificSource Community Solutions is well-established as a CCO, and is expanding its geographic service area. PSCS is applying for expansion of their operations under the umbrella of the single entity of PSCS. As part of the PacificSource holding company system, which includes health insurers, PacificSource Health Plans (NAIC #54976) and PacificSource Community Health Plans (NAIC #12595), PSCS may have access to additional parental resources.

Upon review of the CCO application submission for Columbia Gorge, the results appear to be reasonable for projections provided.

As PSCS is expanding their operations from just the Central Oregon and Columbia Gorge areas into Marion & Polk Counties and into Lane County, resources must be mutually shared/allocated to each of the four (4) divisional CCO operations of the company. Information presented appears to indicate that the resources are wholly and exclusively available to each of the four (4) divisions to the exclusion of the other three (3) divisions. While the company is able to recognize synergetic benefits from diversifying their risk, those resources must be mutually available to all four (4) divisions unless some allocation process is established. As

CONFIDENTIAL

such, the Analyst reviewed the pro forma financial statements as presented by the company indicating that the Applicant may have exclusive and unallocated access to the company's entire resources.

NOTED for CONSIDERATION:

Resource information provided by the Applicant appears to report that all of PSCS' resources would be wholly and exclusively available to the Lane County operations and thus would not be available to the other three PSCSCCO applicants. While the Company would be able to recognize synergetic benefits from diversifying their risk, the Analyst believes that those resources are mutually available to all four (4) operations and thus should not be illustrated as being wholly and exclusively available to only one (1) operation.

Note: This analysis would be substantially different if the Applicant was to be reviewed using only the resources exclusively allocated to the Applicant it alone. Ratios such as Premiums to Surplus, Liquidity Ratio, and RBC & ACL calculations would be significantly different on a resource allocation basis.

There is concern that by using a single entity to operate four (4) different CCO's, but present the financial information as "broken up" between each entity, that the applicant may not have the financial resources available to operate such a large business entity. OHA should ensure that if a contract is offered, that there is a separate legal entity per location with dedicated Capital & Surplus, with calculated RBC amounts per entity. Otherwise, they will need to file a consolidated financial statement for each of the operating areas, with aggregated RBC (ACL) calculations. Doing a consolidated statement provides for the appropriate risk assessment of the operations, but would appear to not provide the clarity and transparency the OHA is looking for in the financial statement presentation for each CCO. Based upon the total C&S provided, they have an aggregate amount in excess of $200 million, which DCBS is unsure how they could raise those types of funds to contribute without being an immediate financial detriment to their insurance companies.

DCBS would consider the financial presentation in the Pro-Forma for all four of the applicant CCO's to be incorrect, misleading and not viable to allow for an assessment of the company for a CCO contract.

Using a combined RBC calculation from the numbers provided (which may include duplications for Asset Risk, which should be a very minor portion of the ACL calculation for RBC) would give the company in their Best Enrollment projection an RBC of 147.9% as of 12/31/2020 at the best guess, or 145.4% under the lowest C&S amount provided. Those values would not meet the OHA standards.

As such, without the Applicant providing allocated resource data, the Analyst reviewed the pro forma financial statements as presented by the Company, indicating that the Applicant has exclusive and unallocated access to the Company's entire CCO resources.

CONFIDENTIAL UNTIL 7/9/19

A complete review could not be conducted given the lack of scenario data provided, as noted periodically in the Analyst Calcs worksheet and in the review conclusions below.

RBC Review/Enrollment Projections:

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 76%, Minimum ('MIN') 59%, and Maximum ('MAX') 145%.

The Applicant is able to maintain an adequate RBC at all three levels of enrollment (Best Estimate, Minimum, and Maximum), and all Claims +2%, +4%, +6% projections, and combined enrollment/claims deviation projections for all three years, beginning with 2020, through 2022.

At Best Estimate, the applicant would not see a reduction in RBC down to the 200% level until claims hit 81% higher than projected in the first year, and 80% in the second and third year.

That being said, changes in enrollment, either up or down, do not appear to significantly impact profitability and RBC of the company.

At no point in these scenarios are the losses close to even 5%, much less 20% of C&S, or anywhere close to 50% of C&S, except for a 6% increase in claims costs at the maximum enrollment, Years 1-3, at which point it exceeds 5%. The CCO met the basic capital and surplus and RBC requirements under all presented scenarios.

BE MM Years 1-3:

5% of Surplus:	2,417,851	2,486,293	2,560,788
+2% Claims	334,427	418,465	507,223
20% of Surplus:	9,671,403	9,945,171	10,243,152
+4% Claims	(584,703)	(531,909)	(475,456)
50% of Surplus:	24,178,509	24,862,928	25,607,879
+6% Claims	(1,503,833)	(1,482,283)	(1,458,136)

MIN MM Years 1-3:

5% of Surplus:	2,407,053	2,463,433	2,524,535
+2% Claims	322,717	388,418	457,747
20% of Surplus:	9,628,211	9,853,731	10,098,141
+4% Claims	(392,162)	(350,762)	(306,559)
50% of Surplus:	24,070,528	24,634,327	25,245,354
+6% Claims	(1,107,041)	(1,089,941)	(1,070,865)

MAX MM Years 1-3:

5% of Surplus:	2,447,196	2,542,933	2,642,531
+2% Claims	79,199	90,094	101,731
20% of Surplus:	9,788,785	10,171,733	10,570,122
+4% Claims	(1,682,067)	(1,734,553)	(1,788,485)
50% of Surplus:	24,471,963	25,429,333	26,425,306
+6% Claims	(3,443,334)	(3,559,199)	(3,678,700)

CONFIDENTIAL UNTIL 7/9/19

The pro forma financials included a profit and loss statement for estimated enrollment, minimum enrollment, and maximum enrollment. The three enrollment scenarios include an RBC projection. PSCS – Columbia Gorge projected an RBC of two to three times the minimum requirement for the CCOs within all three scenarios, for all three years.

Additionally, the Assumptions that have been used by the Company for their "ideal" or "best estimate" scenario appear to be right on target, within 2-3% of the capitation rate, and loss ratio. OHA is assuming a 31% higher enrollment rate, based on capacity, but did not note any concern with the assumptions used.

Liquidity Review:

The Applicant appears to have sufficient assets to meet their liability obligations without reliance on positive cash flow from operations under each of the three scenarios. They maintain a liquidity ratio of at least 100% in each year at the "best estimate" scenario with no deviation in claims. It does not appear that claims increases impact liquidity down to the 100% threshold until upwards of 105-106% of an increase in claims costs is projected, which is significant, and not likely. In Year 2 and Year 3, claims would need to surpass 104-105% for liquidity to fall under 100%.

EXPECTED MEMBERSHIP and CLAIMS

Liquidity Ratio (Liquid Assets/Current Liabilities)	628%	605%	586%
At 2% increase in claims costs:	617%	594%	576%
At 4% increase in claims costs:	606%	584%	565%
At 6% increase in claims costs:	594%	573%	555%

MINIMUM MEMBERSHIP and CLAIMS

Liquidity Ratio (Liquid Assets/Current Liabilities)	763.38%	732.43%	706.24%
At 2% increase in claims costs:	752.29%	721.74%	695.91%
At 4% increase in claims costs:	741.20%	711.06%	685.57%
At 6% increase in claims costs:	730.11%	700.38%	675.24%

CONFIDENTIAL UNTIL 7/9/19

MAXIMUM MEMBERSHIP and CLAIMS

Liquidity Ratio (Liquid Assets/Current Liabilities)	389.40%	379.32%	370.83%
At 2% increase in claims costs:	377.72%	368.11%	360.01%
At 4% increase in claims costs:	366.05%	356.90%	349.20%
At 6% increase in claims costs:	354.38%	345.69%	338.38%

Additionally, the Applicant appears to have resources available for further capitalization as needed. However, the assets available could be limited, though, with four CCO applicants within the organization, and the resources may be more strained and limited than if done under a single application.

Net Income Review:

Net Income was positive for each of the first three years under the Best Estimate, Minimum, and Maximum enrollment scenarios.

Net Income (BE MM): Year1=$1,253,557 Year2=$1,368,838 Year3=$1,489,903

Net Income (MIN MM): Year1=$1,037,596 Year2=$1,127,597 Year3=$1,222,053

Net Income (MAX MM): Year1=$1,840,465 Year2=$1,914,740 Year3=$1,991,947

An increase of 2% in claims costs still resulted in Net Income for all three years, and all three scenarios.

Net Income (BE MM): Year1=$334,427 Year2=$418,465 Year3=$507,223

Net Income (MIN MM): Year1=$322,717 Year2=$388,418 Year3=$457,747

Net Income (MAX MM): Year1=$ 79,199 Year2=$ 90,094 Year3=$101,731

An increase of 4% (and 6%) in claims costs, for all three years, and all three scenarios, showed net losses, even with liquidity and RBC intact.

Net Loss (BE MM): Year1=($ 584,703) Year2= ($ 531,909) Year3=($ 475,456)

Net Loss (MIN MM): Year1=($ 392,162) Year2=($ 350,762) Year3=($ 306,559)

Net Loss (MAX MM): Year1=($1,682,067) Year2=($1,734,553) Year3=($1,788,485)

Net Loss (BE MM) Year1=($1,503,833) Year2=($1,482,283) Year3=($1,458,136)

Net Loss (BE MM) Year1=($1,107,041) Year2=($1,089,941) Year3=($1,070,865)

Net Loss (BE MM) Year1=($3,443,334) Year2=($3,559,199) Year3=($3,678,700)

CONFIDENTIAL UNTIL 7/9/19

CONFIDENTIAL

A Net Loss occurs between 2.0% - 3.2%. The point at which a Net Loss occurs is between the given scenarios of a 2% and a 4% increase in claims costs. The company appears to be well capitalized and set to absorb losses, should they occur. However, significant claims costs could be a risk to liquidity and their ability to pay. Changes in claims costs, even at 2%, do impact profitability/net income of the company. The break-even point is between a 2.75% and 3.2% increase in claims.

PREMIUM to SURPLUS

The Applicant's Premium to Surplus ratio is:

Expected Membership & Claims +0%: 1.1:1, 1.1:1, and 1.1:1 for each year, respectively

Minimum Membership & Claims +0%: 0.84:1, 0.84:1, and 0.85:1 for each year, respectively

Maximum Membership & Claims +0%: 2.0:1, 2.0:1, and 2.0:1for each year, respectively

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

These are within the acceptable range and indicate that they are able to continue growth and underwrite new policies.

OTHER

The audited financials for PSCS were reviewed and no material concern was noted. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in each of the three years from 2015 through 2017 and reported net income between $7.5M and $12.0M in each year. Total capital and surplus was $46.3, $47.6M, and $35.8M at year-end 2015, 2016, and 2017, respectively.

NOTE: This is for PSCS as a WHOLE.

The Articles of Incorporation were reviewed and no concern was noted. The Articles of Incorporation provided were in fact Articles of Merger, delineating the process of the merger between Conners Group (CG) and PacificSource Community Solutions, Inc. (PCSI), a then wholly-owned subsidiary of the former, resulting in PacificSource Community Solutions (PSCS), a non-profit corporation. Exhibit A is the Agreement and Plan of Merger, which states that the Articles of Incorporation, Bylaws, and Board of Directors and Officers of CG remained in place, except for the name of the new non-profit entity.

They were filed with the Oregon Secretary of State Corporation Division on June 27, 2016. The Articles of Merger were filed on December 30, 2016, and were accepted as filed. No issue or concern.

CONFIDENTIAL

The biographical affidavits / Resumes were reviewed and no concern was associated with the or Board of Directors members. Every Director or Officer included a statement about regulatory issues that the PSG was subject to through both CMS and DFR, but they did not disqualify anyone from serving in any way. There was only one other disclosure that again, has no bearing on their ability to be appointed. They were recently reviewed in depth via the DFR examination process, revealing no anomalies, records, or other concerns, and they qualify to serve on PSCS's board pursuant to ORS 414.625(2)(o).

[End of summary]

CONFIDENTIAL

ASU Analysis of Applicant Financial Assumptions

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

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

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**
108,000	141,477	206,016	84,000	131%	none

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$450.80		$479.14	$462.46	-3%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
89%	87%	2%

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

Population Trend	
Applicant Assumption	**OHA Assumption**
0.34%	0.34%

OHA assume 100% market share. PSCS - Gorge assumes 76% market share. 100% market share is below applicant's current capacity (8147 in Hood River and 9021 in Wasco.)

PacificSource applicants may be reporting partially combined balance sheets in their pro formas. This would effectively quadruple-count most of their 12/31/2018 C&S, which would in turn inflate the projected RBC

CONFIDENTIAL UNTIL 7/9/19

ratios. ASU agrees with DCBS that if all applicants' RBC was combined, and only one of the reported C&S figures was used, the aggregate RBC level as of 12/31/2020 would be around 145% to 165%.

- Recommend OHA clarify with PS the extent to which C&S is "shared" (i.e. redundantly recorded) across these four applications.
- If C&S is mostly quadruple-counted, suggest OHA consider denying one or both new applications unless additional capital is contributed to get to a total of 200%.
    - For example, denying PSCS - Lane application would result in approximately 200% combined RBC for remaining three CCOs in absence of any additional capital. Similar result holds true if only PSCS – Marion Polk application is denied.
- Suggest OHA consider whether a consolidated pool of capital is acceptable, or whether two to four separately financed entities would be preferable.

Admin load % and profit margin assumption

In the FY2020 projection under the BE MM scenario, three of the four PSCS CCOs (Columbia Gorge, Central Oregon, Marion & Polk) projected high admin load ratios (9.2%, 9.3%, 10%, respectively), which is way above two existing CCOs (Columbia Gorge, Central Oregon)'s admin ratio in the past. From FY2013 to FY2018, PSCSG and PSCSC's admin load ratio ranges between 6.1% to 7.9%.

Capital requirement

PSCS - Gorge and PSCS - Central currently report balance sheet at the consolidated level showing the two entities share the same resources, and their total C&S at end of FY2018 is $43.6M, while $9M of it was goodwill.

Per the applications submitted, the four CCOs' resources are wholly and exclusively available to each of the four divisions, and the aggregated amount of C&S for four CCOs would be up to $198M.

This means that the parent company PSCS needs contribute additional $163M into the four CCOs at the beginning of or during 2020. The capital funding is questionable given the large dollar amount.

Risk: questionable capital funding

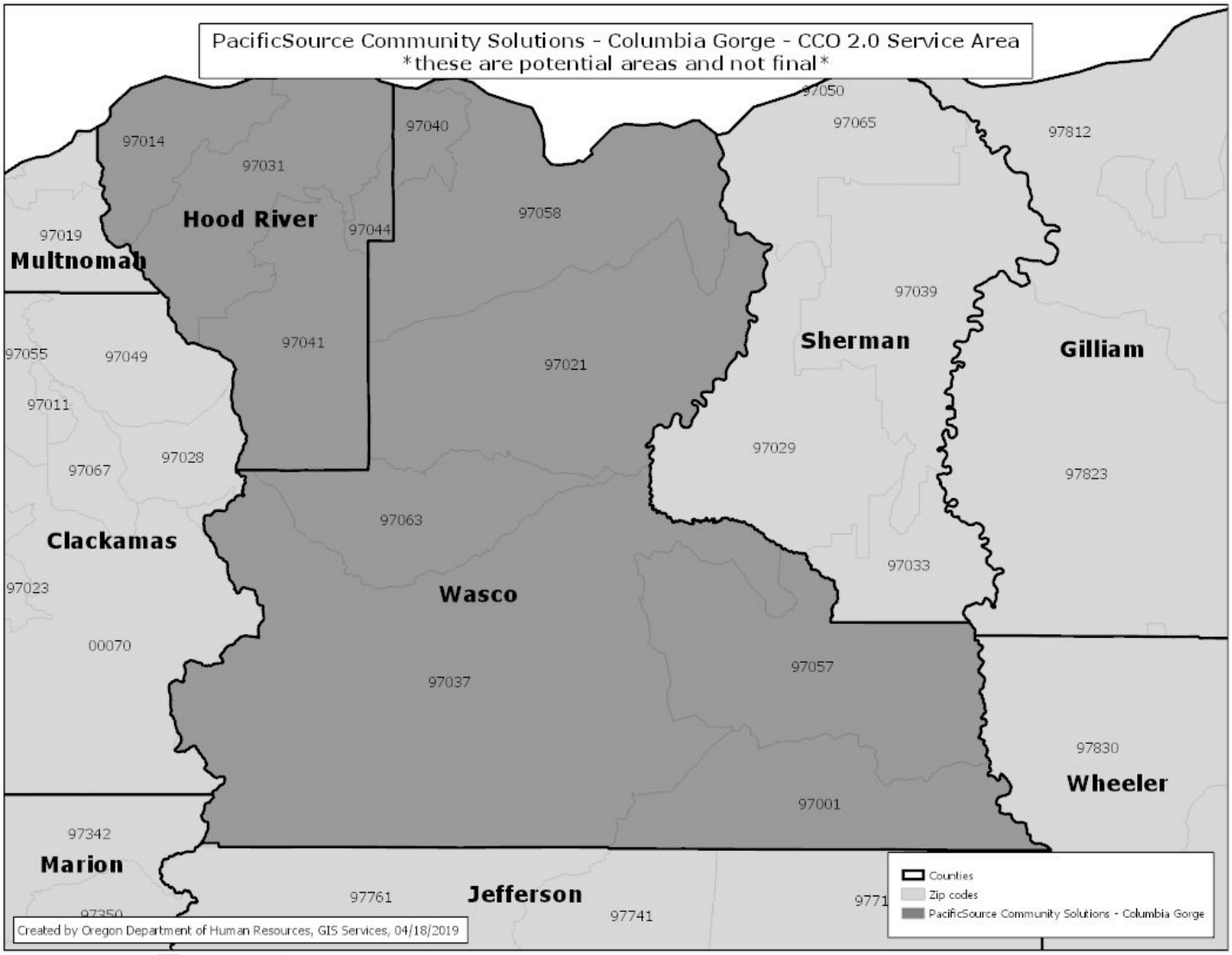
Recommendation: Request PSCS to provide detailed plan of the capital source; or do not award more than 2 PacificSource applications.

CONFIDENTIAL

Service Area Analysis

Requested Service Area

Applicant is requesting to serve the entirety of Wasco and Hood River 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 summary	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Hood River and Wasco	-	No modeling performed. Pacific Source Gorge would be the only CCO serving these counties. A significant number of Open Card members would have to join the applicant, or a significant number of current members would have to leave in order for the applicant's enrollment to fall outside of their min-max range.			

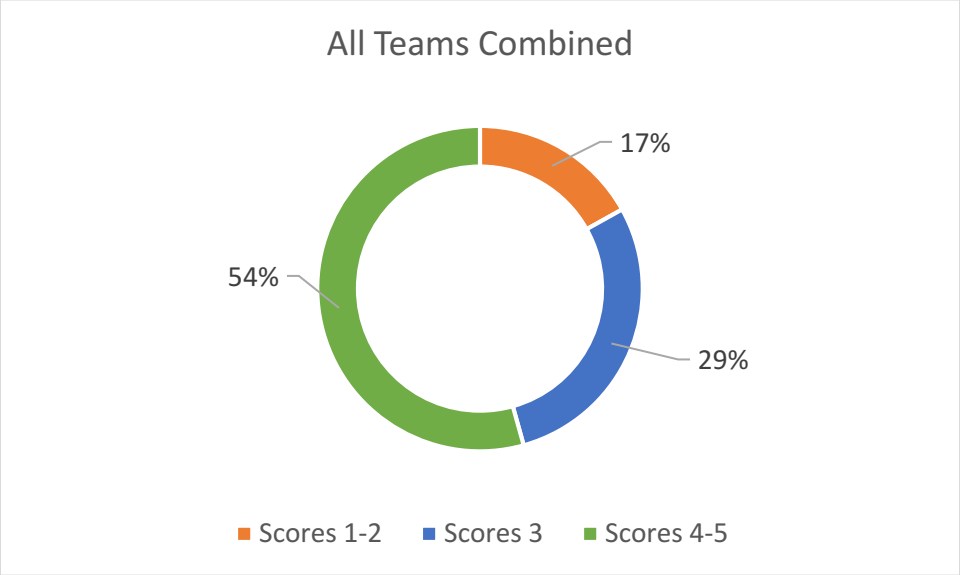
Member Allocation Projection

No member allocation tests performed. PacificSource – Columbia Gorge would be the only CCO serving these counties.

CONFIDENTIAL

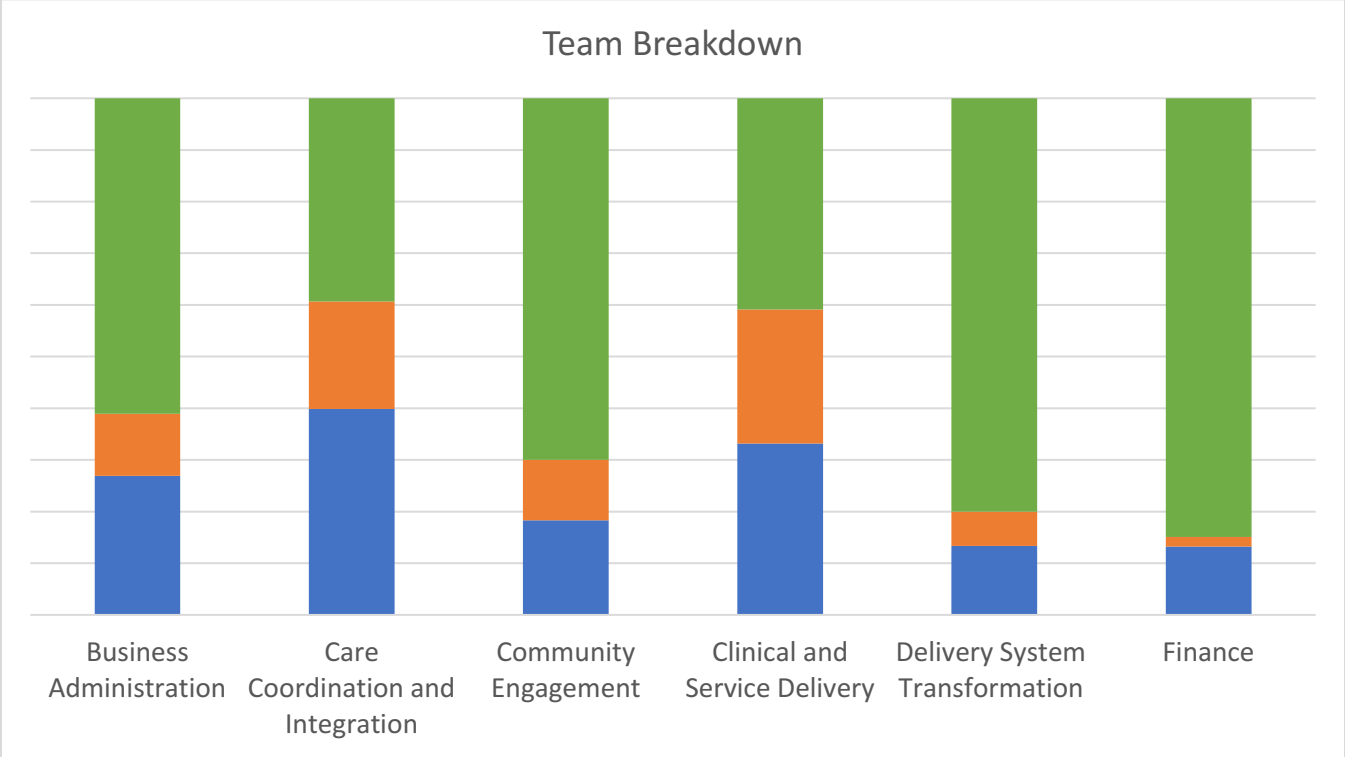
Evaluation Results – Overall Scores

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



CONFIDENTIAL UNTIL 7/9/19

Overall Team Recommendations

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	1	1	34
Cost	1	6	27
Social Determinants of Health	11	18	84
Business Operations	79	130	182
Behavioral Health	35	61	81

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**
Value-Based Payment	1	10	45
Cost	4	8	45
Social Determinants of Health	4	5	24
Behavioral Health	5	18	32
Business Operations	22	26	49

CONFIDENTIAL

Finance

Evaluation of questions related to Pharmacy Benefit Manager arrangements, tracking and reporting of Social Determinants of Health and Health Equity expenditures and outcomes, quality pool funds, Health Related Services investments, managing within the global budget, and sustainable growth.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Value-Based Payment	0	0	20				
CCO Performance and Operations	0	2	13				
Cost	1	5	12				

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

Deficiency Analysis

Value-Based Payment

PSCS Gorge received a passing grade from all members of the financial review team.

CCO Performance and Operations

PSCS Gorge had no significant deficiencies related to CCO performance and operations.

Cost

There were no deficiencies identified related to cost.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that PacificSource Community Solutions – Columbia Gorge be given a “pass” for the financial section. PCSCG had no significant deficiencies in any of the categories.

CONFIDENTIAL

Business Administration

Evaluation of questions related to CCO business operations, claims and prior authorization, Health Information Technology adoption, data collection, communication to providers, publication of coverage guidelines and criteria, encounter data processing and validation, member transition, including processing incoming members, identifying providers, communicating information to members, and supporting the migration of members during transition.

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Health Information Technology	7	4	29	X			
Social Determinants of Health	2	6	20	X			
Member Transition	4	12	20	X			
Administrative Functions	7	23	33	X			

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

Deficiency Analysis

Administrative Functions

This section was largely responsive but lacked a little detail on how Medicare services would be monitored for FWA. There was no mention of the exact business functions of subcontractors and how they will be monitored. These issues **could be fixed relatively quickly**.

Health Information Technology

HIT roadman was submitted as a narrative, but major components were present. Missing info on 5-year plans for E.H.R. All deficiencies **could be remedied fairly quickly**.

Member Transition

All answers lacked some detail. Warm handoff responses were very high level and no activities were specified. These was some detail missing on how information/data would be shared or collected from other CCOs and their responses regarding coordination with providers omitted specialty providers. Deficiencies identified **can be addressed relatively quickly**.

Social Determinants of Health

Limited detail on how funding for SDOH projects is awarded and applied for. No overall strategy for how SDOH money is being tracked -only grant money is mentioned. Didn't answer how technology will be used to comply with reporting plan and lacked detail in how information on SDOH money would be communicated to providers and community. **All issues could be remedied relatively quickly**.

CONFIDENTIAL UNTIL 7/9/19

Team Recommendation: **PASS**

- Vast majority of answers were responsive to questions and only missing smaller amounts of detail. All deficiencies identified were considered to be **easily remedied**.
- Recommendation that member transition deficiencies be addressed – more specifics needed on how Applicant plans to share data with other CCOs, how they will coordinate care with specialty providers during transition, and what types of warm handoff activities they will offer.
- More detail needed on who Applicant's major subcontractors are and how they will be monitored.

CONFIDENTIAL

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
Care Integration	2	2	17	X			
Behavioral Health Covered Services	8	13	15	X			
Health Information Exchange	3	14	11				
Behavioral Health Benefit	3	5	4				
Care Coordination	20	35	21	X			

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

Deficiency Analysis

Applicant failed to provide milestones or dates for behavioral health benefits plan. Local Mental Health Authority seemed to lead Behavioral Health initiatives, minimal role was ascribed to the Applicant. No processes were described for assessing Behavioral Health workforce and weak strategies were defined for identifying SPMI member needs and how to connect those members with housing partners. Planned outreach to tribal partners was provided but vague, indicating a lack of planning.

Care coordination activities did not address Dual Eligible population, coordination with DHS LTSS or cross-system collaboration. Limited detail was provided on crisis management, screening and follow up; family involvement in care planning and discharge; existing agreements with current Behavioral Health partners.

Team Recommendation: **PASS**

Care integration responses generally well received, however, the applicant provided limited detail on how primary care will execute referrals to other services. No plans were provided for performance monitoring of providers. Applicant provided no strategy to ensure access to services for tribal populations.

Applicant's ability to support Health Information Exchanges (HIE) was well developed and did not raise concerns among reviewers.

CONFIDENTIAL UNTIL 7/9/19

Clinical and Service Delivery

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	5	5	23	X		X	
Service Operations	11	14	21				
Behavioral Health Covered Services	19	36	29	X		X	
Administrative Functions	19	14	12	X		X	

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

Deficiency Analysis

Administrative Functions

Reliant on case by case resolutions, not a lot of process or strategy that is standardized; no approach that dealt with issues at the root cause; no mention of grievances impacting wait time;

No mention of members ability to access care from non-par and out of area providers; strengthen methodology for analyzing information, discussed specific programs but not how they are using them; if community standard is removed Applicant will need to work on another method to calculate network adequacy. The deficiencies identified (standardized processes and better strategies, etc.) are estimated to take **smaller amount of effort to remedy**.

Behavioral Health Benefit

Services, tools and measurements are reliant on future work for a governance council, didn't discuss the interim plan while the long term strategy is being developed; no clear process for in-home services; would need to provide detail on their actual process in lieu of stating they will develop one; did not address capacity or how clients are engaged, measuring and monitoring, not clear about how the member voice would be included. The deficiencies noted (missing strategies and processes) could be remedied with **small amount of effort**.

Behavioral Health Covered Services

No communication to members described, used language that may be viewed as disrespectful in describing specific groups of people ("aged"), mostly reliant on a welcome call for care coordination; no detail around how to educate or engage members; unclear how members are informed about services, mostly conversation about providers rather than members; member perspective not reflected; only discussed OSH as connection to ACT does not reflect understanding of the program, seemed disconnected from services.

CONFIDENTIAL UNTIL 7/9/19

Did not answer the question around monitoring members and utilization; dismissive of communication and support of peer delivered services.

The deficiencies noted in this section (processes and shift towards more member-oriented perspective) **could be remedied with small amount of effort**.

Service Operations

No detail about how information is provided to members; no detail on medical necessity; no differentiation between ambulatory and acute; could be addressed with a clearer process. The deficiencies noted (additional detail needed and clearer process) **could be remedied with a small amount of effort**.

Team Recommendation: **PASS**

- In general, the answers provided were responsive to questions
- Would need to see that Applicant has developed strategies for applying the data for quality improvement
- The deficiencies identified in all sections (more standardized processes, better strategies, and a more member-oriented approach) are estimated to take **smaller amount of effort to remedy**.
- The quality of the answer and deficiencies that would take **smaller amounts of effort to remedy** led to a team recommendation of PASS.

CONFIDENTIAL

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	0	2	16				
Delivery Service Transformation	2	2	8				

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Applicant failed to provide details describing the tools used to push data to stakeholders. Lacking sufficient details about the external programs, their purpose and who administers them. 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, specifically the data infrastructure and key quality indicators and how metrics incentivize improvements in quality of care. Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination.

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

Delivery Service Transformation

Provision of Covered Services – Applicant failed to provide details describing data collection and analysis by sub-categories (by REAL-D).

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as the number of providers and assigned members by tier and provider type. Lacking sufficient information about tier levels, oversight, and engagement of potential new PCPCH providers. Lacking details about the community governance model and joint member engagement and outreach efforts.

CONFIDENTIAL

Team Recommendation: **PASS**

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

Accountability and Monitoring

- Description of the external programs
- How the complaint/grievance information is shared for quality improvement and communicated with providers
- More information about the "data infrastructure" and "key quality indicators" that the Applicant uses
- Detail about referrals and prior authorization process
- Plan for how accountability metrics incentive improvements in care

Delivery Service Transformation

- Specific information about data sources and a plan for collecting data by population sub-category by REALD.
- Plan for oversight of the PCPCH system
- Plan for encouraging potential/new safety net providers to become PCPCH

CONFIDENTIAL

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	8	6	46				
Governance and Operations	3	7	20				
Social Determinants of Health	1	6	13				
Community Engagement	2	3	5				

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

Deficiency Analysis

- Did not describe any of their projects for community engagement.
- Did not discuss tribes in terms of their CAC or health council or engagement.
- Insufficient detail on cultural and linguistic strategies for engaging members in care planning
- SPMI and LTC representation is inadequate on CAC and governance boards
- Lack of detail on capacity and experience related to improving health disparities
- Spending plan didn't include info on how they would ensure an equitable process
- Should have listed the actual milestones/metrics
- Missing COI policy
- Missing info about how outcomes would be shared

Team Recommendation: **PASS**

- Consider how to ensure funding is distributed in a more equitable way
- Develop explicit plan for how outcomes would be shared
- Develop/share COI policy
- Define a QI plan for the CEP
- Engage tribes in a more meaningful way
- Improve community engagement for non-CAC members

CONFIDENTIAL

Community Engagement – Community Letters of Support

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

Organization Name	Type
Advantage Dental	Dental Clinics
Capitol Dental	Dental Clinics
Central Oregon IPA	Provider Association - IPA
Columbia Gorge Health Council	PSCS Columbia Gorge governing and oversight body
DHS District 9	Public SSP and CW Programs
DHS District 9	APD
Hood River Commissioners	Public Health, LMHA
Hood River County Health Department	Public Health
Mid-Columbia Center for Living	Community Mental Health Program
Mid-Columbia Housing Authority	Housing Authority
Mid-Columbia Medical Center	Hospital, Medical Clinics
North Central Public Health District	Local Public Health
North Wasco County School District No. 21	k-12 education
ODS	Dental Clinics
ODS	Dental Clinics
One Community Health	Medical Clinics, Safety Net Providers
Providence Hood River Memorial Hospital	Hospital, Medical Clinics
The Next Door	Youth and family services, Treatment, Health Promo
Wasco County Board of Commissioners	Local Government

CONFIDENTIAL

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 presents services, tools and measurements that are heavily reliant on the future work of the Health Council Governance. This future work, however, has no timelines and very limited detail on its end products. Within this framework, the applicant does not appear to have a clear role in administering the benefit, as it appears that the local LMHA is leading the plans.

Recommendations: Applicant to submit a comprehensive behavioral health plan that details their role and responsibilities. Applicant to provide detailed timelines, milestones and finished products to be delivered by the Health Council Governance. Applicant to provide a detailed interim plan for services while the Health Council Governance completes their plan and deliverables.

CONFIDENTIAL

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.

CONFIDENTIAL

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	7	3	0

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

Team Analysis Meetings

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

CONFIDENTIAL

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.

CONFIDENTIAL

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>

CONFIDENTIAL

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

CONFIDENTIAL

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.

CONFIDENTIAL

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%

CONFIDENTIAL

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%

CONFIDENTIAL

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%

CONFIDENTIAL

CONFIDENTIAL UNTIL 7/9/19

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

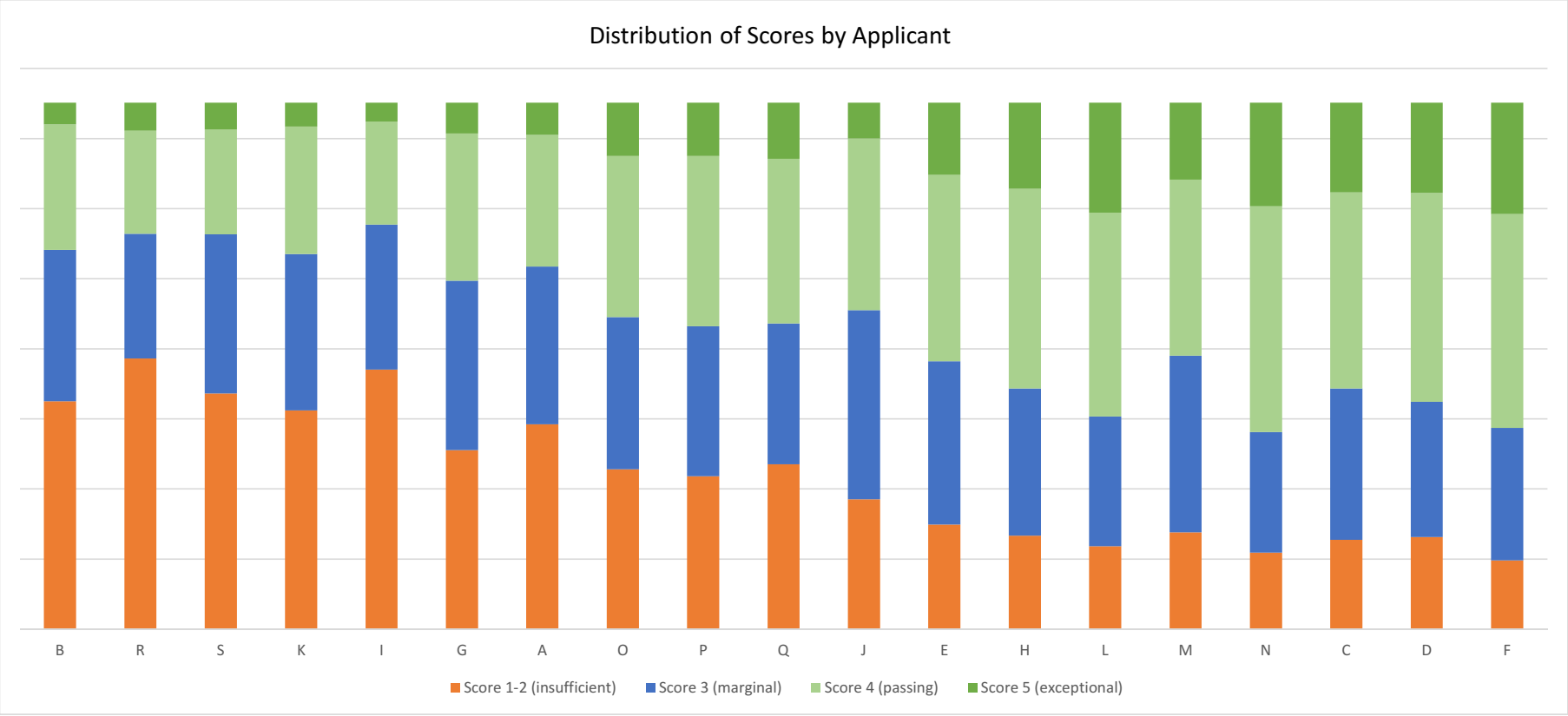
If no claims history exists, then the member's current Case was analyzed. If a member of their case has been assigned to a CCO then this member was assigned to that CCO. If their case has no CCO assignments, then the member moved to the even distribution process. With no claims history and no family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

CONFIDENTIAL

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