RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant L
PacificSource Community Solutions – Marion Polk

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

- PSCS – Marion Polk is a CCO division of PSCSCCO. All four PSCS divisions are potentially sharing resources. The resource allocation method is unclear.
- 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 – Marion Polk is requesting to serve Marion and Polk counties. There is no service area exception requested.
- PSCS – Marion Polk is one of two applicants for this service area. There is low or no risk that the applicant will fail to meet minimum enrollment or exceed maximum enrollment.

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

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

Evaluation Results: Policy Alignment

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

Financial Analysis

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

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: CCO2.0 Financial Review

PacificSource Community Service CCO-Marion&Polk County

I have performed a financial evaluation of PacificSource Community Service CCO (PSCS-MP) application for their Marion and Polk Counties operations based on the materials provided. PSCS is a CCO with current operations in Central Oregon and Columbia Gorge. PSCS is applying for expansion of their operations into Marion & Polk County and into Lane County, all 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.

NOTED:

Resource information provided by Applicant appears to report that all of PSCS' resources would be wholly and exclusively available to the MP operations and thus would not be available to the other three PSCSCCO applicants.

While Company would be able to recognize synergetic benefits from diversifying their risk, analyst believes that those resources are mutually available to all 4 operations and thus should not be illustrated as being wholly and exclusively available to only one operation.

Note: Analysis would be substantially different if 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 166.5% 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 Applicant providing allocated resource data, 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 resources.

Complete review could not be conducted given to the lack of scenario data provided as noted in review conclusions below.

ENROLLMENT

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 33%, Minimum ('MIN') 10%, and Maximum ('MAX') 84%.

RBC REVIEW

RBC, prepared by the Applicant, projects Best Estimate ('BE') RBC of 514.9%, 519.5%, and 524.1% for year-ending 2020, 2021, and 2022, respectively. The applicant would 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 CCO met the basic capital and surplus and RBC requirements under all presented scenarios.

To breach the 200% RBC threshold, Claims would need to increase roughly:

20+% for Expected Membership & Claims +0% scenario;

80+% for Minimum Membership & Claims +0% scenario;

10+% for Maximum Membership & Claims +0% scenario;

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

NET INCOME

To breach the Net Loss threshold of $0, claims would need to increase roughly:

1.5% for Expected Membership scenario;

2.8% for Minimum Membership scenario;

1.1% for Maximum Membership scenario.

LIQUIDITY REVIEW

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:

33+% for Expected Membership scenario;

105+% for Minimum Membership scenario;

19+% for Maximum Membership scenario.

PREMIUM TO SURPLUS

The Applicant's Premium to Surplus ratio is:

3.3:1 for Expected Membership & Claims +0% scenario;

1.1:1 for Minimum Membership & Claims +0% scenario;

5.6:1 for Maximum Membership & Claims +0% scenario;

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

[End of summary]

ASU Analysis of Applicant Financial Assumptions

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

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary.

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**
385,980	396,056	982,920	120,000	103%	385,980

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$460.84		$478.33	$461.11	0%

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

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

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

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 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.

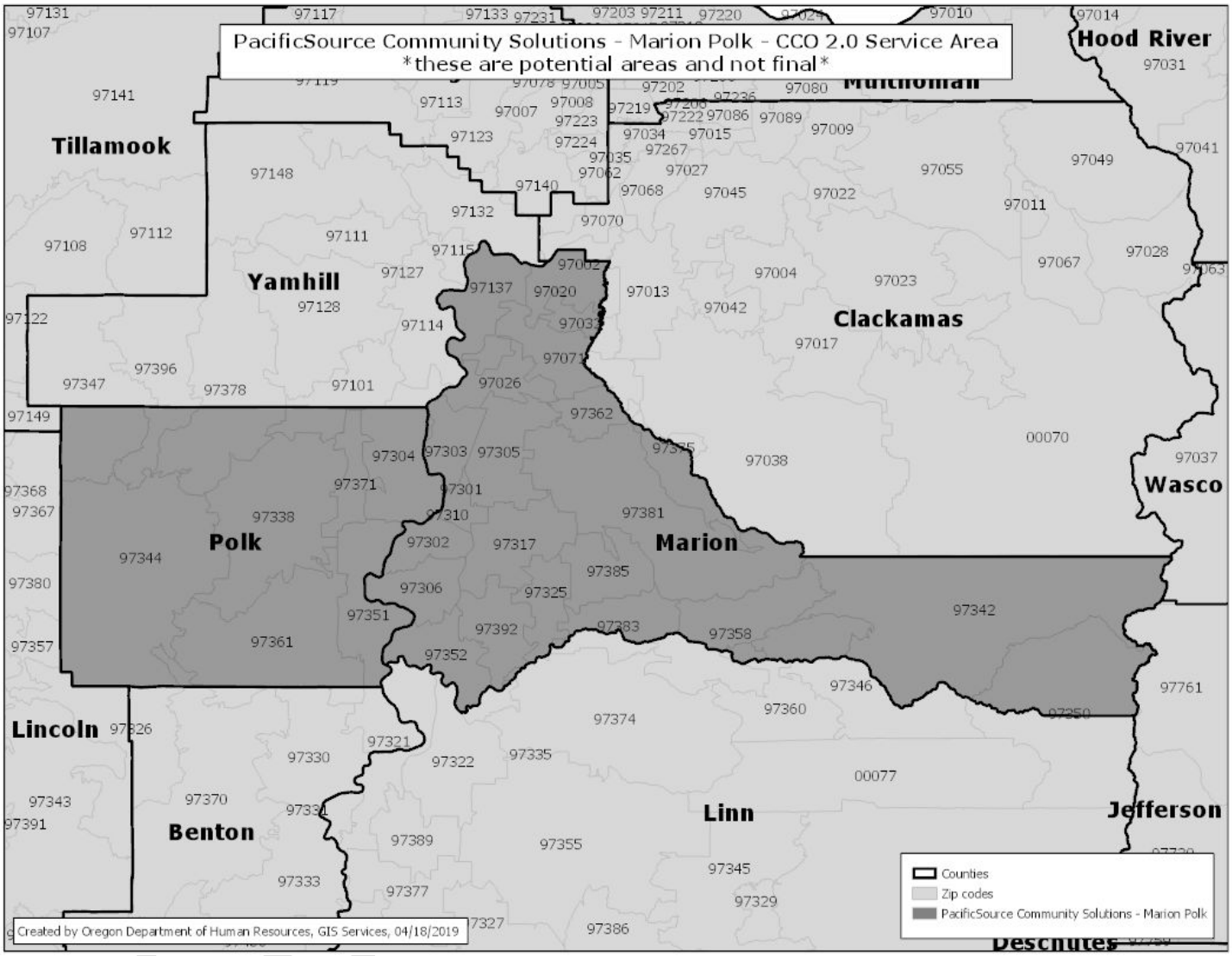
Risk: questionable capital funding

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

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Polk and Marion 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
Marion and Polk	-	Marion Polk Coordinated Care also proposes to serve these two counties, with Yamhill CCO proposing to serve parts of both as well. Pacific Source Marion Polk's minimum enrollment is 10,000 (as compared to Marion Polk Coordinated Care's 62,000)	No scenarios show enrollment below applicant's minimum	No scenarios show enrollment exceeding applicant's maximum	Low risk

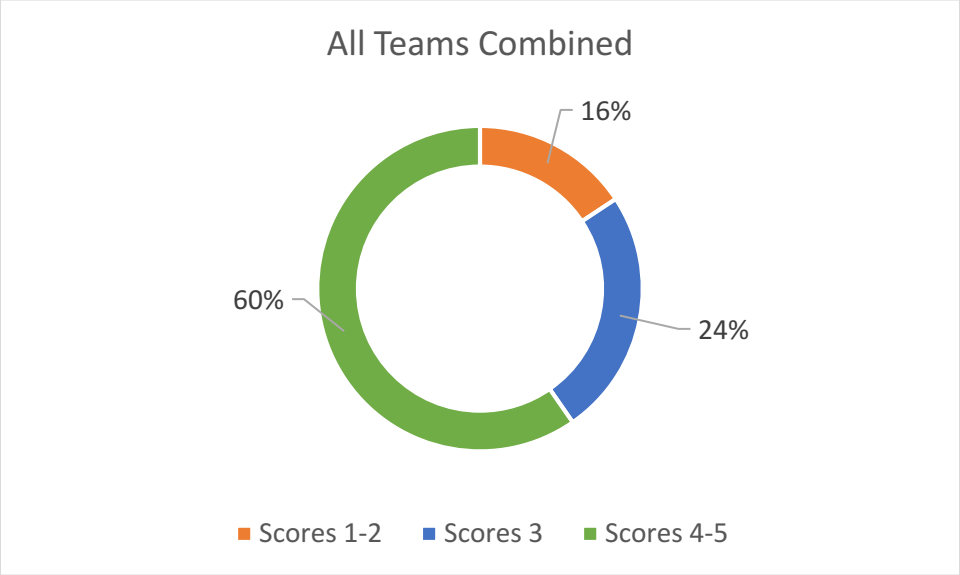
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, PacificSource – Marion Polk is likely to receive approximately 43,667 members out of the 10,000 minimum required.

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

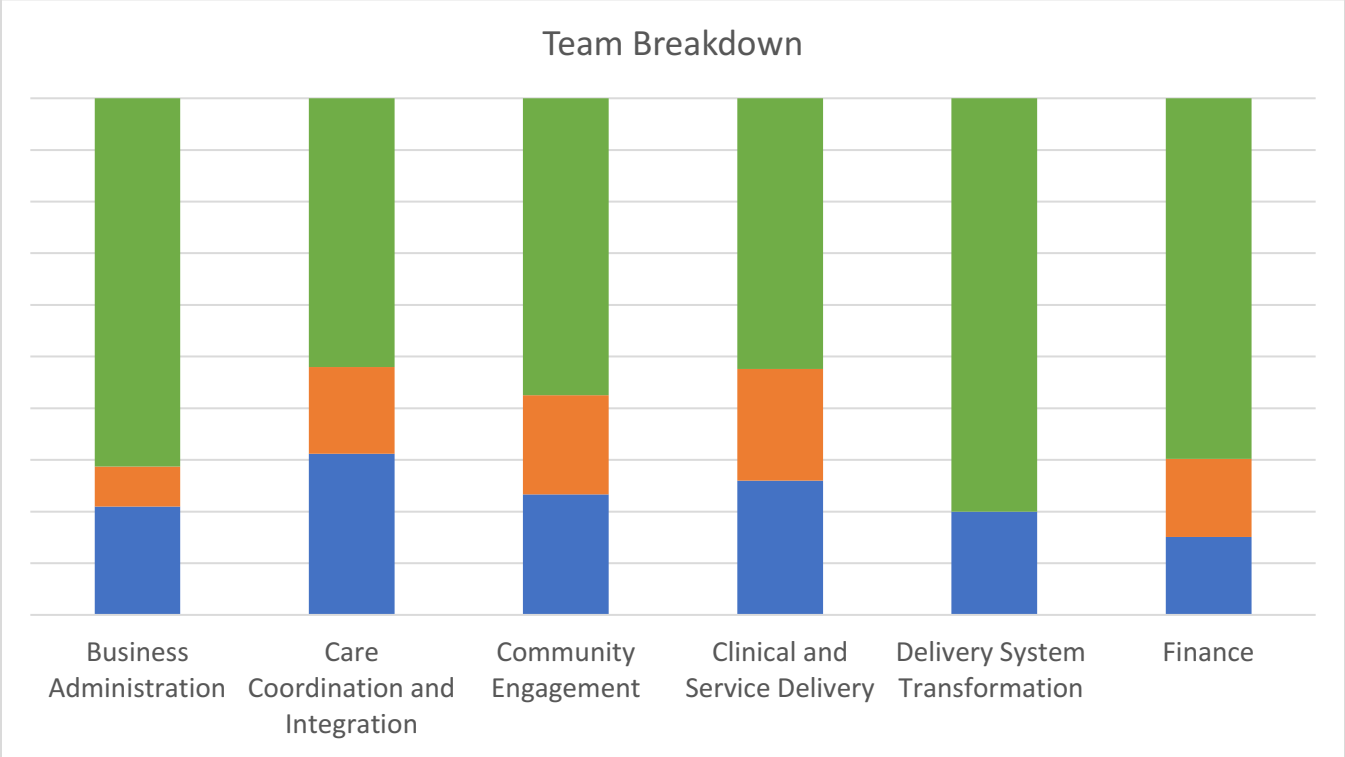
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	2	5	29
Cost	6	5	23
Social Determinants of Health	13	29	71
Behavioral Health	21	47	109
Business Operations	76	99	216

Evaluation Results: Informational Assessment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	3	5	49
Value-Based Payment	0	12	44
Behavioral Health	3	11	41
Social Determinants of Health	2	11	20
Business Operations	16	28	53

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	2	2	16				
CCO Performance and Operations	3	2	10				
Cost	3	4	11				

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

Deficiency Analysis

Value-Based Payment
There are no concerns regarding VBP

CCO Performance and Operations
While PSCS was well-reviewed in this section, the score would be even higher if they had addressed strategies for using Health Related Services to reduce unnecessarily utilization, cost, and create efficiencies.

Cost
While additional detail regarding tracking services across spectrum of care would be beneficial, the plan is adequate.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that PacificSource Community Solutions – Marion Polk be given a “pass” for the financial section.

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	0	6	34				
Member Transition	3	4	29				
Administrative Functions	7	17	39	X			
Social Determinants of Health	3	8	17			X	

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

Deficiency Analysis

Administrative Functions

There was no discussion of accessibility of pharmacies in the region and the pharmacy website information was lacking some detail. For TPL section, there was limited detail on how Medicare coverage is monitored. All deficiencies noted are relatively easy to remedy. The governance structure is difficult to interpret due to blinding however there could be difficulties enforcing subcontracts if Applicant is contracted to a parent company that makes all decisions.

Health Information Technology

For the HIT/VBP responses, only lacking some detail on SDOH-HE data sources. Only small amount of detail missing so this deficiency would be **easy to remedy**.

Member Transition

The responses for receiving members contained adequate detail but the responses on transferring members had some detail missing. These deficiencies would be **easy to remedy**.

Social Determinants of Health

Missing detail on what technology and methods will be used to collect and analyze SDOH info. There was no mention of how to build capacity to address SDOH-HE concerns. Some details were missing for the work force diversity questions. American sign language is not addressed and it appears that they are only addressing Spanish speakers in their language access policies but there are many other languages that need to be included. These deficiencies would be **easily remedied**.

Team Recommendation: **PASS**

- In general, this Applicant's responses were complete and adequately detailed.
- All deficiencies noted were smaller and estimated to be **easily remedied**.
- Applicant should produce materials in languages other than English and Spanish.
- Recommended that OHA verify that Applicant's governance structure allows for them to adequately enforce contract requirements with subcontractors.
- The quality of the answers and **easily-remedied deficiencies** pointed to a PASS 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
Care Integration	0	4	17				
Behavioral Health Covered Services	1	8	27	X			
Health Information Exchange	4	7	17				
Behavioral Health Benefit	0	5	7				
Care Coordination	24	30	22	X		X	

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

Deficiency Analysis

Behavioral health covered services responses were generally well received. Applicant failed to provide detailed information on plans to develop increased capacity for SPMI population. Little detail was provided on known barriers and plans to address those barriers.

Care coordination responses failed to provide information on how services would be coordinated for the dual eligible, 1915i or LTSS populations. Applicant provided no plan for follow up activities after receipt of a new member. Limited information was provided on plans to involve oral health providers in care coordination activities. Applicant failed to provide answers for care coordination in transition care settings—reviewers seek to understand how this care would happen for members with special needs.

Team Recommendation: **PASS**

Applicant's responses on behavioral health benefit plans were well received.

Care integration responses were well received; however, additional detail was requested for person-centered planning, and care coordination planning for targeted populations.

Applicant's ability to support Health Information Exchanges (HIE) was clearly demonstrated. However, limited detail was provided on HIE support available for behavioral health providers. This included a lack of detail on plans to continue hospital event notifications in the event that OHA discontinues subscription to these services.

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	6	6	21				
Service Operations	5	15	26			X	
Behavioral Health Covered Services	14	25	45			X	
Administrative Functions	20	8	17			X	

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

Deficiency Analysis

Administrative Functions

The responses for this section were largely responsive with some responses missing some detail. The responses could seem a little generic at times like stating that they had a robust system in place but not providing an actual plan. It appeared as if there were plans for conversation around network adequacy but minimal plans for action. The grievance and appeal section was lacking strategies for how this data could be used for system improvement. The deficiencies noted are **relatively easy to resolve**.

Behavioral Health Benefit

The responses in this section were largely responsive. There was limited detail regarding barriers to billing and no plan for how to coordinate care with DHS/LTC members in in-home settings but these deficiencies are **easily remedied**.

Behavioral Health Covered Services

The response in this section were largely responsive and missing only some detail. There was a limited amount of detail on feasible strategies for delivering prevention services in a culturally and linguistically competent manner. Strategies for communicating with providers was not addressed. Applicant indicates they do not currently serve members in acute psychiatric care SPMI and they will a needs assessment which will be done in time for CCO 2.0. Applicant used “aged” as a category which could be considered disrespectful. Applicant states that they rely on computer generated reports but they don’t discuss how the reports will be used. There were no plans to contact members who have had no services for 6 months. All deficiencies identified would take a **small amount of effort to remedy**.

Service Operations

The responses in this section were largely responsive but missing some detail. Applicant does not indicate how they will communicate with members and there is limited detail on access to care and medical

necessity criteria. They are also lacking detail on monitoring service utilization– they say which program they use but not how they will use the data. The Applicant does not specify how they will accommodate different targeted member populations. For the LTSS questions, there is no detail on how they will deliver services to their members – the role of DHS is unclear in this process. The deficiencies noted are estimated to take a **small to moderate amount of effort to remedy** depending on the presence of absence of underlying processes.

Team Recommendation: **PASS**

- The responses to these sections were generally responsive with a few questions missing some detail.
- The deficiencies noted required mostly **small amounts of effort to remedy**. The deficiencies in the Service Operations section would take a **moderate amount of effort to remedy** if underlying processes are missing.
- The quality of the answers and the presence of deficiencies that could be remedied with mostly **smaller amounts of effort** led to a team recommendation of PASS.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Accountability and Monitoring	0	3	15			X	
Delivery Service Transformation	0	3	9	X			

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

Deficiency Analysis

Accountability and Monitoring:

Accountability – Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Response is missing a description of "staffing" experience

Delivery Service Transformation:

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

Transforming Models of Care – Lacking sufficient information about oversight of the PCPCH system, member outreach and the community governance model.

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

- Describe how complaint/grievance information is shared and communicated with providers
- Provide description of staffing experience

Delivery Service Transformation

- Describe data collection for REAL-D
- Provide information about "How oversight of the PCPCH system works"
- Provide more info about "community governance model", joint member engagement and outreach efforts.

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	1	1	8	X			
Social Determinants of Health	2	5	13	X			
Community Engagement Plan	8	15	37			X	
Governance and Operations	12	7	11	X			

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

Deficiency Analysis

- Community Engagement Plan was lacking a description of SDOH projects
- Insufficient detail on how they'll engage with unrepresented populations and tribes to recruit CAC members, no recognition of ORS requirements for CAC composition - BH clinicians are not sufficient representation of members with SPMI (needs lived experience)
- Outreach to counties/partners included no information about written agreements, although they indicated that all counties agreed to participate
- Communication and engagement is unclear between members and Board/decision makers
- Community engagement appears limited to those on health council – not sufficient and Insufficient detail around how to engage community around health disparities

Team Recommendation: **PASS**

- Need clear strategies for engaging unrepresented communities referenced, including tribes, in CAC engagement
- Ensure culturally and linguistically appropriate outreach methods are used
- Fully engage with all members in community, beyond Health Council
- Develop a Quality Improvement plan for CEP
- Ensure tribes have a role in HRS decision making
- Provide information about steps to establish formal agreements with county government, including timelines
- Strengthen CAC recruitment plan – develop a detailed plan for CAC recruitment that aligns with demographics of the community served, and that aligns with ORS
- Strengthen COI process; needs a formal policy and form
- Ensure that funding will be distributed in an equitable and transparent process with a clear plan for how outcomes will be shared with the public

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
Bridgeway Recovery Services	BH, SUD
Capitol Dental	Dental Clinics
Center for Addiction and Recovery Services	BH, SUD
CHAOS	Medical, BH Clinics
Kaiser Health Foundation	Hospital, Medical, Dental, BH, SUD Clinics
Legacy Health Systems, Silverton Medical Center	Hospital, Medical Clinics
NW Human Services	Homeless, Housing, Crisis, Medical and BH Clinics
Options	BH, SUD
Oregon Family Support Network	Family, children, youth BH, resource services
Polk County Commissioners	Local Mental Health Authority, Local Public Health Authority
Salem Women's Clinic	Medical Clinic
Valley Mental Health	BH
Willamette Family Medical Clinic	Medical, BH Clinics
Woodburn Pediatric Clinic	Medical Clinics
Yakima Valley Farmworkers Clinic	Medical and Dental Clinics, BH, SUD, Community Action Center, Community Health Services, HIV/AIDS treatment, Outreach

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.

Applicant reports planning to manage the Global Budget and the BH benefit in a way that is in alignment with CCO 2.0 policies.

No additional comments included.

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	5	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.

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.

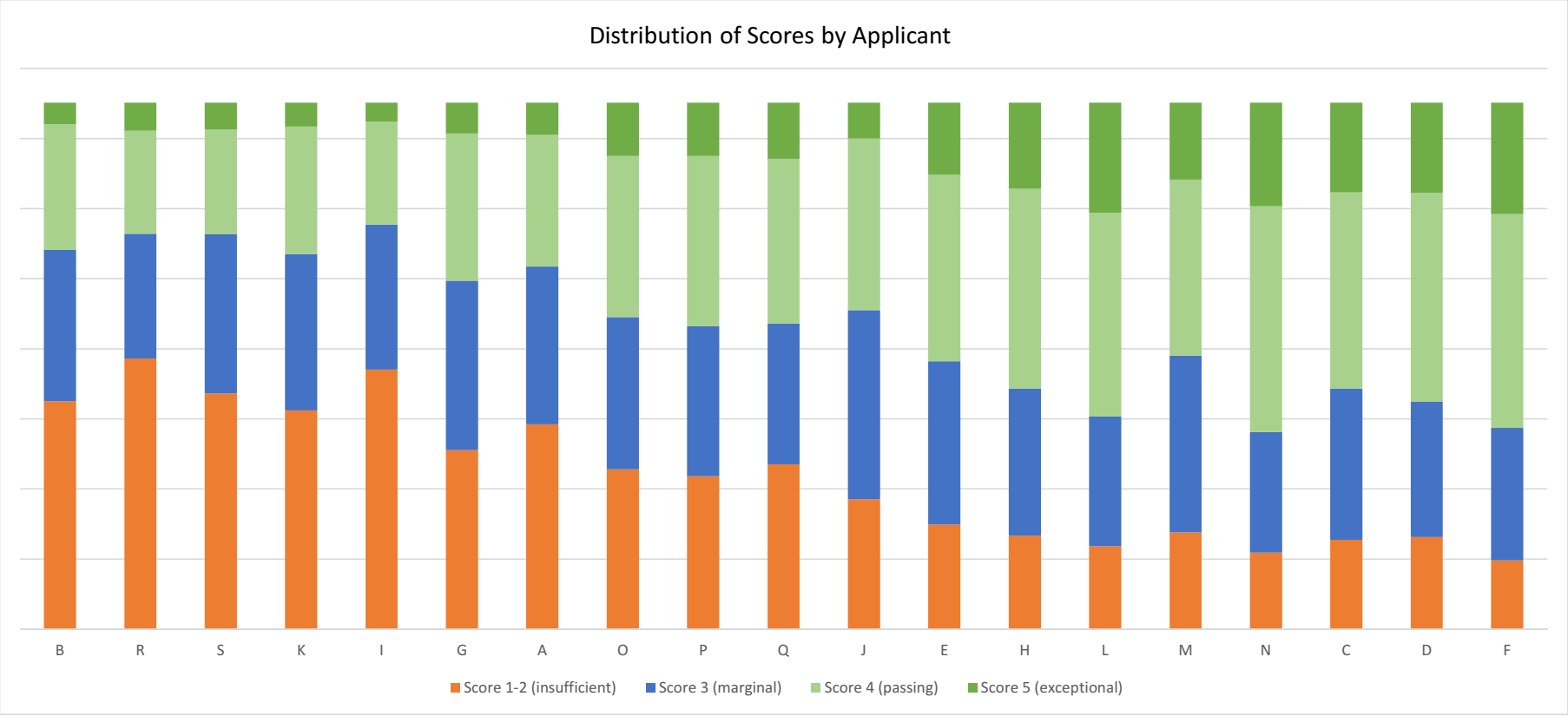
Members with no claims history

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