RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant J
PrimaryHealth

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

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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

- ASU determined that PrimaryHealth may have under-estimated liabilities might have a negative impact on applicant's liquidity. OHMS, its parent company, is in a distressed financial situation as well so very limited help is expected from the parent company.
- PrimaryHealth appears to be underfunded and would not meet RBC or minimum capital requirements at the start of the contract. This created challenges to stress-testing, because further variations and impacts would only lead to results that are further below the requirements.
- DCBS financial review found that pro forma results appear to be reasonable for projections provided.

Service Area Analysis

- PrimaryHealth is proposing to cover the entirety of Josephine and Jackson counties, and partial Douglas county.
- There is a service area exception request to serve only part of Douglas County. PrimaryHealth received passing scores in all but one category (Finance) for this exception request.
- PrimaryHealth is one of three applicants in this service area. There are concerns around PrimaryHealth's relatively low maximum enrollment limits.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Fail; majority of the responses were lacking detail and some responses were missing components. Missing information in preemptive FWA activities, EHR program, and member transition that would take a significant level of effort to remedy.
- Care Coordination and Integration – Pass
- Clinical and Service Delivery – Fail; responses are generally missing detail, and some components of questions were not answered at all. Missing detail about behavioral health covered services
- Delivery System Transformation – Pass
- Community Engagement – Pass

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

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

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 31, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: CCO2.0 Financial Review

PrimaryHealth of Josephine County LLC dba PrimaryHealth (PrimaryHealth)

I have performed a financial evaluation of PrimaryHealth of Josephine County LLC dba PrimaryHealth CCO application for their Jackson, Josephine, and Southern Douglas County operations based on the materials provided. PrimaryHealth is an existing CCO, operating in the above counties since 01/01/2012.

PrimaryHealth of Josephine County LLC dba PrimaryHealth (PrimaryHealth) is part of a **holding company system** in which it is 100% owned by Grants Pass Management Services, Inc. dba Oregon Health Management Services (OHMS), who is the ultimate controlling entity. There are currently 17 shareholders of OHMS that are noted within the documents received by the Applicant. Note that Agreements were not reviewed by DCBS as they were not provided.

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

PROFORMA REVIEW

The pro-forma results provided appear to be reasonable for projections provided.

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

ENROLLMENT:

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 100% (144,000 Member Months), Minimum ('MIN') 75% (108,000 Member Months), and Maximum ('MAX') 125% (180,000 Member Months).

CAPITAL AND SURPLUS:

(C&S) appears to be sufficient to absorb net losses within the 3 years referencing the information provided in this review, with all other estimated amounts remaining the same for each scenario. Their BE for 2020 started at $2.15M C&S and they would need to have net income of at least $385K to be at the minimum C&S of $2.5M. Company would have to be profitable to meet all requirements.

RBC:

RBC was above the OHA required 200% in all scenarios and all years, presented for Best Estimate (BE), Minimum (MIN), and Maximum (MAX) Estimates, being 283%, 387%, & 489%, for 2020 to 2022 in the Best Scenario respectively. If PRIMARYHEALTH incurs a 2% increase in claims then it would fall below 200% in all three years and scenarios, except 2022 under the maximum enrollment scenario. .RBC calculations was not provided by Applicant for any of the +6% scenarios.

***OHA ASU Calculated that the MLR provided by the company, which is roughly 85.5% is excessively low, and that they should be using a value of 89%. After making adjustments for those calculations to impact net income and capital & surplus, under the best scenario on a cumulative basis, the company would have an RBC of 107% in 2020, 37% in 2021 and -31% in 2022, with the company being insolvent in 2022. This is before any considerations for negative deviations from their expected results.

Based upon this impact, the applicant would not be considered to have a viable business plan that would allow for the operation of a CCO in a manner that would be financially viable through the contract period without causing a detriment to the OHP members, Oregon citizens, the impacted providers and OHA, as a whole.***

NET INCOME:

Per the estimates provided, PrimaryHealth would operate at a **net income** position for all three years and under all three scenarios. In a stressed environment, if claims cost are approximately 2% higher, with all other items remaining the same, PRIMARYHEALTH would incur a net loss in 2020 in all scenarios but not in 2021 nor 2022 in all three scenarios. With a 4% increase in Claims, PRIMARYHEALTH would experience Net Losses in all three years under all scenarios. Cumulative losses in multiple years would bring the company below the 200% RBC ratio

LIQUIDITY:

For the years 2020-2022 the **liquidity** ratio's for the period noted would be 173%, 194%, & 224% under the Best Estimate, noting that the higher the ratio the better the ability of the Company to pay off its obligations in a timely manner. The applicant shows adequate liquid assets to meet the needs of the company as estimated at this time, based upon their projections. PRIMARYHEALTH has not provided information that there are funds readily available from another source to improve liquidity or Capital & Surplus, unless their plans for a new financial investment go through. Due to transactions of that nature, OHA planning on support prior to the close of the transaction would provide significant risk to the applicant and OHA. If there are negative deviations from their planned amounts, the company would be dependent upon positive cash flow from operations to be able to fund all liabilities. Based upon the expectation that the company has reduced their claims basis compared to premiums, if that scenario is accurate, then there is more likely than not that the company would be loosing cash to match the anticipated net losses, and may be reducing these available assets very quickly. Continued cumulative losses of assets could bring them near the point of not being able to meet obligations by the fifth year, assuming projections hold firm.

***Some manual calculations were needed by analyst for review and answering questions noted above.

[End of summary]

ASU Analysis of Applicant Financial Assumptions

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

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

Focus of this review is given to reasonability of projected numbers stated in Balance Sheet and P&L pro formas (BE MM scenario) by comparing to most recent year's Exhibit L financial results (FY2018).

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**
144,000	186,155	180,000	108,000	129%	**Too high**

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$413.69		$433.73	$457.26	-10%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
85%	91%	-6%

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

Population Trend	
Applicant Assumption	**OHA Assumption**
0.00%	0.28%

Underestimated liabilities

Analysis: Applicant's projected liability balance for BE 2020 scenario shows significant drop ($3M or 38%) from its actual balance at 2018 year-end. As the decrease of asset ($1.25M) could explain for part of the liability drop, however not enough to validify the overall drop. Further, applicant's BE 2020 assumes 25% member month increase from 2018, so the claims related liabilities balance is expected to increase accordingly,

however, applicant's projected claims related liabilities shows 8% drop instead. Based on this analysis, applicant's liabilities level for BE 2020 scenario appears to be under-estimated (this is in line with OHA's earlier finding that the applicant under-estimated its 2020 MLR ratio by projecting less medical expense).

	FY 2018	BE 2020	Change	
MM	114,989	144,000	29,011	25%
Assets	$ 9,589,616	$ 8,336,380	$ (1,253,236)	-13%
Claims related liabilities	$ 3,915,622	$ 3,621,296	$ (294,326)	-8%
Other payables	$ 3,899,344	$ 1,194,509	$ (2,704,835)	-69%
total liabilities	$ 7,814,966	$ 4,815,805	$ (2,999,161)	-38%

Risk: Under-estimated liabilities might have a negative impact on applicant's liquidity

Recommendation: Recommend DCBS to rerun the liquidity analysis by increasing the liability balance to a more reasonable level.

Parent company OHMS's going concern called out in FY2017's audit

PHJC's 2017 audit contained a "going concern" note, which is essentially a red flag. The applicant is 100% owned by its parent company Oregon Health Management Services (OHMS), and in OHMS' FY2017 financial audit its auditor Moss Adams noted the following going concern as well as the managements plan:

Oregon Health Management Services, Inc.
Notes to Financial Statements

Note 13 – Managements Plan Related to Going Concern

As shown in the accompanying financial statements, the Company incurred a net loss of $2,700,744 during the year ended December 31, 2017 and as of that date, the Company's liabilities exceeded its current assets by $1,090,055. These factors create a doubt about the Company's ability to continue as a going concern for the year following the date the financial statements are available to be issued. However, the Company believes the following factors will allow the Company to continue as a going concern.

1. Capitation rates from the state increased by 3.2% for 2018 compared to 2017 resulting in an increased revenue.
2. The Company's capitated contracts were negotiated resulting in a potential savings for 2018.
3. A new contract was negotiated for addiction recovery services resulting in a potential savings in 2018.
4. A new capitation agreement was negotiated with our mental health provider resulting in a potential savings in 2018.
5. 2017 included a one-time expense of $544k relating to a recoupment by the state.
6. The Company has restructured administrative staff and implemented other operating efficiencies resulting in a potential savings for 2018.

These items will result in a potential increase in net income of $3 million in 2018 when compared to 2017.

PHJC replied to that note that it expected 2018 financial performance to improve significantly, and it did record a $1.9 million profit in its unaudited Exhibit L. However, this profit may be in part attributable to retaining quality pool cash received and retained in 2018 ($1.4 million). A total of $4 million of undistributed quality pool is shown in the 12/31/2018 Exhibit L.

- Recommend OHA request an advance copy of PHJC's 2018 audit and reviewing for a going concern note.

Further, OHA financial analyst also noted the following risk areas from the applicant's Exhibit L reporting in FY2018:

(1) PHJC didn't meet net asset requirement as of 12/31/2017, however it met the requirement each quarter in 2018 and is showing an improvement in its financial situation.

Note: the net asset requirement will be changed to the $2.5M new rule in CCO 2.0 contract which is a higher standard and the applicant's $1.8M net asset balance at 2018 YE doesn't meet this requirement.

(2) PHJC's current liability exceeds current asset throughout FY2018 which signals a liquidity risk:

	12/31/2017	3/31/2018	6/30/2018	9/30/2018	12/31/2018
Current asset	$ 6,806,433	$ 7,769,112	$ 7,839,331	$ 7,805,138	$ 7,499,578
Current liability	$ 7,934,456	$ 8,222,469	$ 7,887,057	$ 7,332,020	$ 7,814,966
	$ (1,128,023)	$ (453,357)	$ (47,726)	$ 473,117	$ (315,388)
LT asset in restricted reserve	$ 1,553,003	$ 1,553,386	$ 1,553,774	$ 1,554,165	$ 1,654,581

Risk: The applicant has high liquidity risk; further, its parent company is in a distressed financial situation as well so very limited help is expected from the parent company if the applicant's operation incurs loss in the CCO 2.0 contract period.

Recommendation: Add more capital contribution by adding other shareholders

PHJC's liabilities at 1/1/2020 appears to be under-estimated. Projected liability balance at 1/1/2020 shows a significant drop ($3M or 38%) from actual balance at 2018 year-end. PHJC also assumes a 25% member month increase from 2018, so the claims related liabilities balance should increase; however, projected claims related liabilities decreases 8% instead.

PHJC loss ratio assumption of 85.5% is aggressive, especially in light of recent experience. It may have been selected in order to increase projected reserves in future years. DCBS reran pro forma with ASU-suggested 89% loss ratio and projected insolvency in 2022.

PHJC's actual C&S as of 12/31/2018, and projected as of 1/1/2020, is less than the $2.5 M C&S requirement anticipated to be placed into statute by HB 1041. Current liabilities exceed current assets in FY 2019.

- Recommend OHA consider denying overall application based on current and projected finances, or instead requiring additional capital and possibly additional shareholders.

PHJC currently has 1% of Douglas County enrollment and 2% of Jackson County enrollment. Its proposed expansion to all of Jackson County may not be consistent with ALLC and JCC viability.

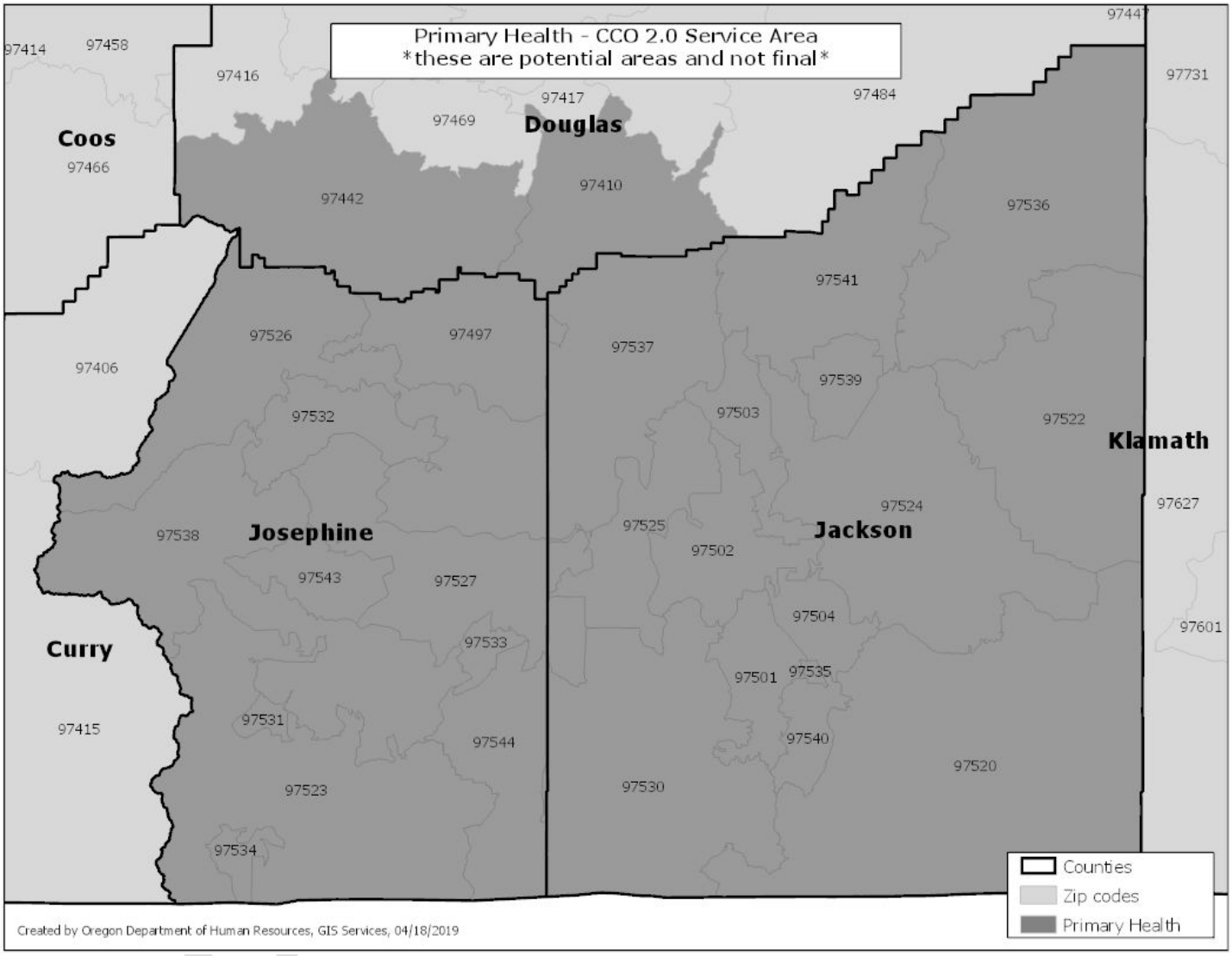
- Combined with concerns about current and projected finances, suggest OHA deny expansion.

PHJC enrollment is listed in the attachment as "too high". This estimate was made on the basis of PHJC's application and provider network. If the issues above are addressed, the "too high" issue would likely be resolved.

Service Area Analysis

Requested Service Area

Applicant is proposing to cover the entirety of Josephine and Jackson counties, and partial Douglas county. The partial county request is aligned with the Applicant's current service area. Three Applicants are requesting to cover the two zip codes in southern Douglas county.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	14	16
Care Coordination and Integration	8	22
Community Engagement	5	10
Clinical and Service Delivery	9	24
Delivery System Transformation	3	9
Finance	6	4

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

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

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

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Josephine and Jackson	Douglas	AllCare CCO also proposes to serve Josephine, Jackson, and parts of Douglas. Jackson Care Connect also proposes to serve Jackson county. Primary Health reported 15,000 as their maximum.	No scenarios show enrollment below applicant's minimum	72% chance Primary Health would receive too many enrollees.	High risk

103,000 OHP members live in Jackson and Josephine, of which 9,000 are in Primary Health. If more than 6,000 of the remaining 94,000 members opt into Primary Health, the applicant's enrollment would exceed their maximum.

Additional Analyses on High Risk Areas

Southwest Oregon

The analysis for southwestern Oregon differs from those above because in this region we must consider the relatively small maximum thresholds for Primary Health of Josephine to ensure there is enough capacity.

Over 110,000 members reside in Curry, Josephine, and Jackson Counties. Three applicants propose to serve different configurations of the three counties.

Applicant	Maximum threshold	Proposes to serve
AllCare CCO	91,596	Curry, Josephine, and Jackson
Primary Health of Josephine CCO	15,000	Josephine and Jackson
Jackson Care Connect	56,031	Jackson

County	Non-open-card population	Open-card population	Total member population
Curry	5,200	1,900	7,100
Josephine	27,400	5,600	33,000
Jackson	56,100	14,000	70,100

Because Primary Health's maximum is only 15,000, OHA must restrict enrollment in that applicant for Josephine and Jackson Counties. Jackson Care Connect could theoretically absorb nearly all non-open-card members in Jackson County and AllCare could absorb all non-open-card members by itself, without Primary Health or Jackson Care Connect.

The sum of all three applicants' maximum thresholds is over 162,000 yet the sum of all members, including open-card, in the three counties is only 110,200. The capacity theoretically exists among the applicants, but OHA should closely monitor enrollment trends, especially because both All Care and Primary Health propose to serve parts of Douglas County, which is not included in the member numbers above.

The table below shows the various scenarios and the impacts for each Applicant.

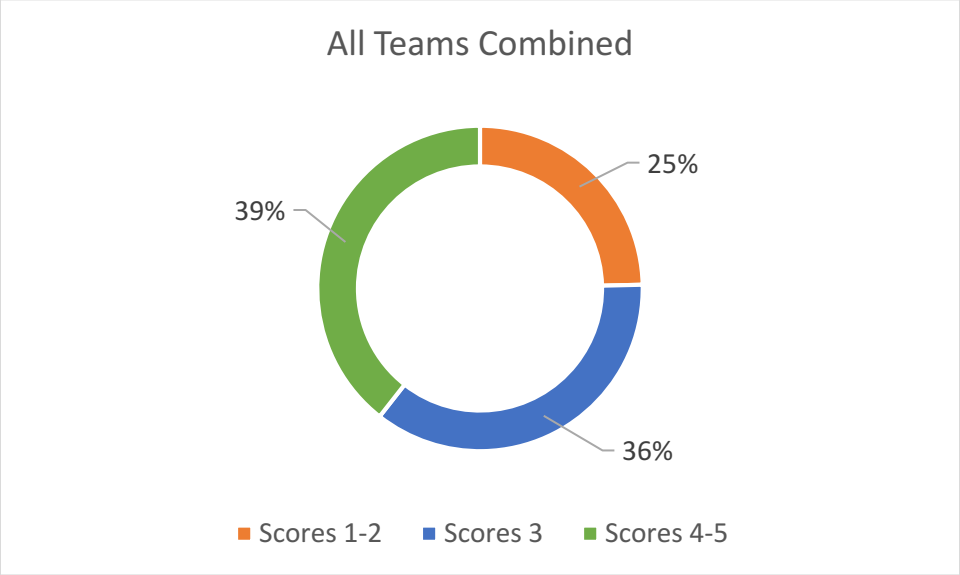
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, PrimaryHealth is likely to receive approximately 21,173 members out of the 9,000 minimum required and 15,000 maximum. OHA would be required to cap the enrollment and divert members to other plans to avoid PrimaryHealth exceeding their maximum membership levels.

Scenario description	Impact on AllCare	Impact on Primary Health	Impact on Jackson Care Connect	Analysis and Comments
All three applicants awarded	3% chance AllCare may not receive enough members in the proposed areas. If AllCare is limited to only full counties, the chance of not enough members increases to 75%.	Projected enrollment falls within the applicant's parameters	Projected enrollment falls within the applicant's parameters	
AllCare and Primary Health awarded	Projected enrollment falls within the applicant's parameters	100% chance Primary Health receives too many members. However, OHA can monitor this and curtail enrollment as Primary Health's total approaches their max.	Not awarded in this scenario	If Primary Health receives its max (15,000 members), AllCare can absorb all other members in the three counties. However, there are also 21,500 open-card members. AllCare can absorb all but 3,604 open-card members. There will be a capacity constraint if more than 17,896 open-card members opt to join a CCO.
Primary Health of Josephine and Jackson Care Connect awarded	Not awarded in this scenario	Primary Health would be the only CCO serving Josephine County. The 27,400 CCO members would exceed Primary Health's max of 15,000	JCC would have to serve all of Jackson County because Primary Health would be over capacity serving only Josephine. Jackson County's 56,100 members exceeds JCC's max of 56,031. Any open card members moving to CCOs would exacerbate the problem.	Untenable scenario. All CCOs would be over capacity. In addition to Primary Health and JCC being over capacity, Advanced Health would have to serve Coos and Curry Counties alone. Over 29,000 members live in the two counties and that would exceed Advanced Health's max of 22,463.
AllCare and Jackson Care Connect awarded	Projected enrollment falls within the applicant's parameters. AllCare has the capacity to serve all of Josephine County	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters. JCC could theoretically serve nearly all current CCO members in Jackson County.	AllCare and Jackson Care would meet their minimums and would not exceed their maximums.

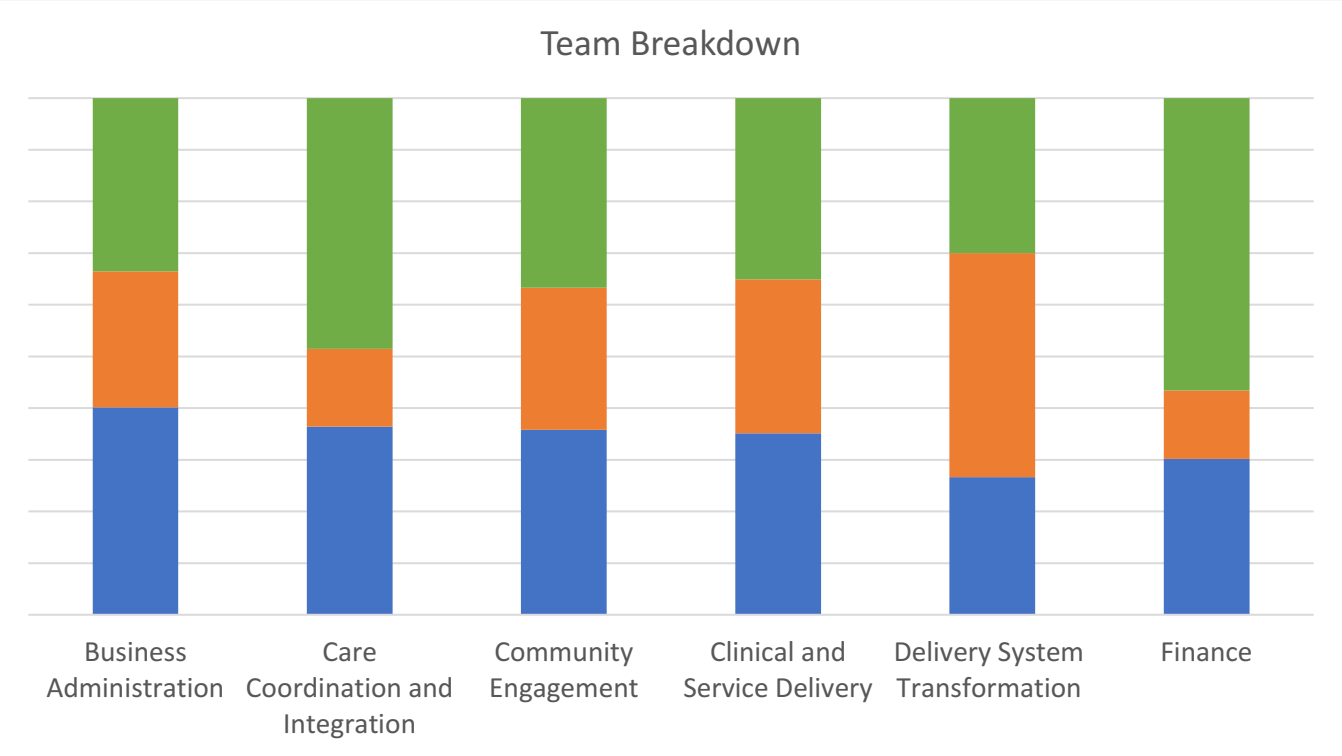
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

Evaluation Team	Recommendation	Lacks Detail	People	Process	Tech
Finance	PASS			X	
Business Administration	FAIL	X		X	
Care Coordination and Integration	PASS	X	X	X	
Clinical and Service Delivery	FAIL	X	X	X	
Delivery System Transformation	PASS	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**
Behavioral Health	19	57	101
Cost	4	13	17
Social Determinants of Health	33	36	44
Business Operations	115	155	121
Value-Based Payment	14	9	13

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**
Behavioral Health	7	15	33
Cost	10	22	25
Social Determinants of Health	8	11	14
Business Operations	27	38	32
Value-Based Payment	23	27	6

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
Cost	2	3	13	x			
Value-Based Payment	4	6	10	x			
CCO Performance and Operations	1	7	7	x		x	

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

Deficiency Analysis

Cost

Section was passable but lacked detail. There is a feasibility concern about using only savings to invest in addressing SDOH and health equity, which could result in no investment depending on whether savings are realized.

Value-Based Payment

Responses were adequate. Mitigation strategies provided were vague.

CCO Performance and Operations

The HRS strategy and evaluation plans of Primary Health lack detail. Referenced lessons learned from initial CCO phase, but does not connect these lessons learned to 2.0 changes/improvements.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Primary Health be given a “pass” for the financial section. Primary Health adequately addressed all questions in the application, although nearly all sections would benefit from more detail.

Business Administration

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Administrative Functions	14	22	27			X	
Health Information Technology	10	14	16	X		X	X
Social Determinants of Health	9	8	11			X	
Member Transition	11	23	2	X		X	

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

Deficiency Analysis

Administrative Functions

No specifics on how Third Party Liability information would be shared was provided, and no mention of the frequency of monitoring for Medicare coverage. Pharmacy was lacking business hours and how member calls will be handled after business hours. Fraud, Waste and Abuse responses were not responsive for this section - they did not reference using claims edits and there were no other preemptive mechanisms for FWA monitoring. The majority of the deficiencies **could be remedied relatively** quickly. The FWA deficiencies would take **a moderate amount of effort to remedy**.

Health Information Technology

For EHR adoption the responses did not address the different providers types requested (physical, behavioral and oral health). Applicant mentioned the Medicare E.H.R program which will sunset soon. EHR adoption plans were missing detail for oral health providers in particular – appeared as if Applicant was delegating this work to the oral providers.

The HIT for VBP and population health questions were missing a lot of detail. There were no strategies for how to match SDOH data to claims, plan 1 info is missing entirely and Applicant is currently not using risk stratification and states that this will not be available for 2-5 years. The importance of risk stratification to the creation of VBP model, care coordination and other essential CCO functions is critical and indicates that the deficiencies in this section would take a **significant amount of effort to remedy**.

Member Transition

There is a lack of detail throughout this section whether transferring or receiving processes are being discussed. An attestation to adhere to standards of care was provided on care coordination only but not on

continuity of care or other transition activities. The Warm handoff description focused on BH providers only and left out other provider types. Applicant would frequently claim that they provided an activity, but details were frequently missing. The large amount of detail and info missing in this section indicates that this would take a **significant amount of effort to remedy**.

Social Determinants of Health

The responses addressing how SDOH funds will be applied for is missing detail.

The responses on health equity were very limited – there was limited detail on health equity training that would be provided, there were no policies that supported access to linguistic services and these services were limited to the telephone. There was very little assistance provided to those with disabilities.

The missing processes, education required to increase knowledge on federal requirements around access to services and getting process and polices in place would require a **significant amount of effort**.

Team Recommendation: **FAIL**

- A clear majority of the responses were lacking detail and some responses were missing components.
- Preemptive FWA activities appeared to be missing. Implementing these processes **would require a moderate amount of effort.**
- The Applicants missing provider-specific info in the E.H.R sections suggests they are not aware of provider-specific challenges with E.H.R. They also indicate reliance on a Medicare E.H.R program that will sunset soon which means they will need to come up with another solution. The biggest gap in this section is the lack of risk stratification and no plan to implement for 2-5 years. The lack of risk stratification models calls into question how this CCO is assigning members to different care coordination levels and indicates a larger gap in knowledge, processes or both. The deficiencies in this section would require a **significant level of effort to remedy.**
- There was a large amount of detail missing from the Member Transition section. The Applicant would frequently state that they provided a certain process or service and even offered an attestation that they were providing care coordination during the transition process, but the significant lack of detail suggested otherwise. Implementing all transition process and procedures needed would require a **significant level of effort to remedy.**
- The amount of detail missing from responses and multiple areas requiring **moderate amount of effort to remedy**, point to a FAIL recommendation.

Care Coordination and Integration

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Care Integration	0	2	19				
Behavioral Health Covered Services	0	8	28				
Behavioral Health Benefit	0	3	9	X			
Health Information Exchange	4	12	12				
Care Coordination	22	38	16	X	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 well received but included no information on how person-centered planning would take place. Limited detail was provided on behavioral health policies. Coordination with Medicare Advantage plans was only briefly addressed.

Care coordination generally lacked detail or missed required components. Neither tribal partners, or Medicare plans were addressed, and limited information was provided on how the applicant will coordinate efforts across systems. Plans to meet linguistic and cultural needs are unclear. Discussion of member transitions failed to include a discussion of all requested populations.

Care integration responses were well received; however, little information was provided on tribes and tribal health.

Team Recommendation: **PASS**

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

Clinical and Service Delivery

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Covered Services	16	26	42	X		X	
Behavioral Health Benefit	2	18	13				
Administrative Functions	25	10	10	X	X	X	
Service Operations	19	19	8	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 missing a moderate amount of detail – there were statements of what Applicant would do but no plans. Some questions were not answered at all. Network adequacy response didn't separate out physical, behavioral and oral health providers and components of that question were not answered. Applicant did not answer how they would use grievance and appeal data to monitor correct application of medical necessity criteria or to identify areas for improvement. The lack of detail made it difficult to determine what type of deficiencies were present however high-level answers can indicate that underlying processes, technology, knowledge or other infrastructure, are missing. The deficiencies noted in this section would take a **moderate to large amount of effort** to correct if underlying aspects are missing.

Behavioral Health Benefit

The responses in this section were missing detail. The Applicant didn't address measuring or monitoring of the behavioral health benefit and didn't identify any billing barriers for warm handoff services. The deficiencies in this section would be **relatively easy to remedy**.

Behavioral Health Covered Services

The responses in this section were missing detail, some components of questions were found in other areas and some were missed entirely. In general, questions were not fully addressed, for example, there were no standards or screening mentioned for the pregnant women and children. The SUD responses did not mention how they would communicate with members. The was very little information on cultural and linguistic competencies – there appeared to be no other languages than Spanish. The Applicant appeared to misunderstand what PCIT (parent and child interaction therapy) was and Wraparound was mentioned as a therapy, which also demonstrates a large gap in knowledge. Measuring, monitoring and access parts of questions were also not addressed for Wraparound services. The deficiencies noted in this section are

considered to take a **large amount of effort to remedy**, mostly due to the demonstrated lack of understanding of basic behavioral health concepts and services but also due to unanswered questions covering standards, screening, measuring and monitoring of BH services.

Service Operations

The responses in this section were missing some detail. Not all settings were addressed in the DHS/LTC question – all care settings were lumped into one. Not all care coordination models for DHS/LTC population were addressed. The DHS/LTC utilization management questions were not addressed – there was no distinction of how acute and ambulatory levels of care are authorized. Methodology and criteria for identifying over and underutilization of services was not provided. Pharmacy response did not address how funded condition/treatment pairs were covered, it was unclear how a pharmaceutical issue would be resolved after hours. It appeared as if a member would need to ask a pharmacy to resolve any issues after hours. The searchable document containing all pharmacy PA criteria on website, is not necessarily member-friendly. Hospital services did not address timeliness, amount duration or scope of inpatient or outpatient services. The deficiencies noted in this section **could be remedied relatively quickly**.

Team Recommendation: **FAIL**

- This Applicant's responses were in general missing small to moderate amounts of detail, and some components of questions were not answered at all.
- The deficiencies noted for the Administrative functions and Behavioral health covered services sections were estimated to take **moderate to large amounts of effort** to address, depending on the underlying processes, people, technology or other infrastructure that was missing.
- The quality of the responses along with multiple areas requiring **moderate to large amount of effort** to fix and a demonstrate gap in understanding basic behavioral health concepts and services, led to a team recommendation of FAIL.

Delivery System Transformation

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

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

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Applicant failed to provide details describing the measurement and reporting system, such as how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking information about the tools that will be used to push data to the provider network. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

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

CCO Performance - Lacking sufficient information about the process for measure aims and quality indicators, including tracking Hospital Services by population sub-category (by REALD).

Delivery Service Transformation

Provision of Covered Services – Applicant failed to provide details describing gaps in workforce and methods for identifying and counting workforce need. Lacking information about how data is collected.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as tier levels, the number of assigned members by provider type, oversight, and engagement of potential new PCPCH providers. Lacking sufficient information about plan for member engagement and outreach. Lacking sufficient information about care coordination, evidence for success, effective wellness and prevention, and emphasis on whole person care. Lacking sufficient information about monitoring the non-PCPCH model to ensure fidelity.

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 staffing, policies and procedures missing
- Description of process to track quality expectations and performance if there are gaps

Delivery Service Transformation

- Details on PCPCH system for oversight
- Information about encouraging use of PCPCH system

Community Engagement

Evaluation of questions found in the RFA Community Engagement Plan, and questions aimed at an Applicant's level of community engagement during the development of the Application.

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Social Determinants of Health	7	3	10	X			
Governance and Operations	8	10	12	X			
Community Engagement Plan	16	24	20			X	
Community Engagement	2	6	2			X	

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

Deficiency Analysis

- There were minor and one major component of the CEP that were missing. Douglas County and the Tribes were missing, and the CHA/CHP was not submitted as requested.
- There is no clear pathway for communication from the CAC to the Board and from Board to OHP consumers, between the different CAC's and between members and the CAC.
- Appears the Applicant is not aware that they will need a CAC for all Counties, even those with a small number of members. A better definition of their population is needed.
- More detail needed on milestone and timelines for vetting SDOH priorities. SDOH priorities are not the same as the CHA/CHP. No indication of how SDOH-HE project outcomes will be broadly shared.
- Unclear if alignment between CHP and HRS/CBI spending. No mention of tribal role in HRS spending.
- Member engagement in QI activities is not mentioned.
- Member engagement in care planning not mentioned except in regard to the Intensive Care Coordination.
- Doesn't mention how the community will be engaged to address disputes.

Team Recommendation: **PASS**

- Recommendation to receive significant TA and guidance from OHA
- Need a clear plan for what community engagement looks like within and beyond the CAC – and how to engage community when addressing disputes.
- Need clear strategies for engaging with each population they want on their CACs
- Ensure CAC membership complies with statute
- For SDOH-HE projects – a process is needed to ensuring projects are awarded equitably, and outcomes are shared

Community Engagement – Community Letters of Support

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

Organization Name	Type
Advantage Dental	Dental Clinic
Asante Health System	Hospital, Medical Clinics
Boys and Girls Club, Rogue Valley	K-12 Education, after school programs, medical and dental clinics
Capitol Dental	Dental Clinic
Choices Counseling Center	BH, SUD
City of Medford	Local Government
Clear Creek Family Practice	Medical Clinic
Club Northwest	Health Club, Gym
Consumer Credit Counseling Service, United Way	Financial Counseling, Student and Housing finance
Douglas Public Health Network	Public Health Organization
Grants Pass Clinic LLP	Medical, Dental, BH, SUD
Grants Pass School District no. 7	K-12 Education
Grants Pass Sobering Center	BH, SUD
Healthy U	BH
Hearts with a Mission	Serves Homeless, Runaway, And Transitional Youth In Crisis By Providing Shelter, Educational Support, Mentoring, Family Reunification, And Transition Planning
Housing Authority of Jackson County	Local Housing Authority
Illinois Valley Community Development Organization	Community, Economic, Environmental Programs
Jefferson Regional Health Alliance	Regional Health Collaboration
Josephine County Prevention and Treatment Services	BH, SUD
Josephine County Public Health	Local Public Health Department
KidZone Community Foundation	Physical Activity programs for families, children and teens
Maslow Project	Homeless Services, Families and Children
Options for Southern Oregon	CMHP
Oregon Internal Medicine LLC	Medical Provider
OSU Extension Office - Josephine County	Family and Community Health Programs
Pediatric TLC	Medical Clinic
Rogue Community Health	
RVCOG Deaf & Medical Providers Workgroup	Disability Services Workgroup
RVTD TransLink	NEMT

Community Letters of Support

Organization Name	Type
ShareCare/Blue Zones	Community Wellness Initiatives/Programs
Siskiyou Community Health Center	Medical, Dental, Pharmacy, Walk-in Clinic
Southern Oregon Early Learning Services	Early Learning Hub
Southern Oregon Success	Family Health, Early Childhood, Education, Youth Services
Three Rivers School District	k-12 Education
UCAN	Community Action Network
United Way of Jackson County	Community Support Programs
VCOG - Senior and Disability Services	Senior and Disability Services
Women's Health Center of Southern Oregon, Inc.	Medical Clinic, Obstetrics
YMCA Grants Pass	Family Fitness Center

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 provided.

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
6	4	2	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

Baker	4,909
Benton	15,301
Clackamas	74,615
Clatsop	11,241
Columbia	11,951
Coos	22,155
Crook	7,170
Curry	7,095
Deschutes	42,865
Douglas	36,419
Gilliam	461
Grant	1,827
Harney	2,457
Hood River	6,950
Jackson	70,113
Jefferson	9,403
Josephine	32,864
Klamath	24,127

Lake	2,335
Lane	103,382
Lincoln	16,005
Linn	38,219
Malheur	12,633
Marion	107,237
Morrow	3,796
Multnomah	206,241
Polk	20,497
Sherman	458
Tillamook	7,828
Umatilla	23,645
Union	7,547
Wallowa	2,056
Wasco	8,758
Washington	107,778
Wheeler	397
Yamhill	26,515

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

Members with no claims history

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

Full County Coverage Exception Request – Full Text

PrimaryHealth has proposed to retain partial coverage of Douglas County with zip codes 97410 and 97442, which are within our current service area. These small rural communities house approximately 400 current health plan members.

Geographically, a mountain pass separates Southern Douglas County from the larger metropolitan areas of Douglas County. This creates a natural access pattern for residents of these zip codes to travel south into Josephine County when seeking medical, dental, mental health, and community services. Even school services are often accessed within the Three Rivers School District for many of these residents. Allowing these OHP members to access services through natural geographic patterns removes barriers to health care and vital services and improves health equity.

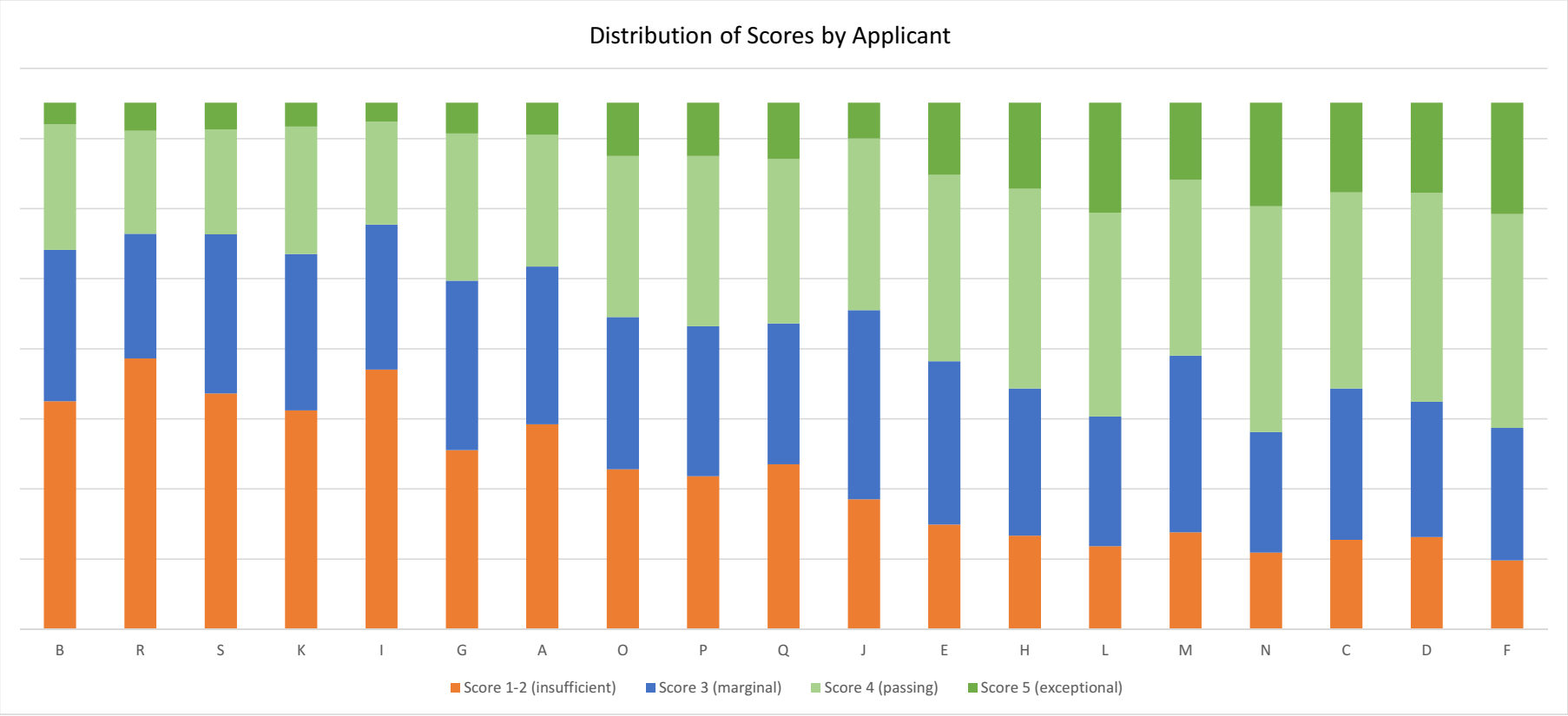
To ensure we meet the needs of these communities, PrimaryHealth will seek a Douglas County resident for the Josephine County CAC. Currently, the CAC includes representation from our outlying rural areas. We also have sought agreements with Douglas County government, which holds the Public Health Authority and Mental Health Authority. While most medical and mental health services will be provided by Josephine County network providers, contractual arrangements are also held with Douglas County providers for mental health and public health services. Options for Southern Oregon will provide behavioral health services for the residents of these zip codes. Given there are no actual provider clinics in these communities, cost-containment and value-based payment efforts for this population will occur through the implementation of VBP in our Josephine County provider network.

The drive from Glendale, OR to Grants Pass, OR is 33 minutes, or 27.5 miles. The distance to Roseburg, OR from Glendale is 50 min or 45 miles. Because of the shorter travel time and mountainous terrain, which can be treacherous in the winter, most individuals seek services in Josephine County rather than traveling north. While we do not wish to serve the full county, we believe that allowing these OHP members to access services through natural geographic patterns removes barriers to health care and vital services and improves health equity. The request for inclusion of these zip codes is not based on an assessment that mitigates financial risk. These codes are currently under the CCO's contract with OHA. This request is made based on geographical access patterns and a desire to provide continuity of care for individuals in our community

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