RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant N
Trillium Community Health Plan, Inc.

CONFIDENTIAL UNTIL 7/9/19

Evaluation Overview

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

Criteria Development

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

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

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

Passing Score

Team Analysis

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

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

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

Evaluation Results: Policy Alignment

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

Evaluation Results: Informational Assessment

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

CONFIDENTIAL

Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

CONFIDENTIAL UNTIL 7/9/19

CONFIDENTIAL

Ex:

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

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

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

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

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

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

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

CONFIDENTIAL

Executive Summary

Financial Analysis

- DCBS financial review found that the pro forma financials appear positive, and there is a little margin for error if the Company's projections are higher than actual results. Cumulative results below their projections would be problematic and compound the issue.
- Applicant did not provide details about administrative services or management agreements and cost allocation, or expense arrangements with parent entities or affiliates.

Service Area Analysis

- Trillium is requesting to cover the entirety of Lane, Clackamas, Multnomah and Washing counties, and partial Linn and Douglas counties.
- There is service area exception request for the partial counties. Trillium failed in the Business Administration, Community Engagement, Clinical and Service Delivery, and Finance areas. Trillium passed in the Care Coordination and Delivery System Transformation areas.
- Trillium is one of multiple applicants for these service areas. There is low or no risk that Trillium will be below the enrollment minimum or exceed the enrollment maximum.

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

- 113 letters were received from various provider groups and local entities
- NOTE - There are no letters of support from PDX Metro area hospitals and only one hospital in network for the Lane County Area. Letters of support are divided by region.

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

Trillium's responses to informational questions scored high in all five categories – Behavioral Health, Cost, Social Determinants of Health, Business Operations and VBP.

CONFIDENTIAL

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 29, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Trillium Community Health Plan

I have performed a review of Trillium Community Health Plan that includes pro forma financial information, audited financials, Articles of Incorporation, and biographical affidavits.

The pro forma financials include a profit and loss statement for estimated enrollment, minimum enrollment, and maximum enrollment. The three enrollment scenarios include an RBC projection. Trillium projected RBC of 301.2% or higher on the profit and loss statement for each of the three enrollment scenarios. It appears the company will have capital contributions to maintain sufficient financial position to meet the requirements of CCO 2.0 as well as DCBS financial requirements.

The pro forma profit and loss statement from Trillium was used by DFR to estimate a scenario that the Company's RBC would qualify for a regulatory action level. The pro forma calculations by the Company for expected, minimum, and maximum enrollment were loaded by DFR to include an extra percentage for hospital and medical expenses, other professional services, prescription drugs, and aggregate write ins for other hospital and medical expenses. The same percentage was applied to all four expenses. DFR estimates a 2.27% negative deviation to the four expenses on line 13 of the pro forma profit and loss statement will result in a regulatory RBC action level at the end of 2022 at expected enrollment.

CONFIDENTIAL

The estimations in the above paragraph were used to identify a scenario that the Company would enter a mandatory control level. DFR estimates a 3.28% negative deviation to the four expenses on line 13 of the pro forma profit and loss statement will result in a mandatory RBC control level at the end of 2022 at expected enrollment.

The pro forma financials appear positive, but there is little to no margin for error if the Company's projections are higher than actual results. And cumulative results below their projections would be problematic and compound the issue.

The above calculations made by DFR include changing the formula used for beginning year surplus in line 29 of the pro forma P&L statement of the second and third years to equal the end of year surplus on line 34 of the prior year.

There is a substantial difference between the estimated total capital and surplus used in the pro forma financials at 1/1/2020 (P&L Statement, line 29) and the total capital and surplus reported in Trillium's 3/31/2019 Quarterly Statement of $55.0 million. The pro forma financials (P&L Statement, line 29) estimate 1/1/2020 surplus of $258.3 million in the maximum enrollment, $77.0 million in the best estimated enrollment, and surplus of $52.4 million at minimum estimated enrollment.

My opinion, based on a review of Trillium's profitability over the last five years, is that a substantial capital infusion will be required to cover the difference between Trillium's 3/31/2019 surplus of $55.0 million and the estimated amounts at 1/1/2020 for maximum enrollment and for best estimated enrollment. I was unable to find any information about the availability of additional capital in the information that was provided, but a review of Centene's 2018 audited financials used in Form 10K indicates Centene has 12/31/2018 stockholders' equity of $10.9 billion. Centene appears to have the ability to make the required capital contribution to increase total capital and surplus to the amounts used at 1/1/2020 on line 29 of the P&L Statement.

The audited financials for Trillium were reviewed and no material concern was noted. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in each of the four years from 2014 through 2017 and reported net income between $5.0 million and $22.2 million in each year. Total capital and surplus was $43.5, $41.3, $64.5 million, and $65.5 million at year-end 2014, 2015, 2016, and 2017, respectively. The substantial increase to surplus in 2016 is partially due to a $19.3 million capital contribution.

Information available in the NAIC/ISITE financial profile was used to supplement the information provided in the audited financials. Trillium reported a YTD net loss of $8.9 million, $7.3 million, $6.8 million, and $13.6 million at 3/31/2018, 6/30/2018, 9/30/2018, and 12/31/2018, respectively. Net income of $1.5 million was reported at 3/31/2019 but a longer trend is required to determine if the favorable results are likely to

CONFIDENTIAL UNTIL 7/9/19

continue. Trillium's ratio of liquid assets and receivables to current liabilities is 153.1% at 3/31/2019 and decreased by 0.5 points from the prior year-end. The ratio is below the considered "ideal benchmark" of 200% and is also below the current health insurance market average, which was 175.4% at 12/31/2018.

Trillium's financial position suggests that an additional capital contribution could be required to maintain adequate liquidity, especially if there is a negative deviation of 2.27% or greater to expenses for policyholder benefits. Centene's financial position, including $10.9 billion in shareholders' equity suggests that Centene has the ability to infuse additional capital. No information was identified in the information provided that would indicate Centene's desire to make the additional capital contribution.

An actuarial review performed by OHA expressed the possibility that Trillium may not obtain enough members. The pro forma financials for minimum enrollment project a net loss of $393 thousand in 2020, $0 in 2021, and net income of $7.7 million in 2022. Trillium appears to have adequate surplus and liquidity at 3/31/2019 to absorb any unfavorable results associated with low enrollment.

The Articles of Incorporation were reviewed and no concern was noted. My review did not include verifying the Articles comply with the applicable statute because Trillium has an Oregon certificate of authority. DFR's procedures for reviewing an Oregon domiciled certificate of authority application require a review of the Articles. I relied upon the review that was performed by DFR during the certificate of authority application process to ensure that the Articles comply with the applicable statute.

The biographical affidavits include one charge for a criminal offense related to a minor in possession of alcohol and four bankruptcies. The alcohol charge is reported to have occurred as an 18 year old student. The five individuals that reported the unfavorable information on the biographical affidavits appear qualified to serve on Trillium's Board pursuant to ORS 414.625(2)(o) rather than ORS 731.386. No material solvency or financial concern was associated with the review of the biographical affidavits that would be expected to impact the company.

[End of summary]

Additional commentary from DCBS not included in Summary Memo:

Analyst recommends OHA request additional information to determine the level of support for capital infusions and the amount of capital that Agate and Centene are willing to contribute if Trillium experiences unexpected and unfavorable results to profitability.

CONFIDENTIAL

ASU Analysis of Applicant Financial Assumptions

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

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary. 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**
1,506,810	1,095,068	5,181,808	510,000	73%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$434.63		$446.42	$469.03	-7%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
90%	92%	-2%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.28%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.26%	0.30%

TCHP's 12/31/2018 C&S is $59 M, as opposed to $77 M as of 1/1/2020. Note however that either figure is comfortably in excess of 200% RBC. The increase in C&S may be in part due to anticipated expansion into the TriCounty area.

CONFIDENTIAL UNTIL 7/9/19

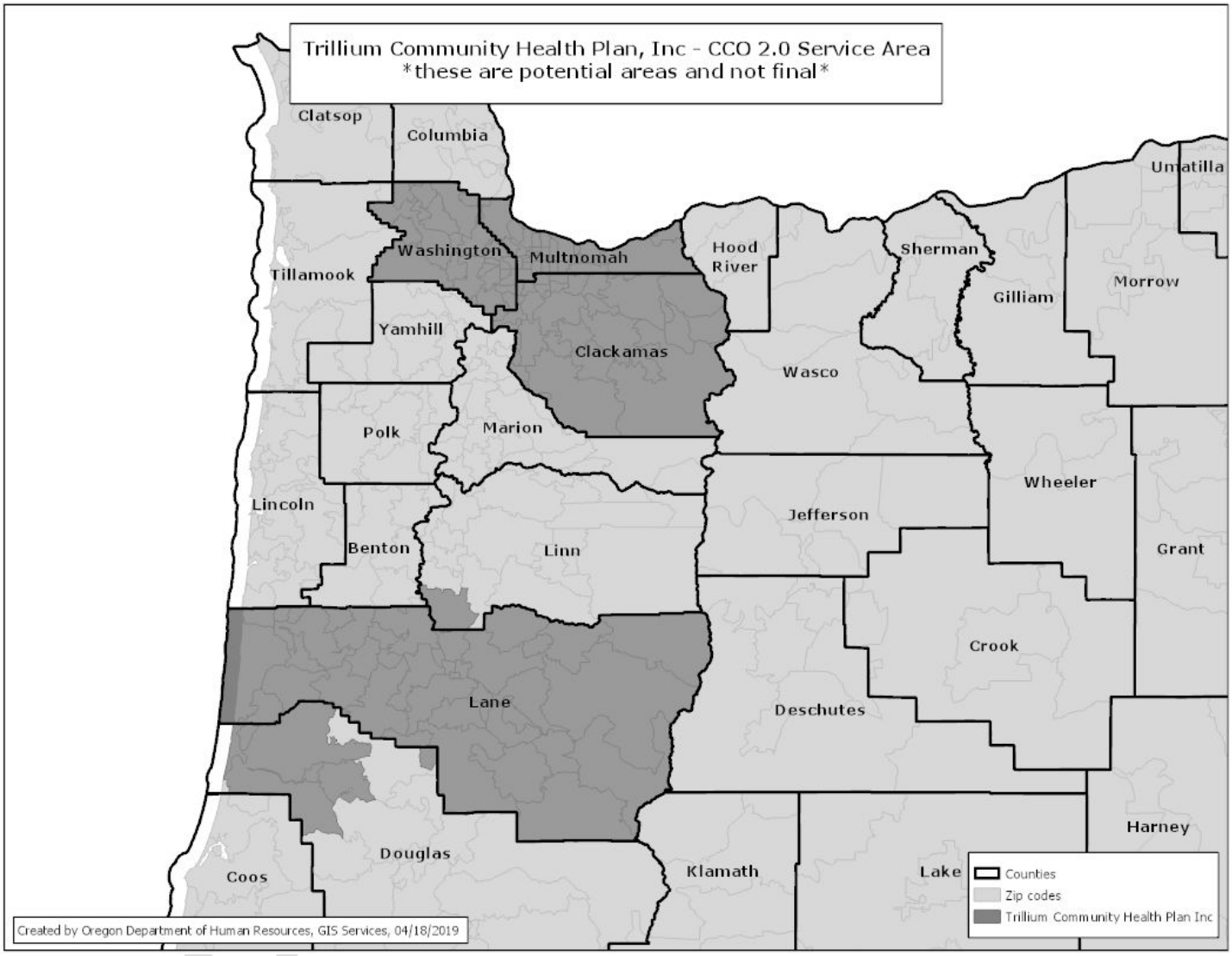
TCHP enrollment is noticeably lower than their best estimate. A primary reason is that they anticipated a 25% market share in TriCounty. However, the size of their listed provider network is about 17% of HSO. ASU estimated 20% market share in Multnomah and 10% in Washington and Clackamas Counties on the basis of the total and primary care network listings. Trillium is however likely to obtain more than 50% market share in Lane County if one of the other two applicants for that county are declined. We also note that ASU's total expected enrollment is close to TCHP's 2018 total enrollment.

CONFIDENTIAL

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Washington, Multnomah and Clackamas counties in a new regional expansion. Applicant is requesting to cover the entirety of Lane county, and partial Linn and Douglas counties in alignment with the existing service area.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	19	11
Care Coordination and Integration	8	22
Community Engagement	10	5
Clinical and Service Delivery	17	16
Delivery System Transformation	4	8
Finance	7	5

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

CONFIDENTIAL

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
Lane, Washington, Multnomah, and Clackamas	Douglas and Linn	Multiple Applicants propose serving the service area Trillium proposes.	No scenarios show enrollment below applicant's minimum	No scenarios show enrollment exceeding applicant's maximum	Low risk

Additional Analyses on High Risk Areas

Lane County

Three applicants have proposed to serve Lane County members, which contains nearly 103,400 members.

Applicant	Minimum threshold
Pacific Source Lane	10,000
West Central	35,200
Trillium*	42,500

*Note: Trillium's min and max reflect all proposed service areas, including Lane County and the Portland metro area.

Over 21,000 members in Lane County are in open-card. Assuming these individuals remain in open-card, 82,400 members remain to be allocated to the applicants. If Trillium does not serve the Portland metro area and must attract all their members from Lane County, the sum of all three applicants' minimum thresholds is 87,700 which exceeds the number of non-open-card members in the county. The only scenario in which all

CONFIDENTIAL UNTIL 7/9/19

three applicants meet their minimum threshold is if 5,300 – or a quarter – of open-cards are willing to join a CCO.

Trillium's minimum enrollment is 42,500 and their maximum is nearly 432,000 which is the highest of any applicant.

The table below outlines different scenarios and the impacts on each Lane County applicant, as modeled by the Monte Carlo simulations which rely on at most 35% of members opting to leave their CCO and move to another.

Scenario description	Impact on Pacific Source Lane	Impact on West Central CCO	Impact on Trillium
All three applicants awarded	74% chance the applicant does not meet their minimum threshold. (See Findings table above)	100% chance the applicant does not meet their minimum threshold. (See Findings table above).	Because Trillium currently serves Lane County, it is likely that a significant share of enrollees remain with Trillium.
Trillium and Pacific Source Lane awarded	23% chance the applicant does not meet their minimum threshold.	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.
Trillium and West Central awarded	Not awarded in this scenario	100% chance the applicant does not meet their minimum.	Projected enrollment falls within the applicant's parameters.
Pacific Source Lane and West Central awarded	Projected enrollment falls within the applicant's parameters.	2% chance the applicant does not meet their minimum threshold	Not awarded in this scenario
Only Pacific Source Lane awarded	Projected enrollment falls within the applicant's parameters.	Not awarded in this scenario	Not awarded in this scenario
Only West Central awarded	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.	Not awarded in this scenario
Only Trillium awarded	Not awarded in this scenario	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.

CONFIDENTIAL UNTIL 7/9/19

Member Allocation Projection

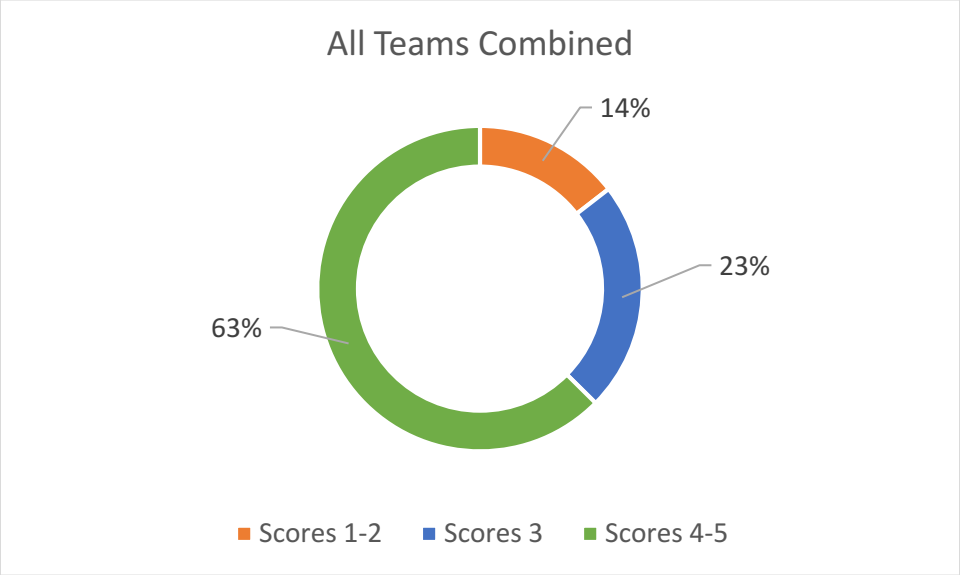
Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Trillium is likely to receive approximately 100,843 members out of the 42,500 minimum required. This includes all service areas in the Application.

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.

CONFIDENTIAL

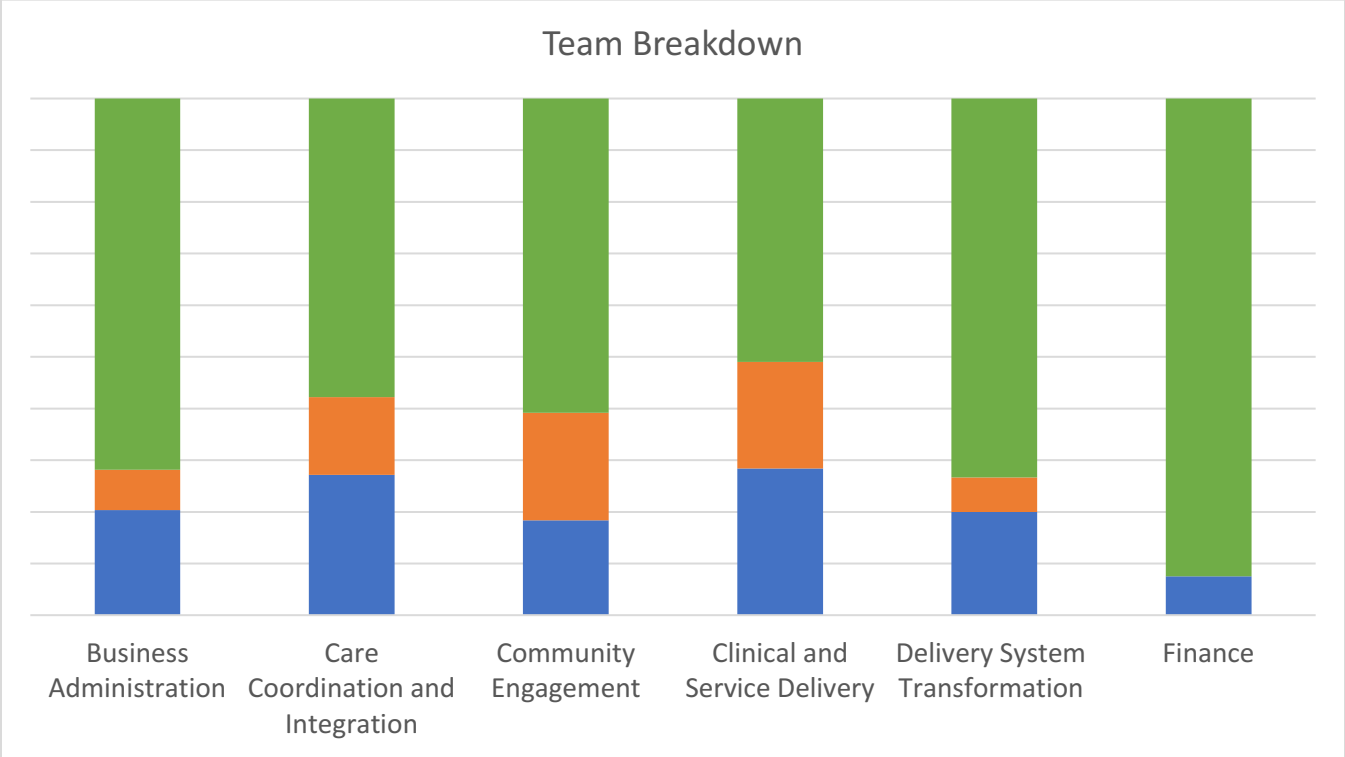
Evaluation Results – Overall Scores

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



Scoring by Team

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



CONFIDENTIAL UNTIL 7/9/19

Overall Team Recommendations

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	X	X
Clinical and Service Delivery	PASS	X		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	0	3	33
Cost	0	3	31
Behavioral Health	16	45	116
Social Determinants of Health	19	20	74
Business Operations	74	101	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**
Behavioral Health	4	6	45
Social Determinants of Health	2	4	27
Cost	9	8	40
Value-Based Payment	0	20	36
Business Operations	15	25	57

CONFIDENTIAL UNTIL 7/9/19

Finance

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Value-Based Payment	0	1	19				
Cost	0	1	17				
CCO Performance and Operations	0	2	13				

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

Deficiency Analysis

Value-Based Payment
No deficiencies noted

Cost
No deficiencies noted

CCO Performance and Operations
No deficiencies noted

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Trillium Community Health Plan, Inc. be given a “pass” for the financial section. There were no financial concerns or deficiencies.

CONFIDENTIAL

Business Administration

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Member Transition	0	7	29				
Health Information Technology	3	5	32				
Social Determinants of Health	1	7	20				
Administrative Functions	9	15	39	X		X	

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

Deficiency Analysis

Administrative Functions

The responses in this section largely contained adequate amount of detail. The Third Party Liability sections were the exception, detail was lacking on TPL data sources, and TPL validation processes. Also, no mention of how Medicare coverage would be monitored. The pharmacy section was missing info on a public facing website, how pharmacy coverage information would be communicated to member and a description of the pharmacy prior authorization process. The pharmacy deficiencies could be addressed **relatively quickly** but the TPL deficiencies may take a **moderate amount of time** to address if TPL processes are missing entirely.

Health Information Technology

The clear majority of answers in this section were responsive and adequately detailed.

Member Transition

The majority of answers in this section were high-level and lacked detail. Responses to some questions were located under adjacent questions. Responses to continuity of care for members at risk were particularly lacking in detail. These deficiencies could be addressed **relatively quickly**.

Social Determinants of Health

The SDOH-HE responses failed to relay how Applicant would communicate the SDOH-HE spending strategy and how interested parties would apply for SDOH-HE funds. There was no mention of limitations in regards to collecting or analyzing the SDOH-HE data and it was not clear how SDOH-HE data would inform decisions. For the health equity response, there appeared to be an over-reliance on health equity officers and

CONFIDENTIAL UNTIL 7/9/19

individual health inequities – little consideration given to how health equity principles are applied on an organizational basis. Proactive plan for how members can access different languages or formats is missing.

The deficiencies noted could be remedied **relatively quickly**.

Team Recommendation: **PASS**

- The quality of responses varied by section, but overall there were only a few, easily remedied deficiencies noted.
- Recommendation that Applicant provide detailed information on their TPL processes.
- Recommendation that Applicant provide detailed information on their public facing pharmacy website, processes for communicating pharmacy benefits to members and process for pharmaceutical prior authorization.
- Recommendation that Applicant provide additional detail on how they will administer SDOH-HE funds and mange SDOH-HE data.

CONFIDENTIAL

Care Coordination and Integration

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	2	0	10	X			
Behavioral Health Covered Services	0	7	29				
Care Integration	7	2	12		X		
Care Coordination	14	24	38	X		X	
Health Information Exchange	3	14	11	X			X

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

Deficiency Analysis

Applicant's responses on behavioral health benefit plans were well received. Reviewers noted that responses lacked some detail on processes for establishing MOUs with CMHPs. More information was desired regarding the applicant's future plans for this activity.

Behavioral health covered services responses were generally well received. However, the Applicant demonstrated a lack of engagement in moving toward treatment of behavioral health conditions, especially among the SPMI population. Additional detail was also desired with respect to the applicant's plans for care coordination activities.

Care coordination responses were seen to lack information on how care coordination activities would occur for adults with behavioral health needs. Additionally, no detail was provided on existing partnerships; crisis management services or how the applicant plans to work across systems. The applicant failed to clarify how coordination activities would occur for the 1915i and Developmental Disabilities populations. Responses in this section lacked detail on:

- Plans to provide language services
- Care transition process
- Strategy to meet dental health needs
- How to reach out to members with special care coordination needs.

CONFIDENTIAL

Team Recommendation: **PASS**

Care integration responses were generally well received; however, additional detail on how information sharing will happen in EHR systems, how agreements will allow for care coordination and how coordination for the dual eligible population will work. Reviewers noted that if these responses lacked detail due to technological shortcomings that they would likely be difficult to resolve. The applicant generally lacked detail on how they plan to coordinate care for complex members with transitions occurring across systems.

Applicant's ability to support Health Information Exchanges (HIE) was relatively clear, though much of their responses on HIE were focused on hospital event notifications. Reviewers also felt that the applicant conflated EHR systems with an event notification system. Limited detail was provided on how the Applicant would ensure access to HIE data across contracted provider types.

CONFIDENTIAL

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	0	6	27				
Service Operations	2	14	30				
Behavioral Health Covered Services	14	30	40				
Administrative Functions	27	9	9	X		X	

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

Deficiency Analysis

Administrative Functions

The responses in this section lacked detail. For the network adequacy questions, there was not enough detail provided how they will monitor and fix deficiencies and no indication of how frequently Applicant is monitoring wait time to appointment. Applicant neglected to specify network adequacy in term of provider type – physical, behavioral health and oral. The main remediation strategy to increase network capacity was to require all providers receiving a VBP to maintain an open panel as a condition of payment. The grievance and appeals section was not properly formatted and lacked detail. The deficiencies noted could be remedied with a **small amount of effort.**

Behavioral Health Benefit

This responses in this section were largely responsive.

Behavioral Health Covered Services

The responses in this section were largely responsive. The process for member notification about care coordination relies on members reading their member handbooks which no one does. This process should be revised to be more member friendly. This deficiency could be **easily remedied.**

Service Operations

The responses in this section were largely responsive with minor amount of missing detail. There is limited info on communicating with members on pharmacy benefit; detail is needed on the frequency and monitoring of utilization; the LTSS section did not address a care model in congregate settings. It was difficult to tell if their care models were just general care models or if they were being adjusted to use with the LTSS population, but it seemed like they were not LTSS specific. The deficiencies noted could be remedied with a **minimal amount of effort.**

CONFIDENTIAL UNTIL 7/9/19

Team Recommendation: **PASS**

- The responses for these sections were largely responsive, with the exception of those in the Administrative function section.
- Recommendation that Applicant provide detailed descriptions for all of the network adequacy and grievance and appeals questions in the Administrative function section.
- Recommendation that the process to access care coordination be made more member-friendly by removing steps that require the member know how to read and have access to a phone/computer.
- All deficiencies noted could be remedied with a **minimal amount of effort**.

CONFIDENTIAL

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Accountability and Monitoring	0	1	17	X		X	
Delivery Service Transformation	2	5	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 sufficient information about complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination specific to BH, Oral and PH services.

Delivery Service Transformation

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

Transforming Models of Care – Applicant failed to provide sufficient information about auto-assignment. Applicant failed to provide sufficient details about PCPCH, plans for auto-assignment, oversight, and engagement of potential new PCPCH providers. Lacking sufficient information about member outreach. Lacking sufficient information about monitoring the non-PCPCH model to ensure fidelity. Lacking sufficient information about care coordination, evidence for success, effective wellness and prevention, and emphasis on whole person care.

CONFIDENTIAL

Team Recommendation: **PASS**

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

Accountability and Monitoring

- Describe how complaint/grievance information is shared and communicated with providers
- Provide information about referral and pre-authorizations specific to BH, Oral and PH services

Delivery Service Transformation

- Describe plan and process for collecting data by population sub-category (by REAL-D)
- Describe methods that will be used for member engagement and outreach
- Provide plan to monitor the non-PCPCH model

CONFIDENTIAL

Community Engagement

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Social Determinants of Health	3	3	14			X	
Governance and Operations	3	7	20				
Community Engagement Plan	15	10	35	X			
Community Engagement	4	2	4	X		X	

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

Deficiency Analysis

- Community Engagement Plan is missing a description of the expansion of 1 out of 5 initiatives and narrative about the other 4 expansion is extremely high level and void of detail.
- No strategies provided for how they will engage/align CAC with demographics with current or expanded service area beyond indicating "all appropriate communities represented" and no strategy for collaborating with CACs from other CCOs. Accountability and reporting of Board decision is expected to happen through the 2 CAC members which is not necessarily adequate.
- No mention of MOU with Multnomah County
- Unclear how non-CAC members are engaged or how their voice is elevated.
- No process for ongoing Quality Improvement of the CEP and no mention of member voice
- Community partner engagement - Incomplete engagement with LPHAs, hospitals, and tribes
- Some SDOH priorities were not aligned with OHA SDOH definition and no discussion of how decision making on SDOH funding process is transparent and equitable
- Doesn't address their experience or capacity to address disparities

CONFIDENTIAL

Team Recommendation: **PASS**

- Need better plan for engagement of non-CAC OHP members, including elevating member voice to leadership
- Ensure engagement of OHP members (CAC and non-CAC) and LPHA, hospitals, and tribes from the entire service
- Need plan for quality improvement of the community engagement plan
- Develop culturally and linguistically strategies for recruiting/engaging CAC members that are specific to the diverse populations in the geographic area
- Define member role in quality improvement activities
- Ensure MOU with Multnomah County established
- Develop more robust strategy for accountability and transparency of CAC recommendations back to the CAC
- Ensure sufficient capacity to address disparities
- Develop a plan to establish transparent and equitable decision-making processes that can be applied to the SDOH-HE monies

CONFIDENTIAL

Community Engagement – Community Letters of Support

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

Lane County

Organization Name	Region	Type
Cascade Health Solutions Behavioral Health	Lane	Counseling and Mental Health Services
Cascade Health: Pete Moore Hospice House	Lane	Hospice Provider
Center for Family Development	Lane	Behavioral Health Provider (THW), Outpatient Mental Health and Substance Use Disorder (SUD) Treatment
Centro Latino Americano	Lane	Culturally-Specific Behavioral Health, BH THW, interpreter
Christians as Family Advocates (CAFA)	Lane	Behavioral Health Provider
Community Health Centers of Lane County	Lane	Primary Care/Behavioral Health/Safety Net Provider
Community Health Centers of Lane County (Consumer Advocate): Rick Kincade	Lane	CAC member
Consumer	Lane	Trillium Board Member
Consumer	Lane	Rural Advisory Council Member
Consumer	Lane	CAC Member
Consumer Advocate: Cindy Williams	Lane	CAC Member
Cornerstone Community Housing	Lane	
Cornerstone Community Housing (Consumer Advocate): Caitlyn Hatteras	Lane	
Cornerstone Community Housing (Consumer)	Lane	CAC Member
Court Appointed Special Advocates – CASA (Consumer Advocate): Heather Murphy	Lane	Children's Court Advocates
Daisy C.H.A.I.N.	Lane	Doula (THW)
Department of Human Services District 5 (Consumer Advocate): John Radich	Lane	CW, SSP
Direction Service	Lane	Family Support
Domestic Violence Resource Center (Oregon Coalition Against Domestic and Sexual Violence)	Lane	DV, DA Services
Douglas Education Service District: South-Central Early Learning Hub	Lane	South-Central Oregon Early Learning Hub
Douglas Public Health Network	Lane	Local public health authorities
Early Childhood CARES	Lane	Early Childhood Development Provider
Emergence (Florence and Eugene)	Lane	Outpatient Behavioral Health

CONFIDENTIAL UNTIL 7/9/19

Organization Name	Region	Type
Eugene Pediatrics Associates	Lane	Primary Care, Pediatrics
FOOD for Lane County	Lane	
HeadStart Program (Consumer Advocate): Val Haynes	Lane	Preschool Programs, Early Childhood
HIV Alliance	Lane	
Homes for Good	Lane	
Integrated Health Clinic (Eugene)	Lane	Substance Use Disorder (SUD) Treatment
Jewish Family Services	Lane	
Keiperspine	Lane	Specialist: Surgery
Kids First (Forensic Intervention Response & Support Team)	Lane	Referrals and Support
Lane Council of Governments (LCOG) Senior & Disability Services	Lane	Area Agency on Aging (AAA) /Aging and Persons with Disabilities (APD) Local Office
Lane County Behavioral Health	Lane	Local Government Behavioral Health Provider
Lane County Behavioral Health	Lane	Local mental health authorities
Lane County Developmental Disabilities (Consumer Advocate): Carla Tazumel	Lane	IDD
Lane County Public Health	Lane	Local public health authorities
Lane County Public Health (Consumer Advocate): Jocelyn Warren	Lane	Public Health
Lane Equity Coalition (LEC)	Lane	
Lane Independent Living Alliance (LILA)	Lane	
Laurel Hill Center	Lane	Intensive Mental Health Services
Linn County Mental Health	Lane	Local mental health authorities
Linn County Public Health	Lane	Local public health authorities
Looking Glass	Lane	Counseling and Residential Services
Madrone Mental Health Services	Lane	Outpatient Mental Health Services
McKenzie Family Practice	Lane	Primary Care/Clinic
McKenzie Family Resource Center (Consumer Advocate): Robin Roberts	Lane	Food Pantry
McKenzie-Willamette Medical Group	Lane	Primary Care, Emergency Department, Behavioral Health
Medical and Surgical Specialists (MASS) Women's Care	Lane	Primary Care, OB/GYN
Oregon Community Programs	Lane	Research and Non-Profit Organization
Oregon Imaging Centers	Lane	Specialist: Medical Imaging
Planned Parenthood of Southwest Oregon	Lane	Medical Clinics
Prevention Plus Clinic	Lane	Primary Care/Clinic
Relief Nursery	Lane	

CONFIDENTIAL UNTIL 7/9/19

Organization Name	Region	Type
Serenity Lane	Lane	Substance Use Disorder (SUD) Treatment
Shangri-La	Lane	Outpatient Behavioral Health Services
ShelterCare	Lane	
South Hilyard Clinic (Cultural Training- CT and ASL Signage)	Lane	Primary Care/Clinic
Sponsors	Lane	Substance Use Disorder (SUD) Treatment and Counseling
Springfield Family Physicians	Lane	Primary Care/Clinic
Springfield Treatment Center	Lane	Substance Use Disorder (SUD) Treatment
St. Vincent DePaul	Lane	
Successful Aging Institute: Lane Community College (Senior Companion Program)	Lane	Aging Supports and Education
The Child Center	Lane	Outpatient Behavioral Health and Crisis Services
Trans*ponder	Lane	Support Services
Trauma Healing Project	Lane	
Turning Point Center	Lane	Specialist: Acupuncture
United Way of Lane County: Lane Early Learning Alliance	Lane	Lane Early Learning Alliance
Volunteers in Medicine	Lane	Primary Care/Clinic
Western Lane Behavioral Health Network	Lane	Behavioral Health Collaboration
White Bird Clinic (Chrysalis Behavioral Health	Lane	Substance Use Disorder (SUD) Treatment, Counseling, Crisis Services
Willamette Family Inc.	Lane	Behavioral Health Provider (THW), BH, SUD
Womenspace	Lane	DV, SA Services
Youth ERA	Lane	

CONFIDENTIAL

Portland Metro

Organization Name	Region	Type
Boys & Girls Clubs of Portland Metropolitan Area	PDX Metro	
Cascade AIDS Project (CAP)	PDX Metro	
Clackamas County Behavioral Health	PDX Metro	Local mental health authorities
Clackamas County Public Health Division	PDX Metro	Local public health authorities
Dress for Success	PDX Metro	Workforce Development
Innovative Housing Inc.	PDX Metro	
Lift Urban Portland (Lift UP)	PDX Metro	
Morrison Child & Family Services	PDX Metro	Mental Health/SUD
Multnomah County Health Department	PDX Metro	Local public health authorities
Multnomah County Mental Health and Addiction Services Division	PDX Metro	Local mental health authorities
Neurotherapeutic Pediatric Therapies	PDX Metro	Mental Health and Rehabilitation Services
Planned Parenthood Columbia Willamette	PDX Metro	
Portland Impact/Impact NW	PDX Metro	Area Agency on Aging (AAA) /Aging and Persons with Disabilities (APD) Local Office
Quest Center for Integrative Health	PDX Metro	Mental Health/SUD
Sequoia Mental Health Services/Tri County Behavioral Health Association	PDX Metro	Mental Health/SUD
The Children's Center	PDX Metro	
Washington County Department of Housing Services	PDX Metro	
Washington County Mental Health Authority	PDX Metro	Local mental health authorities
Washington County Public Health	PDX Metro	Local public health authorities
Youth Contact	PDX Metro	Mental Health/SUD
Youth Villages Oregon	PDX Metro	Behavioral Health: Intensive and Crisis
YWCA Oregon	PDX Metro	

CONFIDENTIAL UNTIL 7/9/19

Multiple Regions

Organization Name	Region	Type
Acadia Healthcare/Allied Health Services	Lane, PDX Metro	Mental Health/SUD
Addus Homecare	Lane, PDX Metro	Home Health Provider
Advantage Dental	Lane, PDX Metro	Dental Provider
Capitol Dental Care	Lane, PDX Metro	Dental Provider
Linguava	Lane, PDX Metro	Language Interpretation Services
Native American Rehabilitation Association of the Northwest (NARA NW) (Consumer Advocate): Jackie Mercer	Lane, PDX Metro	Culturally Specific BH, SUD
ODS Community Dental	Lane, PDX Metro	Dental Provider
Options	Lane, PDX Metro	
Orchid Health (Oakridge)	Lane, PDX Metro	Primary Care/Clinic
Oregon Alliance of Children's Programs	Lane, PDX Metro	
Oregon Family Support Network (OFSN)	Lane, PDX Metro	Behavioral Health Support and Training
Oregon Integrated Health (Eugene and Florence)	Lane, PDX Metro	Primary Care/Clinic
Oregon Wellness Network (OWN)	Lane, PDX Metro	Area Agency on Aging (AAA) Association
Trillium Family Services	Lane, PDX Metro	Mental Health and Rehabilitation Services
Willamette Dental Group	Lane, PDX Metro	Dental Provider
Yakima Valley Farm Workers Clinic	Lane, PDX Metro	Primary Care/Clinic

CONFIDENTIAL

Behavioral Health Policy Assessment

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

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

Deficiencies: Applicant states they will contract with a BMHO for behavioral health management. They do not provide information on the oversight, which makes it sound like they are delegating the behavioral health benefit.

Recommendations: Applicant needs to submit plan for how they plan to be accountable for the behavioral health benefit if they are delegating to another entity.

No additional comments received.

CONFIDENTIAL

Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

CONFIDENTIAL

Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
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.

CONFIDENTIAL

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

CONFIDENTIAL

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

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

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

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

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

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

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

The simulations also rely on:

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

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

CONFIDENTIAL

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

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

CONFIDENTIAL

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

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

Open-card enrollees are included above.

CONFIDENTIAL

Comparing July 2018 enrollment data to March 2019

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

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

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

CONFIDENTIAL

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

CONFIDENTIAL

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

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

CONFIDENTIAL

CONFIDENTIAL UNTIL 7/9/19

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

Members with no claims history

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

CONFIDENTIAL

Full County Coverage Exception Request

b. Does Applicant propose a Service Area to cover less than a full County in any County? If so, please describe how:

(1) Serving less than the full county will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:

- Community engagement, governance, and accountability;
- Behavioral Health integration and access;
- Social Determinants of Health and Health Equity;
- Value-Based Payments and cost containment; and
- Financial viability;

(2) Serving less than the full county provides greater benefit to OHP Members, Providers, and the Community than serving the full county;

PRESERVING MEMBER CHOICE AND CONTINUITY IN PARTIAL COUNTY

Partial County Exception. Trillium is proposing less than a full county to preserve member choice and continuity for members and providers. We are not pursuing the full counties in these areas, as our primary objective is to follow existing practice patterns and preserve the member and provider relationships established through our current Service Area. Our greatest ability to achieve the transformational goals of CCO 2.0 and each of the areas described, is to follow current practice patterns and leverage the current community committee structure (e.g. Rural Advisory Council established in Reedsport), BH providers and integration strategies, links to community-based agencies and social services, VBP arrangements with providers, and cost and quality controls in place or planned to ensure financial viability.

Historical Service Area. Since the inception of the CCO program in 2012, Trillium has served members in Lane County and zip codes 97448 and 97456 in Benton County and 97446 in Linn County. In 2015, Trillium expanded our Service Area to include members in Reedsport – located in Western Douglas County (97424, 97436, 97441, 97467, 97473 and 97493) and a contiguous zip code in Coos County (97449) – through a competitive application process.

Application for Partial County Service Area. It would be Trillium's desire to maintain member choice, honor current practice patterns, and preserve continuity in all of our contiguous zip codes. Based on current outreach, Trillium cannot guarantee with confidence our ability to secure MOUs with all of the required entities in Benton County by Readiness Review. In response we are limiting our Application to the partial counties of Linn and Douglas.

CONFIDENTIAL

Honoring Patterns of Care. By continuing to serve members in the contiguous areas in Linn and Douglas Counties for the CCO 2.0 program, Trillium aims to ensure continuity of care and preserve and support existing patterns of care for each community we serve, understanding that members, providers, and other available resources may not always be defined by county boundaries. For example, through detailed analysis of our membership in these areas, we know that our members in Linn County frequently access care in Lane County. Specifically, from 2016-2018, approximately 80% of claims for members in these areas originated in Lane County. Due to coastal patterns of care, many members in Reedsport travel north into Lane County to obtain care, particularly for BH services. For example, since 2016, more Reedsport members received BH services in Lane County than in any other county, including Douglas or Coos. Trillium also found that more Linn members received BH services in Lane County than in any other county. From 2016 to 2018, approximately 78% of BH claims for Linn County members originated in Lane County.

(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas.

Trillium's request to continue serving the contiguous zip codes outlined above in Douglas and Linn Counties is based solely on current practice patterns and maintaining continuity of care for our members and providers and is in no way designed to minimize financial risk or create adverse selection.

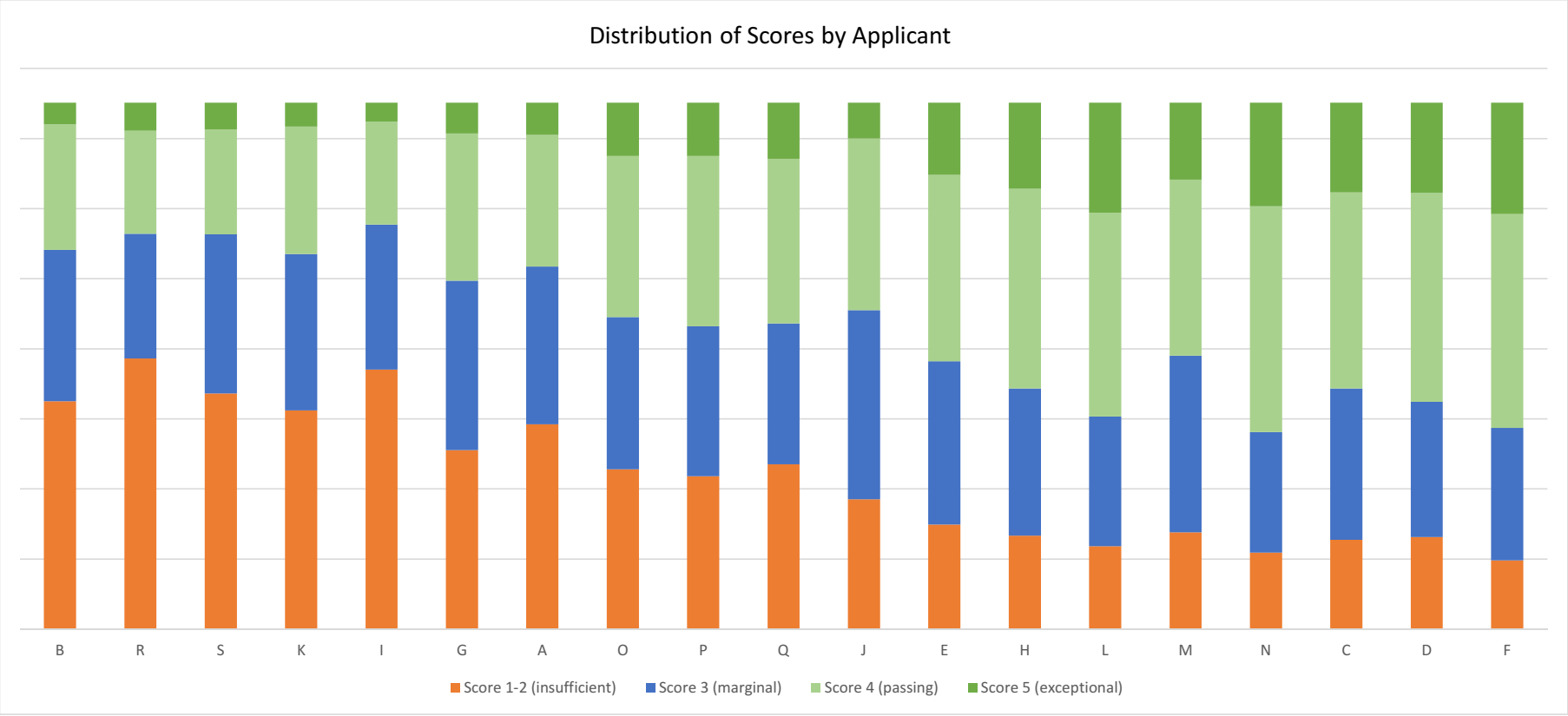
SERVICE AREA TABLE County (List each desired County separately)	**Maximum Number of Members-Capacity Level**
Clackamas County	82,800
Douglas County (97424, 97436, 97441, 97467, 97473 and 97493)	2,700
Lane County	117,750
Linn County (97446)	1,025
Multnomah County	318,600
Washington County	151,200

CONFIDENTIAL

Pass/Fail by Category

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

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



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

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

Note:

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

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

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

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

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

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

using data as of 5/22/19

CONFIDENTIAL UNTIL 7/9/2019