RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant S
Cascade Health Alliance

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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

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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

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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.

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Executive Summary

Financial Analysis

- DCBS financial review found that the results provided appear to be reasonable for the projections provided.
- Expense arrangements with parent or affiliated entities was not described
- ASU noted that there may be a concentration risk if CHA is unable to collect amounts overdue from affiliates.

Service Area Analysis

- CHA is requesting to cover part of Klamath County.
- There is a service area exception request partial Klamath County. CHA's exception request passed in the Business Administration and Care Coordination and Integration categories. The request failed in the Community Engagement, Clinical and Service Delivery, Delivery System Transformation, and Finance categories.
- CHA is the only applicant in this service area, but another Applicant is requesting to cover the northern portion of Klamath county.

Evaluation Results – Team Recommendations

- Finance – Fail; Large gaps in demonstrating ability to implement policies.
- Business Administration – Fail; responses showed fundamental gaps in processes, people, technology and general infrastructure. Deficiencies in HIT, member transition, and SDOH-HE.
- Care Coordination and Integration – Fail; Responses did not address the CCOs role when partnering with other providers and systems. Did not sufficiently address specific approaches to high-needs populations, especially dual eligible, SPMI and tribal populations.
- Clinical and Service Delivery – Fail; lacking sufficient plans for grievance and appeals, pharmacy service and utilization management.
- Delivery System Transformation – Pass
- Community Engagement – Fail; missing significant details about community engagement plan for all communities in service area. Significant technical assistance/guidance from OHA needed.

Community Letters of Support

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

Evaluation Results: Policy Alignment

The responses from CHA showed strong alignment with the Social Determinants of Health and VBP policy objectives. The responses showed weak alignment with the Cost, Behavioral Health, and Business Operations objectives.

Evaluation Results: Informational Assessment

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

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Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 29, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: CCO2.0 Financial Review

CHA=Cascade Health Alliance, LLC CCO

I have performed a financial evaluation of CHA application for their Klamath County operations based on the materials provided. CHA is an existing CCO, operating in the above county since 01/01/2013.

Cascade Health Alliance, LLC (CHA) is part of a **holding company system** in which it is 100% owned by Cascade Comprehensive Care, Inc. (CCC), who is the ultimate controlling entity. Agreements were not available for review by DCBS.

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% (209,040 Member Months), Minimum ('MIN') 75% (156,780 Member Months), and Maximum ('MAX') 125% (261,300 Member Months).

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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 $16.0M C&S and they would need to lose $13.5M to be at the minimum C&S of $2.5M. Claims would need to increase 13% for C&S to be reduced to $2.5M all else remaining the same in the first year.

RBC:

RBC was above the OHA required 200% in all scenarios presented for Best Estimate (BE), Minimum (MIN), and Maximum (MAX) Estimates, being 447.6%, 438.6%, & 453.6% under BE per year 2020 -2022, respectively. CHA would need to incur a 10% increase in claims in order for it to come to approximately 200% from the estimates provided under the BE scenario.

The applicant would meet the RBC requirements in any year across all enrollment projections for Claims +2%, +4% projections. RBC calculations was not provided by Applicant for any of the +6% scenarios.

NET INCOME:

Per the estimates provided, CHA would operate at a **net income** for all three years for all three enrollment scenarios. In a stress environment, if claims cost are approximately 2% higher, with all other items remaining the same, CHA would incur a net loss. Even at a net loss generated by a 6% increase in their claims costs, CHA would have sufficient capital & surplus to absorb the losses and meet the RBC requirements under each of their best, minimum and maximum enrollment numbers for the three-year period presented.

From the estimated data provided, CHA's Medical Loss Ratio for all three years under all scenarios comes to 90% with Claim Expense Ratio at 0% (no amount was recorded) and Administrative Expense Ratio calculated at 9% for a total **Combined Ratio** of 99% per year per scenario. CHA's actual results for periods ending 12/31/17 and 12/31/16 come to 94.70% and 93.99%, respectively for the Combined Ratio of the Company, showing only a 4-5% difference from estimated. A change of that magnitude may provide for a more conservative estimate, or more cost sharing with the providers as well.

LIQUIDITY:

For Best Estimated years 2020-2022, the **liquidity** ratio came to 181.14%, 189.60%, & 195.71%, 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.

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CHA has noted that if needed they would be able to obtain capital from their parent, CCC. In review of the consolidated financial statements for the period ending 12/31/17, it appears that the parent is operating at a net loss and all revenues of the parent is reliant on revenue from CHA. Therefore, the parent may not have the ability to infuse capital in future if needed.

Suggested Questions to pose to Applicant for further information/clarification:

- In reviewing responses from CHA, the Applicant did not address the remaining portions of the questions under the section 06.C.1.b.

    - *CHA did not describe structure in detail.*
    - *CHA did not provide detail of amounts paid under arrangements for the last two years.*
    - *CHA did not provide footnotes to the operational budget when budgeted amounts include payments to affiliates for services under such agreements.*
    - *CHA did not provide an estimated total amount per year or provide for separate amounts for Worker Leasing and Administrative Services Agreement if these are separate agreements.*

[End of summary]

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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**
209,040	200,680	261,300	156,780	96%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$448.56		$463.25	$457.26	-2%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
90%	88%	2%

Cost Trend	
Applicant Assumption	**OHA Assumption**
8.09%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.21%	0.21%

Admitted assets

Applicant's stated total admitted assets for 2020 (BE MM) is $35M, which is consistent with its reported asset number at FY2018 year-end.

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However, per Exhibit L5's breakdown, $18.7M (over 50% of the asset or 139% of the C&S) is "long-term due from affiliates" (this is also consistent to and confirmed by 2017's audited financials for CHA).

There is no more information/detail could be found anywhere regarding this $18.7M balance (such as from which affiliates the balance is due from, and the financial condition of these related affiliates), and thus no more research/analysis could be performed regarding the collectability/creditability of this receivable balance.

(Note: Per the submitted attachment 6_Aol and Org Chart, CHA is 100% owned by its parent company Cascade Comprehensive Care, Inc (CCC), further CCC owns 50% of KMBC, LLC and 33.33% of Atrio health Plans, Inc.)

Risk: This raises a concentration risk. If the collectability/credibility of the $18.7M receivable balance is impaired, applicant's C&S could be dropping below the required capital level and trigger insolvency.

Recommendation: Ask applicant to provide further breakdown about the $18.7M and the related information to prove the collectability of this balance.

Capital and Surplus

2020 YE's beginning C&S shows an increase of $1.6m from 2018 YE, which is reasonable as 2019's net income could easily contribute to this increase (FY2018's net income is $2.5m).

Risk: None identified at this time

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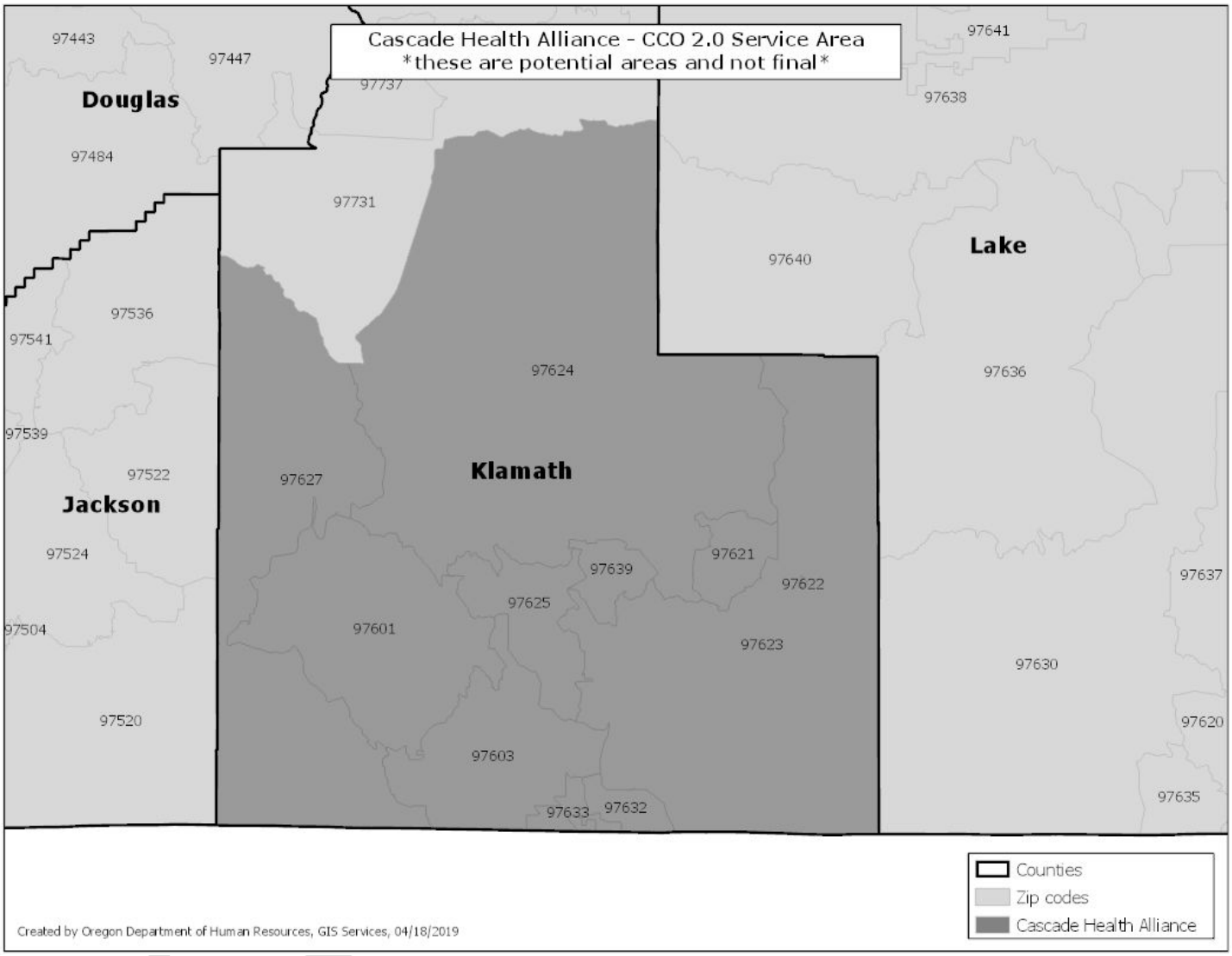
Service Area Analysis

Requested Service Area

Applicant is requesting to cover partial Klamath county.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	14	16
Care Coordination and Integration	15	15
Community Engagement	10	5
Clinical and Service Delivery	18	15
Delivery System Transformation	8	4
Finance	8	4

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

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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
None	Klamath	No modeling performed. Cascade Health Alliance would be the only CCO serving southern Klamath. A significant number of open card enrollees would have to join the applicant, or a significant number of current Cascade Health Alliance enrollees would have to leave in order for the applicant's enrollment to fall outside of their min-max range.			

Member Allocation Projection

No member allocation tests performed. Cascade Health Alliance would be the only CCO serving these counties.

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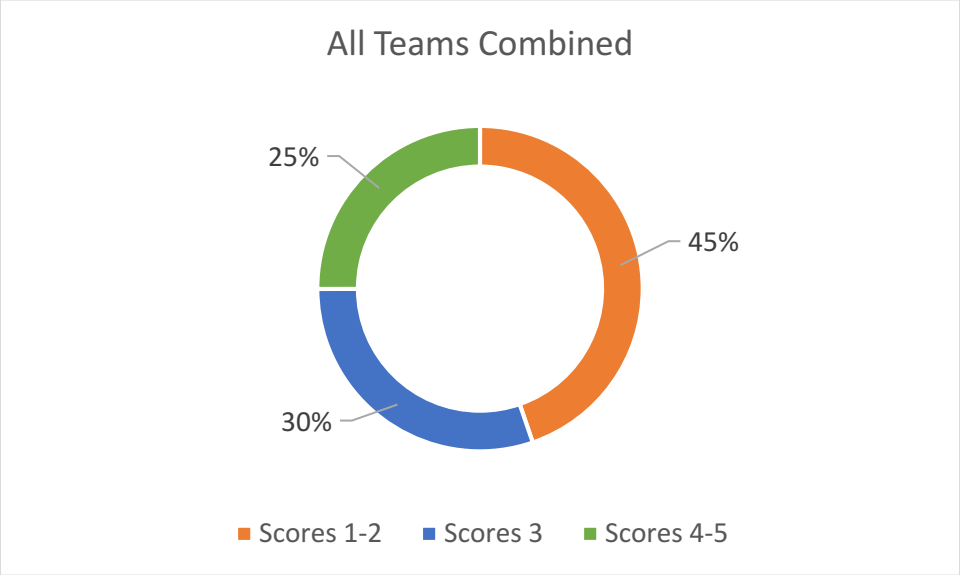
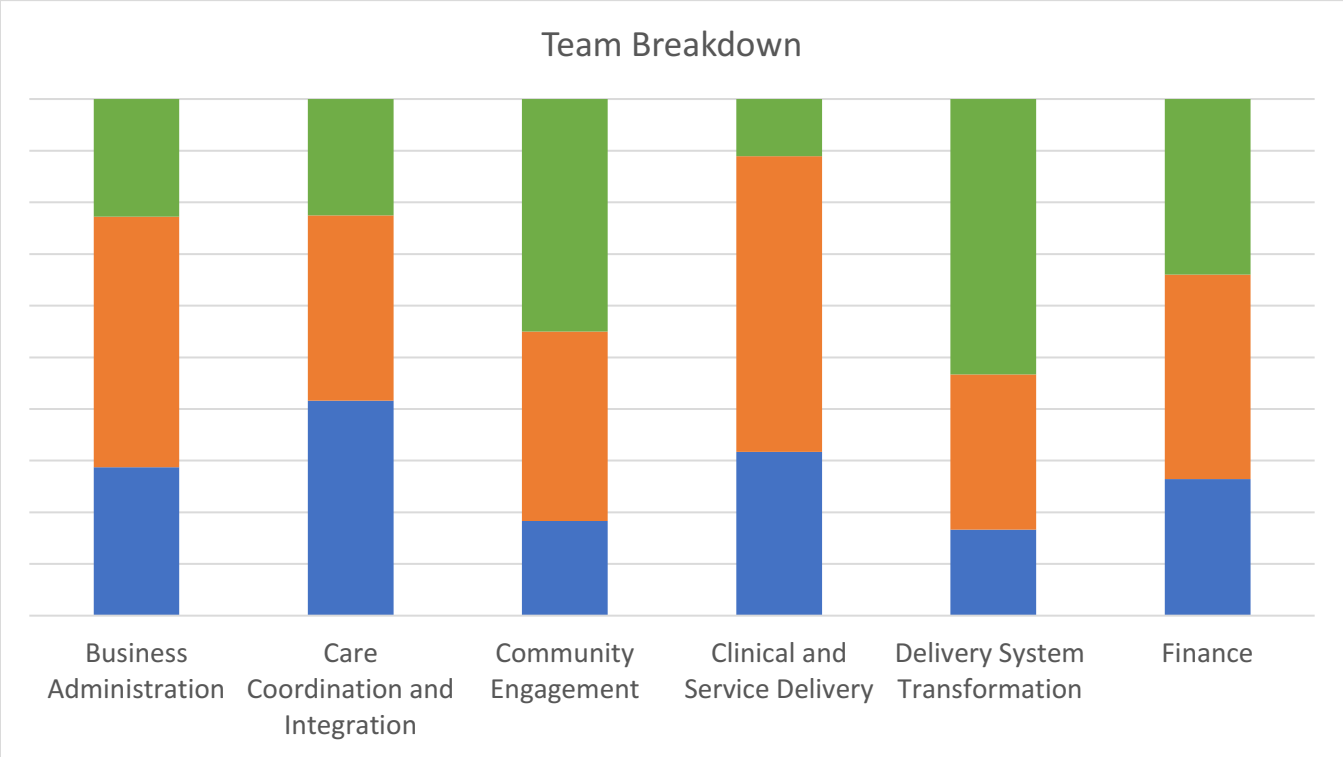
Evaluation Results – Overall Scores

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



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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	FAIL	X		X	
Business Administration	FAIL	X		X	X
Care Coordination and Integration	FAIL	X		X	X
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	PASS	X		X	X
Community Engagement	FAIL	X	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**
Social Determinants of Health	33	22	58
Value-Based Payment	10	10	16
Cost	15	12	7
Behavioral Health	76	64	37
Business Operations	202	119	70

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**
Social Determinants of Health	4	14	15
Cost	20	14	23
Value-Based Payment	19	19	18
Behavioral Health	18	21	16
Business Operations	59	13	25

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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	4	5	11	X			
CCO Performance and Operations	5	6	4			X	
Cost	12	3	3	X			

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

Deficiency Analysis

Value-Based Payment

Inadequate detail on PCPCH payment differentials by tier level and how these rates were developed

CCO Performance and Operations

Gave examples of how a program is currently evaluated, as opposed to providing a broad evaluation strategy for how future programs could be evaluated. Did not appropriately detail how quality would be obtained, focusing more on efficiency.

Cost

Vague answers did not appear to demonstrate an understanding of the underlying cost containment goals or requirements. Information provided did not show how applicant would attain goals and did not give the impression that their plans could be implemented.

Team Recommendation: **FAIL**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Cascade Health Alliance be given a “fail” for the financial section. Large gaps existed in demonstrating the Applicant’s ability to implement policies.

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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
Social Determinants of Health	5	7	16	X		X	
Administrative Functions	28	22	13	X		X	X
Member Transition	21	11	4	X		X	
Health Information Technology	27	8	5	X		X	X

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

Deficiency Analysis

Administrative Functions

Responses missing moderate amount of detail. No indication of how non-formulary meds will be addressed, how pharmacy benefit will be communicated to members, prior authorization process is poorly defined. Poor responses for Fraud, Waste and Abuse prevention, auditing and encounter data validation, and the plan did not appear feasible. No details of how Applicant would monitor and validate Medicare coverage or share Third Party Liability information with providers. No examples of subcontracted activity or how they would be monitored. The deficiencies in this section suggest widespread low-quality administrative functions, due to missing processes and possibly missing technology and other infrastructure. The deficiencies in this area are estimated to take a **moderate to large amount of effort** to remedy.

Health Information Technology

Poor responses to HIT/VBP section related to SDOH data. No key insights are mentioned and no indication of how they would share data information with providers. Almost no responses to assess regarding EHR adoption, no roadmap at all and the responses suggests that the Applicant is not aware of provider-specific challenges to EHR adoption. The deficiencies in this area were widespread and are estimated to take a **moderate to large amount of effort** to remedy.

Member Transition

Lacking significant detail. Applicant indicates they will arrive at a seamless transition of care but no detail on how they will accomplish that goal. Warm handoff responses were limited – no indication of how they will identify at-risk members. No info provided for how primary care assignments will be made, what

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happens when members don't match to a PCP, or how member information will be compiled and relayed to receiving CCO. Responses that were provided seemed more data driven than continuity of care driven.

There were attestations that certain tasks/activities would happen in place of description of how they would happen. The moderate lack of detail suggests that there are no firm plans in place for transferring or receiving members during a transition period. These deficiencies are estimated to take a **moderate to large amount of effort** to remedy.

Social Determinants of Health

Responses in this section were lacking in detail and some responses were missing entirely. REAL-D data was not mentioned and there was no description of how to manage SDOH-HE funds. Reviewers found it concerning that Applicant is planning on using members place of birth as a metric in the SDOH-HE database. No information or policies on materials being offered in other languages or formats. Applicant could benefit from training on ADA provisions and a plan to address how they will adhere to ADA regulations. No information on recruitment or retention of personnel to increase diversity in workforce or how Applicant would monitor any health equity trainings in their network. The deficiencies in this section suggest that the Applicant could benefit from training on ADA provisions and health equity concepts and strategies for implementation. These deficiencies are estimated to take a **light to moderate amount of effort** to remedy.

Team Recommendation: **FAIL**

- This Applicant's responses were in general missing a moderate amount of detail, suggesting that there were fundamental gaps in processes, people, technology or general infrastructure that would hinder them from providing critical healthcare functions.
- The deficiencies in the Administrative services section suggest widespread low-quality administrative functions, due to missing processes and possibly missing technology and other infrastructure. The deficiencies in this area are estimated to take a **moderate to large amount of effort** to remedy.
- The deficiencies in the HIT section were widespread and are estimated to take a **moderate to large amount of effort** to remedy.
- The moderate lack of detail in the Member transition section suggests that there are no firm plans in place for transferring or receiving members during a transition period. These deficiencies are estimated to take a **moderate to large amount of effort** to remedy.
- The deficiencies in the SDOH-HE section suggest that the Applicant could benefit from training on ADA provisions and health equity concepts and strategies for implementation. These deficiencies are estimated to take a **light to moderate amount of effort** to remedy.
- The general quality of the answers and the presence of multiple section requiring **moderate to large amount of effort** to remedy led to a team recommendation of FAIL.

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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	0	7	5				
Behavioral Health Covered Services	7	12	17			X	
Care Integration	8	7	6				
Care Coordination	32	34	10	X		X	
Health Information Exchange	15	12	1			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 benefits were well received; reviewers noted that the Applicant failed to address gaps in covered services as well as plans to engage programs to fill those gaps.

Behavioral health covered services responses failed to include strategies on how to develop patient-centered plans, especially related to SPMI needs. The Applicant provided little or vague information on their perceived responsibility in care coordination efforts. Current approach to engagement does not address strategies to reach a member who fails to respond to a screening. Future plans to improve access only related to specific featured clinics, not the whole system.

Care coordination responses generally failed to provide information on dual eligible populations and failed to address care coordination plans for SPMI, Children, and LTC populations as well as 1915i providers and THW duties. Reviewers identified a lack of outreach strategies especially for families and found no strategies in place for reaching out across systems. In some areas such as APD, AAA and ODDS it was noted that care coordination strategies would not feasibly result in successful care coordination. The Applicant's plans regarding Transforming Models of Care rely heavily on Primary Care, no description was provided of how the Applicant will help in these efforts.

Care integration responses attested to having agreements in place, but no detail was provided on plans or process for communication, documentation, monitoring, transition planning and planned primary care roles. The Applicant provided limited detail on their experience providing equitable or culturally appropriate care. Limited detail was provided on their plans to coordinate with tribal populations.

Applicant's ability to support Health Information Exchanges (HIE) was not demonstrated. Plans to facilitate hospital event notifications relied on an email list from one hospital—it was unclear how integration will occur moving forward. No plan was provided to implement and utilize additional HIE tools or to ensure that

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providers have access to tools. No strategy for behavioral health or oral health adoption of HIE tools was provided. Reviewers noted significant cut-and-paste through this section of the application. The HIE roadmaps that were provided by the Applicant were high level and included little indication of how HIE adoption would expand across provider types: no roadmap was provided for oral health.

Team Recommendation: **FAIL**

Overall, reviewers felt that while some deficiencies identified could be remedied, the cumulative deficiencies in care coordination, care integration and HIE were too much to overcome in the near term. Reviewers observed a theme in many answers in which the applicant did not address or understand a CCOs role when partnering with other providers and systems. The Applicant did not sufficiently address specific approaches to high-needs populations, especially dual eligible, SPMI and tribal populations. Reviewers expressed concerns in the Applicant's ability to conduct transitions, discharges, and referrals as well as their ability to engage member families.

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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	16	13	4	X		X	
Administrative Functions	22	15	8	X		X	
Behavioral Health Covered Services	48	31	5	X		X	
Service Operations	33	7	6	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 ranged from missing minor detail to missing entirely. The network adequacy section didn't address frequency or how fluctuations in network adequacy would be managed. They also don't address the impact of network adequacy gaps on members or how they would address any identified gaps. The grievance and appeal section was missing significant detail and solutions stemming from the grievance and appeals data appear to be based on complaints only, rather than using all of the data. Many responses are duplicative of other responses, the same which leaves doubts as to whether Applicant approached each question individually and with rigor. All the grievance and appeal questions were rated as failed by all reviewers.

Behavioral Health Benefit

The responses in this section were in general missing detail. There was a lack of detail on barriers; there was no plan for coordination of services or discharge planning. The deficiencies identified seemed like systemic issues that would take a **moderate to large amount of effort to correct**.

Behavioral Health Covered Services

The responses in this section were missing detail and revealed larger gaps in care coordination especially. The Care coordination responses didn't make sense at times and there was no process to identify members who need care coordination. Applicant did mention planning on creating a plan to identify members needing care coordination but there was no timeline or details. The Applicant stated that care coordination would be provided with "focused resources, data-driven tools and proven methods" but didn't provide any detail on their exact methodology. The deficiencies noted in this section point to larger systemic issues especially in regard to care coordination.

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Service Operations

The responses in this section were often missing detail and descriptions were high-level. For the hospital service questions, there no indication of relationships with outside providers, inappropriate hospital readmissions were not defined, there was no methodology to the frequency and monitoring of hospital services and there was no distinction between ambulatory and acute care. For the pharmacy questions, it was not clear how the benefit would be communicated and there was no description of the medication management program. For the utilization management questions, there was no mention of medical necessity criteria and the rest of the questions were lacking a large amount of detail and answered too generally. All reviewers scored all utilization management questions as failed. For the LTSS section, no mention of care models for congregate settings and other answers were high level. The deficiencies in this section are difficult to identify as the answers were too high level. The very high-level answers and lack of methodology or other detail suggest the presence of **moderate to higher level deficiencies**.

Team Recommendation: **FAIL**

- The responses in these sections were often high level and lacked an adequate amount of detail.
- The high-level answers and plans to create plans, especially for critical healthcare services such care coordination and processes such as utilization management, suggest the presence of **moderate to higher level deficiencies**.
- Noteworthy that reviewers agreed to 100% failed scores in three areas: grievance and appeals, pharmacy service and utilization management.
- The quality of the answers and the presence of **moderate to high level deficiencies** in multiple areas, led to a team recommendation of FAIL.

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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	3	5	10	X		X	X
Delivery Service Transformation	6	0	6	X			

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

Deficiency Analysis

Accountability and Monitoring:

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

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 sufficient information about how providers are graded. Lacking sufficient information about how the system provides data to share among all stakeholders.

CCO Performance – Lacking sufficient information about internal measures and utilization measures, including description about how to measure, track and evaluate the quality of care for clinical and Emergency Department utilization.

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data analysis for priority populations, such as types of data will be used to improve quality of care for members with SPMI. Lacking sufficient information about addressing gaps, specifically the ratio of providers to SPMI members.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as oversight, member and provider assignment data, and engagement of members and potential new PCPCH providers.

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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

- Provide details on collection of data to assess performance
- Describe how care coordination processes support continuity of care

Delivery Service Transformation

- Provide details on PCPCH system including oversight, number of members served and total number of PCPCH
- Provide information about PCPCH engagement and outreach

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Community Engagement

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Community Engagement	0	2	8	X	X		
Community Engagement Plan	18	10	32			X	
Social Determinants of Health	10	1	9			X	
Governance and Operations	16	9	5			X	

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

Deficiency Analysis

- No plan to ensure continual quality improvement of the Community Engagement Plan
- Insufficient details for how CAC aligns with defined population, including culturally specific strategies for alignment, county government and community members representation
- Doesn't mention how non-CAC members will inform CCO decision making, or how any input informs CCO decision making
- Insufficient mechanism to elevate member voice, including members with limited English proficiency (i.e., CAC Chair sitting on the CCO board is the only mechanism identified
- Doesn't mention how the CCO board will engage with tribes and/or the tribal advisory committee
- Some SDOH priorities that were listed don't count, per OHA definition and no description for ensuring a transparent and equitable process in SDOH funding decisions
- Lacking details in how applicant strengthen relationships with organizations identified
- Doesn't address culturally and linguistically appropriate strategies for involving members in care planning
- Insufficient detail on experience in engaging the community and providers in addressing disparities
- Insufficient SPMI and member receiving LTC services on CCO board
- Unclear whether CAC and tribes have a role in HRS decision making, based on the inclusion of the Community Projects Advisory Committee – lacking detail on how HRS spending will align with CHP.
- Information provided could be used for a metric, but doesn't include a metric
- Limited plan for disseminating outcomes of funded projects

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Team Recommendation: **FAIL**

- Significant technical assistance/guidance needed from OHA
- Develop specific strategies for alignment CAC with defined population, including tribal engagement
- Ensure that input from non-CAC members informs CCO decision making
- Develop more robust strategies for elevating member voice to CCO leadership (including consideration of language access)
- Develop a plan for continual quality improvement of the community engagement plan
- Develop culturally and linguistically appropriate strategies for involving members in care planning
- Ensure capacity exists to engage the community and providers in addressing disparities
- Ensure transparency and accountability for governing body's consideration of CAC recommendations
- Ensure CAC and tribes have a role in HRS decision making
- Ensure transparent and equitable process in making SDOH funding decisions, including widespread dissemination of outcomes of funded projects

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Community Engagement – Community Letters of Support

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

Organization Name	Type
Blue Zones Project	SDOH-HE Improvement Programs
CHA Member	OHP Member
CHA Member and CAC Vice Chair	OHP Member, CAC Member
City of Klamath Falls Parks	Public Parks Dept.
Department of Human Services District 11	Public APD, SSP, CW services
Gospel Mission	Homeless and recovery program
Klamath Basin Behavioral Health	BH
Klamath Community College	Community Ed, Higher Ed.
Klamath County Public Health	Public Health
Klamath County School District	K-12 Education
Klamath Falls City Schools	K-12 Education
Klamath Promise	Education access
Klamath Pulmonary & Critical Care Medicine; Klamath Sleep Medicine Center	Specialist Provider
Lutheran Community Services	BH
Oregon Institute of Technology	Vocational Ed, Higher Ed
Oregon Tech Dental Clinic	Dental
Raul A. Mirande, MD	Specialist Provider
Sanford Children's	Pediatric Provider
Shasta Family Dental	Dental
Sky Lakes	Hospital
South-Central Early Learning	Early Learning Hub
Transformation Wellness Center	SUD
Tucker and Gailis Dental Group	Dental
Zooka	Pediatric Dental

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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: The applicant does not include sufficient information to understand how they plan to manage the behavioral health benefit of budget. They did not explain how contracts will avoid limiting behavioral health spending, they simply stated they would.

Recommendations: Applicant needs to submit a plan for managing the global budget with behavioral health integrated into that global budget.

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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.

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Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
2	4	6	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.

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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.

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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>

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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

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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.

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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%

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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%

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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%

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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.

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Full County Coverage Exception Request

Cascade Health Alliance (CHA) is a Coordinated Care Organization (CCO) in Klamath County, Oregon — a region in which we have cultivated strong relationships with community partners and healthcare providers to provide exceptional care to our members. Our current service area includes the following zip codes: 97601, 97602, 97603, 97604, 97621, 97622, 97623, 97624, 97625, 97626, 97627, 97632, 97633, 97634, 97639. We are aware of OHA's policy on county boundaries for CCO 2.0, which states that applicants that intend to draw boundaries *not* along county lines will need to seek exceptions and provide appropriate justification.

CHA formally requests an exception from this policy to continue operating according to our existing parameters. Residents in our existing coverage territory benefit from receiving services in Klamath County due to geographic proximity to high-quality healthcare. CHA has a steadfast commitment to improving the health outcomes of its population. We meet members where they are and provide excellent care while reducing costs. CHA's dedication to these endeavors is evident in our history of award-winning work as a CCO in Klamath County, including the honor of the Culture of Health prize from the Robert Wood Johnson Foundation. Our approach is to invest in people, processes, technology and infrastructure to deliver superior service and outcomes for Klamath County members.

Retaining our current boundaries for CCO 2.0 ensures members in rural and frontier areas receive access to care equal to those in urban regions as well as work toward achieving the transformational goals of CCO 2.0 effectively.

Behavioral Health integration and access – CHA bridges physical, behavioral and oral healthcare; we have developed successful relationships and programs to support the Klamath County healthcare ecosystem and have changed the culture around healthcare to drive true integration of physical health and behavioral health.

Social determinants of health and health equity – CHA is a convener in Klamath County – facilitating collaboration between our members and community partners. We are uniquely positioned to support our members and have shown our allegiance to Klamath County for 27 years related to the appropriate resources our members may need.

Value-based payments and cost containment – CHA will contain costs through strategic and mutually beneficial provider network contracts. We will continue working to enhance our payment structure in collaboration with our providers, which will ensure value-based payment requirements are met aligned with the sustainable growth rate and quality outcome objectives.

Financial viability – CHA will continue to meet the cost growth expectations of OHA as it has done so in the past three years using our provider network and contracts. CHA is an integral part of its local community. Our deep and ongoing efforts to understand the needs of our members gives us the assuredness to request full-county exception. In 2018, 98% of CHA members received services in Klamath County (our service area). Over the last several years, we have awarded grants to numerous organizations that with more than 7,000 individuals directly benefitting from our social investments. We assure that this exception request is not designed to minimize financial risk and will not create adverse selection.

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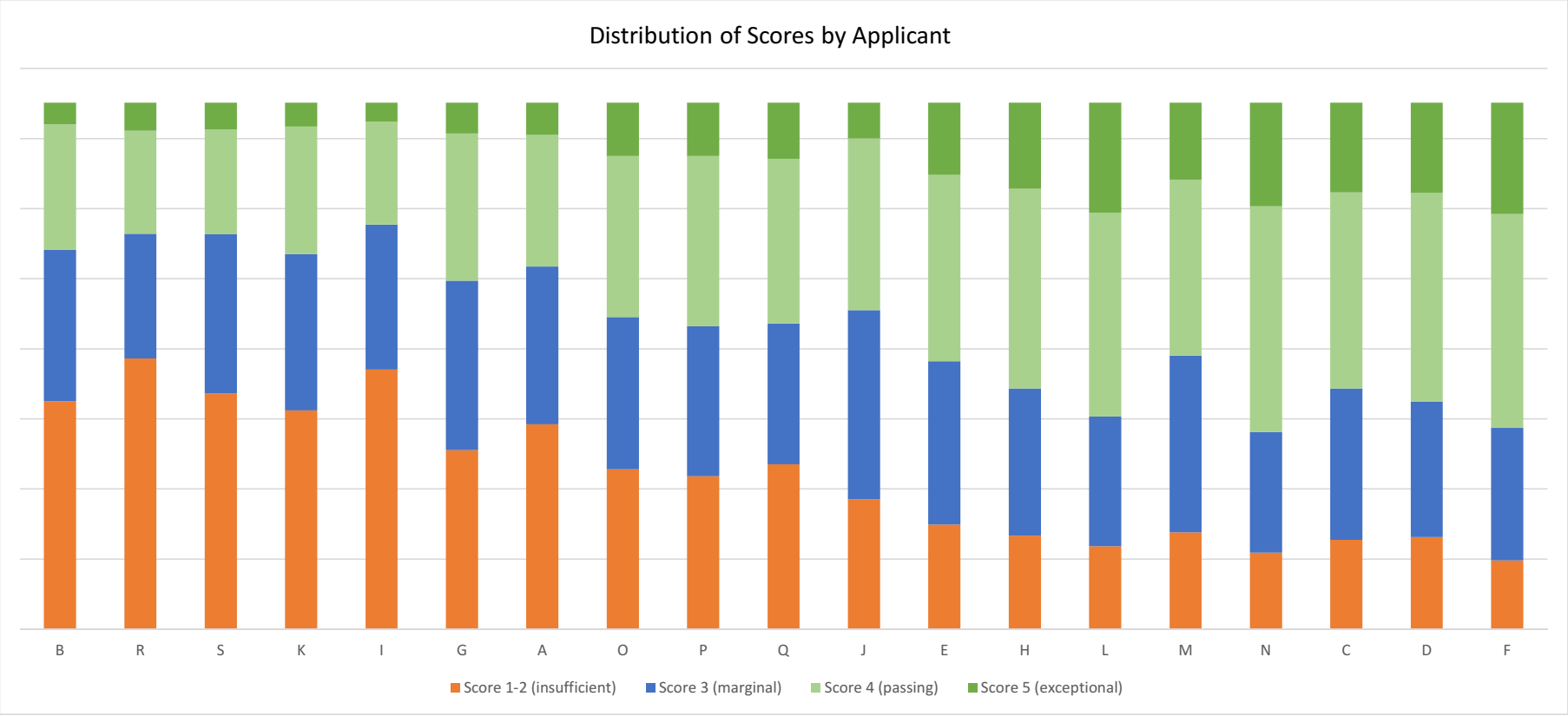
Pass/Fail by Category

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

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