RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant F
Health Share of Oregon

CONFIDENTIAL UNTIL 7/9/19

Evaluation Overview

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

Criteria Development

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

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

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

Passing Score

Team Analysis

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

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

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

Evaluation Results: Policy Alignment

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

Evaluation Results: Informational Assessment

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

Ex:

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

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

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

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

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

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

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

Executive Summary

Financial Analysis

- DCBS financial review found little to no margin for error if projections are higher than actual results. Cumulative results below their projections would be problematic and compound the issue.
- ASU raised concerns that if the RAEs go insolvent, Health Share might not have enough C&S to cover member benefits even the risk is technically transferred to the RAEs.

Service Area Analysis

- Health Share of Oregon is requesting to serve Clackamas, Multnomah and Washington counties. There are no service area exceptions requested.
- Health Share of Oregon is one of two applicants in this service area. There is low or no risk that the applicant will fail to meet minimum enrollment or exceed maximum enrollment.

Evaluation Results – Team Recommendations

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

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

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

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 30, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Health Share of Oregon, CCO (501(3) non-profit membership corporation)(HSO)

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

The pro forma financial information reports services and risks will be transferred to their partner provider groups through capitation agreements, that fully cede the risk to those entities.

No information was provided about the amount of risk that the above four providers (Care Oregon, Inc., Providence, Kaiser Foundation, Legacy, and OHSU Health System) would receive in the capitated agreements. The pro forma financials for HSO report $0 liability for losses, $0 liability for unpaid claims, and in most cases over $1.7 billion in annual premium revenue. The scope of my review was limited to the HSO and did not include any of the other providers that have the liability for the unpaid claims and the unpaid claims expense that is associated with roughly $1.7 billion in premium revenue on the books of the HSO. DCBS is the regulatory authority over two of the risk bearing entities, Kaiser Foundation Health Plan of the Northwest and Providence Health Assurance, which are monitored on a quarterly basis.

The pro forma balance sheet for the best estimate of enrollment projects RBC of 216%, 224% and 232% at the end of 2020, 2021, and 2022, respectively. The Company performed various stress tests on their projections, and if claims costs are 2% higher than projected, the RBC under all scenarios would be below 200%. Under a 4% increase, the RBC would be below the “Mandatory Control Level Event” in all but 2020 for their minimum enrollment projection. Under the Best and Maximum enrollment projections, the Company would be insolvent and not be able to make good on their outstanding liabilities. This is mitigated by the 100% cession of the claims risk for their members to the providers, but that may transfer the financial solvency concerns to entities that do not report their financial position to OHA to be able to identify issues before it is too late.

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 in order to estimate a scenario that the Company would enter a mandatory RBC control level. DFR estimates a 2.1% negative deviation in total

hospital and medical benefits will result in a mandatory RBC control level at the end of 2020 for the ideal, 4.1% at the end of 2020 for the minimum, and 2.1% at the end of 2020 for the maximum enrollment.

A capital infusion/contributions could be used to improve liquidity should a negative deviation occur but no potential sources of additional capital were listed in the information received. 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 audited financials for HSO 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 three of the four years from 2014 through 2017 and reported net income between a $3.0 million net loss in 2017 and a high of $22.8 million net income in 2015. Totals members' equity was $38.1 million in 2014 and increased to $64.0 million in 2017. DFR calculated a ratio of total current assets to total current liabilities of 151.9%, in 2017. This is slightly below the considered "ideal benchmark" of 200%, but is relatively close to the current health insurance market average, which was 175.4% at 12/31/2018.

HSO paid $16.6 million in 2017 for administrative services, leased employees and professional services & consulting.

HSO has roughly $1.2 billion in annual premium revenue and no liability for unpaid claims. Reviewing audited financial statements for the entities that have booked the unpaid claims liability associated with the $1.7 billion annual premium would provide a better picture on their financial ability to fulfill policyholder obligations. There is some concern that if the entities receiving the capitated payments are unable to meet the requirements, there is not sufficient resources in HSO to be able make good on the contractual requirements of the CCO. As noted previously, two of the capitated partners are regulated and monitored by DCBS.

A small deviation to claims expense could require a capital infusion in order to maintain adequate liquidity. A 2% negative deviation to total hospital and medical expenses would put RBC under 200% for all enrollment scenarios.

No concern was associated with the review of the biographical affidavits.

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

[End of summary]

ASU Analysis of Applicant Financial Assumptions

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

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary. Focus of this review is given to reasonability of projected numbers stated in Balance Sheet and P&L pro formas (BE MM scenario) by comparing to most recent year's Exhibit L financial results (FY2018).

Enrollment					
Applicant Assumption (MM)	**OHA Assumption (MM)**	**Applicant High Assumption (MM)**	**Applicant Low Assumption (MM)**	**Percentage of OHA's Est to CCO's Est**	**Enrollment Flag**
3,842,868	3,086,774	4,801,200	2,390,981	80%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$438.18		$450.33	$462.16	-5%

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

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

Population Trend	
Applicant Assumption	**OHA Assumption**
0.31%	0.33%

Health Share's Best Est is at 100% market share, min est. is at 62%. OHA assumes 80% market share based on Trillium's potential entry.

Admin load %

Compared to the historic admin load % in the past (7.1%-8.5% for FY2014-FY2018), the projected admin load 9.8% for FY2020 under BE scenario is high.

Capital and Surplus

At the end of FY2018, HSO's C&S balance is over $71M. Per the pro-forma, HSO only plans to start the CCO 2.0 contract period with $57.8M at the beginning of FY2020.

Given that HSO transfers risks to sub capitated entities, it doesn't record any claims related liabilities on its (projected) balance sheet.

Among the four RAEs, two of them (Kaiser and Providence) are under DCBS's monitoring, however the other two main players (CareOregon and Tuality)'s financial status is not reported to OHA/DCBS and thus not monitored.

Risk: If the RAEs go insolvent, HSO might not have enough C&S to cover the member's benefits even the risk is technically transferred to the RAEs.

Recommendation: Either request for financial information from the two RAEs CareOregon and Tuality to perform a further analysis, or request HSO to retain its 2018 YE C&S level without distributing dividends to its members before FY2020 so it would have higher C&S balance to cover the potential risk in the event of RAEs go insolvent.

HSO is one of many CCOs that subcapitate substantially all of their claims to risk accepting entities (RAEs). If the RAEs go insolvent, these CCOs might not have enough C&S to cover the members' benefits even though the risk was technically transferred to the RAEs.

- Suggest OHA request additional financial information for RAEs whose CCOs subcapitate substantially all services, perhaps as part of readiness review, to perform further analysis. Such information could include corporate audits or DCBS filings/analysis for RAEs that account for a sufficiently large (however defined) portion of a CCO’s total revenue.

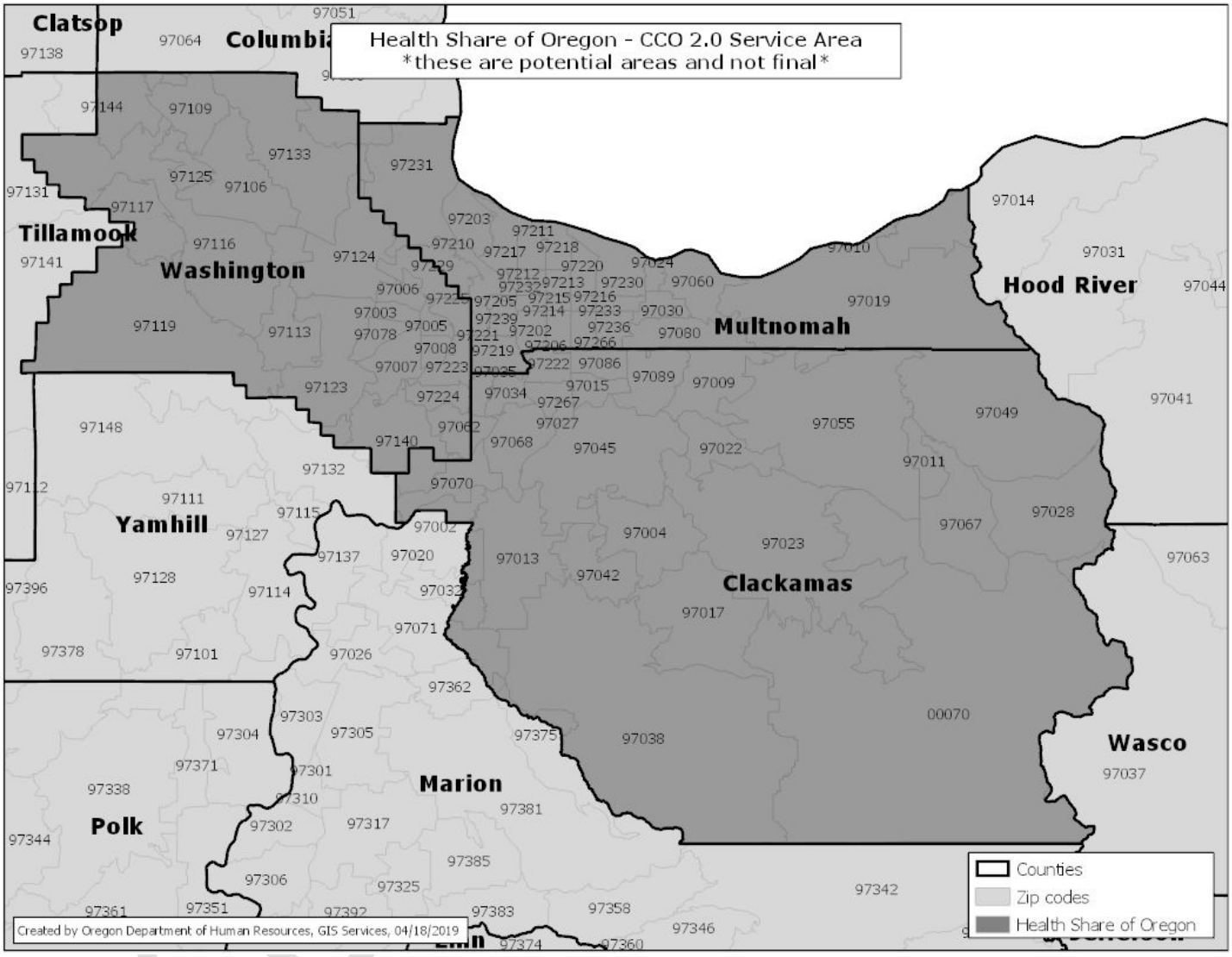
HSO anticipated 1/1/2020 C&S is $57.8 M, as compared with $71.4 M outstanding C&S as of 12/31/2018. It is not clear whether any capital withdrawal is planned that would result in this decrease, and if so, for whose benefit. Alternatively, it seems possible that HSO could be anticipating a “loss” in 2019 which may in part result from paying its RAEs more in order to arrive at a target EOY C&S balance.

- Suggest OHA require minimum retained capital of $58 million as of 1/1/2020 (estimated 200% RBC ratio). Higher levels of C&S would be preferable in light of currently available assets, as well as high exposure to subcapitated entities, but that may be more difficult for OHA to require.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Washington, Multnomah, and Clackamas counties.



Full County Coverage Exception Request

Not applicable.

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

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

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Clackamas, Multnomah and Washington	-	In addition to Health Share, one other applicant (Trillium) proposes to serve the tri-county metro area. Yamhill CCO also proposes to serve parts of Washington and parts of Clackamas, and Marion Polk Coordinated Care proposes to serve part of Clackamas.	No scenarios show enrollment below applicant's minimum	No scenarios show enrollment exceeding applicant's maximum	Low risk

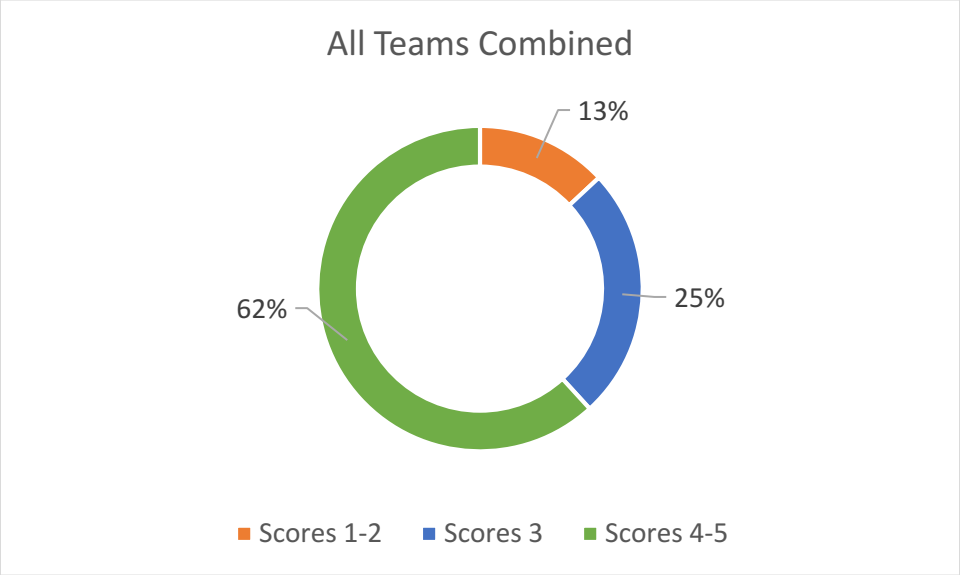
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, HSO is likely to receive approximately 217,106 members out of the 199,248 minimum required.

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

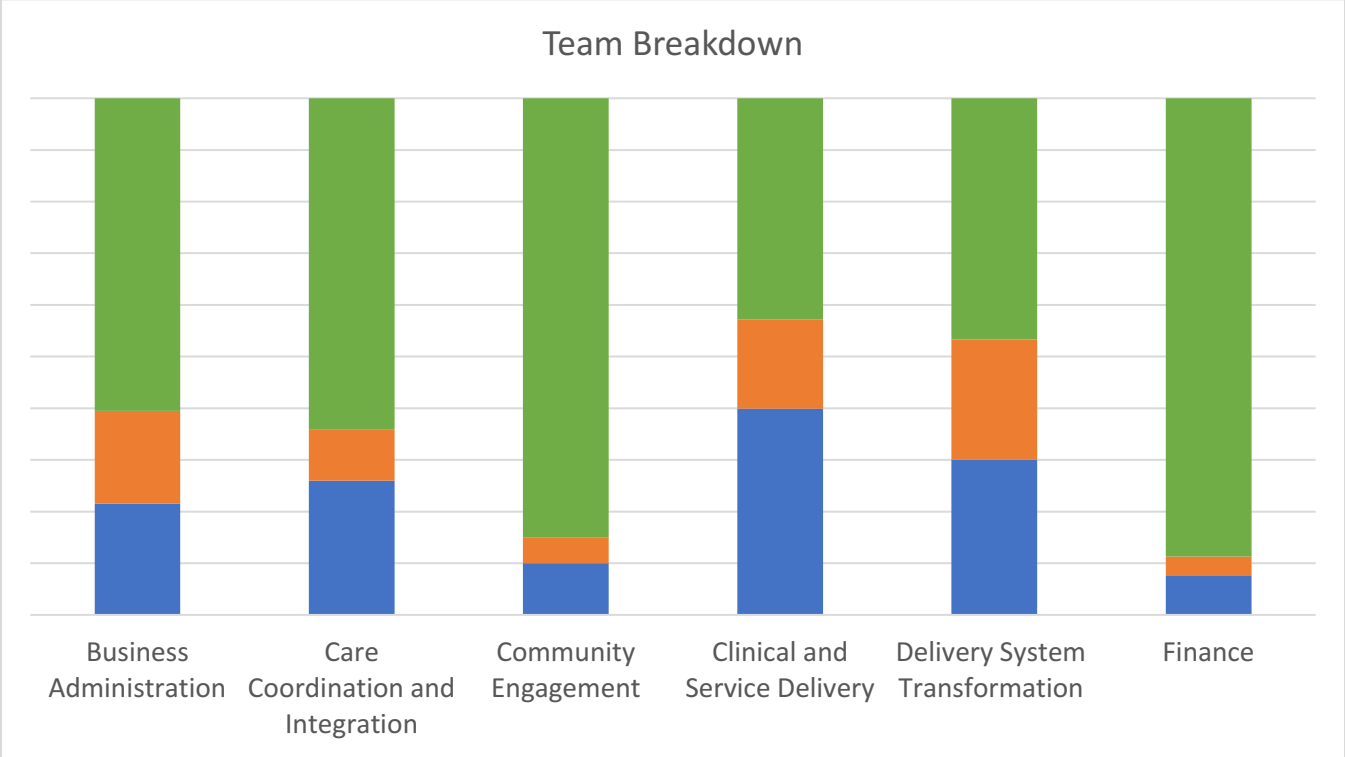
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	1	5	30
Social Determinants of Health	7	12	94
Cost	5	3	26
Behavioral Health	16	56	105
Business Operations	69	113	209

Evaluation Results: Informational Assessment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	4	6	47
Social Determinants of Health	2	5	26
Value-Based Payment	6	8	42
Behavioral Health	2	17	36
Business Operations	22	28	47

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	2	18				
Cost	2	0	16				
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

Health Share of Oregon had no deficiencies regarding value-based payment.

Cost

HSO had primarily satisfactory answers regarding cost. However, there was an inadequate explanation for how social supports would be incorporated for members, and the explanation of how VBP strategies connected to cost containment efforts were unclear.

CCO Performance and Operations

HSO had no deficiencies regarding performance and operations.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Health Share of Oregon be given a “pass” for the financial section. There were no deficiencies that caused major concern for the financial team.

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	4	1	31				
Social Determinants of Health	1	6	21				
Health Information Technology	4	7	29				
Administrative Functions	21	22	20	X			

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

Deficiency Analysis

Administrative Functions

Many responses in this section were missing detail, some components were missing entirely. For governance, there was no info on how frequently subcontractors are monitored, what the reporting relationships are between CCO governance structure the composition of major committees and missing detail on reporting responsibilities. TPL was missing info on the frequency of monitoring. Pharmacy responses did not address how quickly info on pharmacy benefit will be communicated to providers and to a public website, following a formulary change, how requests for non-formulary meds will be addressed or strategies/solutions used to meet the 24-hour PA processing timeline. Encounter data responses had limited detail on capacity, tools used and no systematic reviews or processes to address issues of timeliness, correctness and accuracy. All deficiencies notes are **relatively quick to remedy** with exception of setting up encounter data processes and procedures if these are not already in place – this would require a **moderate amount of effort.**

Health Information Technology

Clear majority of answers were responsive to questions and included good level of detail. Plans for year 1 and over the 5- year contract were not clear and the frequency of monitoring EHR, on roadmap, is unclear.

Member Transition

Clear majority of answers were responsive to question and included good level of detail. Warm handoff/transition activities were missing as well how treatment plans, case management and transportation will be handled during transition.

Social Determinants of Health

Clear majority of answers were responsive to questions, but details of how SDOH-HE priorities will be promoted, are missing and community outreach efforts appear limited.

Team Recommendation: **PASS**

- This Applicant's answers were largely responsive to questions and **only minor deficiencies noted**, with the exceptions mentioned below.
- Recommend that OHA establish that Applicant has encounter data validation processes in place or feasible plans for them. Also recommend that Applicant readdress the Encounter data questions to fill in missing detail.
- Recommend that Applicant provide OHA with description of how requests for non-formulary medications are made.

Care Coordination and Integration

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Care Integration	0	0	21				
Health Information Exchange	0	1	27				
Behavioral Health Covered Services	1	6	29				
Behavioral Health Benefit	3	3	6	X			
Care Coordination	13	35	28	X	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 lacked information on the composition of groups that would be involved in CMHP work and did not include timelines or milestones. Inclusion of these specific details (**identified as a light-lift to correct**) would rectify these issues. Responses on behavioral health covered services demonstrated a clear understanding of the subject. Reviewers noted that timelines provided did not match the RFA standards.

Although high-level care coordination activities were mostly responsive, these same activities have been identified as lacking detail. It is expected that these issues **could be resolved with little effort**. Specific areas lacking detail include:

- Interaction with LTSS providers
- Future plans for crisis management activities
- Plans for involvement of family members in care management, treatment managing and transitions.
- Specific processes for children, adolescents and adults
- Detailed processes for coordination with Medicare and DHS.

Team Recommendation: **PASS**

Care integration responses were well received. No deficiencies were identified.

Applicant's ability to support Health Information Exchanges (HIE) was clearly demonstrated. No deficiencies were identified.

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	2	10	21				
Behavioral Health Covered Services	8	34	42				
Service Operations	6	21	19				
Administrative Functions	20	18	7	X			

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

Deficiency Analysis

Administrative Functions

Responses are responsive in general and lacking detail on only some questions. Lacking process; no mention of periodic evaluation, no separate discussion of PH/BH/OH providers; grievance system not being used to monitor the correct application of criteria; unclear about the plan for improvement; could be remedied by addressing wait times or a plan for how they would address specific adequacy standards. The deficiencies identified in this section could be **remedied fairly quickly** (smaller amounts of missing detail and plans for using grievance and appeals data).

Behavioral Health Benefit

Missing detail only on barriers and strategies for access to care. These deficiencies (details and strategies) could be remedied with a **small amount of effort.**

Behavioral Health Covered Services

No process for identified which members need which level of care coordination; care coordination process is over-reliant on people reading, completing and returning their mail which is not reasonable for identifying who needs CC services. The deficiencies identified (process needed to match members to correct level of care coordination and additional processes needed for communicating with members) could be remedied with a **small amount of effort.**

Service Operations

Responses in this section were largely incomplete. They do not include response for LTC regardless of setting; no detail on monitoring claims (only stated that they followed Medicare guidelines); unclear roles or process for determining medical necessity and access to care; unclear on PA timelines. These deficiencies (additional detail on new processes for medical necessity, access to care and prior authorization, as needed) would take a **small to moderate level of effort** to address.

Team Recommendation: **PASS**

- The responses from this Applicant were largely responsive and lacking light to moderate amount of detail.
- All deficiencies identified were estimated to take **a smaller amount of effort to remedy** with the exception of the Service operations deficiencies. If additional processes are needed for establishing medical necessity, access to care or prior authorization, these would take a **moderate amount of effort**.
- The quality of the responses and identified deficiencies that required mostly **lower levels of effort to remedy** led to a team recommendation of PASS.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Delivery Service Transformation	2	3	7			X	
Accountability and Monitoring	5	6	7			X	

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

Deficiency Analysis

Accountability and Monitoring:

Accountability – Applicant failed to provide details describing the measurement and reporting system, such as standards and expectations and how those are communicated and enforced with providers and sub-contractors. Lacking sufficient information about the external program, its purpose and how it is administered. Lacking sufficient information on complaints, grievances and appeals.

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

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data collection and how it is used to improve quality of care for members with SPMI. Lacking sufficient information about methods to measure the workforce and identify gaps.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as member and provider stats, oversight, and plan for integrating Behavioral and Oral health. Lacking sufficient information about engagement of members and potential new PCPCH providers. Lacking sufficient information about the monitoring plan, contracting/subcontracting, and emphasis on whole person care.

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 more information about reporting system
- Provide information specific to the applicant's processes and technical platforms to support care coordination and continuity of care

Delivery Service Transformation:

- Provide information about monitoring SPMI population
- Provide detail on plan for improving quality of services and outcome

Community Engagement

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Community Engagement Plan	3	3	54			X	
Community Engagement	0	1	9	X			
Social Determinants of Health	1	2	17				
Governance and Operations	2	6	22				

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

Deficiency Analysis

- No mention of HRS alignment with CHP priorities, didn't give details for process on how community benefit investment decisions will be made
- Not sure how they'll get CAC member alignment with potentially new members based on analysis (as stated in application)
- Unclear how CAC or member input informs decision-making, and no role defined for tribes or tribal member
- Needed more detail on how members participate in care planning or Quality Improvement beyond a survey
- Plan is not in place yet for how to award funding (criteria, who can apply, etc.). Plan for plan is not sufficient. Did not address how plan would be equitable. Transparency does not equal equitable.
- No mention of plain language or plain language access.

Team Recommendation: **PASS**

- Ensure alignment of HRS spending with CHP priorities
- Consider how they'll align CAC with member demographics and ensure culturally and linguistically appropriate strategies
- Plan for how HRS spending aligns with CHP priorities and ensure CAC and tribes have defined roles
- Ensure understanding and compliance with ORS – possible OHA TA
- Will need TA for language access related to SDOH/HE funding process.
- Ensure a clear plan for SDOH/HE funding that is transparent and equitable.

Community Engagement – Community Letters of Support

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

Organization Name	Type
4th Dimension Recovery Center	BH, SUD
Adelante Mujeres	Family and Education Supports for Latina women
Advantage Dental	Dental Clinics
Adventist Health Portland	Hospital, Clinics
Beaverton School District	K-12 Education, Supports
CareOregon	Health Plan
CareOregon Dental	Dental Clinics
Cascade AIDS Project & Prism Health	LGBTQ+ Health Services, HIV/AIDS care
Center for Improvement of Child and Family Services at Portland State University	Family Services
Central City Concern	Homeless, Self-Sufficiency, Housing, Medical Clinics, BH, SUD
Children's Institute	Early Childhood Health
City of Portland and Multnomah County Joint Office of Homeless Services	Local Government, Homeless Services
Clackamas County Health, Housing and Human Services	Social Services, Housing, Public Health
Clackamas Workforce Partnership	Workforce development
Coalition of Community Health Clinics	Medical, BH Clinics
Dental3	Dental Clinics
Early Learning Hub of Clackamas County	Early Learning Hub
Early Learning Multnomah	Early Learning Hub
Early Learning Washington County	Early Learning Hub
El Programa Hispano Catolico	Social Services
Friendly House	Children's and Community Services
Funded Programs & Early Learning Portland Public Schools	Early Learning Hub
Greater Than	Student Support and Empowerment
Hillsboro Pediatric Clinic LLC	Medical Clinic
Immigrant and Refugee Community Organization	Immigrant and Refugee Assistance Programs
Kaiser Permanente	Health Plan, Hospitals, Clinics
Latino Network	Family and education supports for Latinx community

Organization Name	Type
Legacy Health	Hospital, Clinics
Life Works NW	BH
Mental Health & Addiction Certification Board of Oregon	BH, SUD
Metropolitan Family Service	Early Childhood, Youth Wellness
Mt. Hood Community College's Child Care Resource and Referral of Multnomah County	Family, Children care services
Multnomah County Chair	Public Health, AAA, DD, Community Action Agency
Multnomah Early Childhood Program, David Douglas School District	Early Childhood Development
NAMI Clackamas	BH, SUD
Native American Rehabilitation Association NW	BH, SUD, Native American
North Clackamas School District	K-12 Education, Supports
Northwest Regional Education Service District-Early Intervention/Early Childhood Special Education Program	K-12 Education, Supports
ODS Community Dental	Dental Clinics
OHP Member, CAC Member	CAC Member, Consumer
OHSU - Doernbecher Children's Hospital	Hospital
OHSU - Doernbecher Children's Hospital, Foster Medical Programs	Hospital, Clinics, Foster Children
OHSU Health System	Hospital, Clinics
Oregon Community Foundation	Community support funding agency
Oregon Community Health Workers Association (ORCHWA	Workforce Development
Oregon DHS District 2 Child Welfare	Public CW Programs
Oregon Food Bank	Food, Education
Oregon Health Equity Alliance (OHEA)	Health Equity Reasearch and Programs
Oregon Public Health Institute	Public, community health research and advocacy
Oregon Spinal Cord Injury Connection	Disability Supports, Programs
Oregon Wellness Network, O4AD	Senior Services
Outside In	FQHC, BH, SUD, social services, homelessness, housing, education

Organization Name	Type
Portland Children's Levy	Early Childhood, Youth Wellness
Project Access NOW	Community Assistance Program, Regional Community Health Network
Providence Health and Services	Health Plan, Hospitals, Clinics
Provider - Benjamin Hoffman MD CPST-I FAAP	Provider
Randall Children's Hospital	Hospital
Reach Out and Read	Early Childhood, Youth Wellness
Reynolds School District	K-12 Education, Supports
Self Enhancement, Inc.	Early childhood education
Social Venture Partners	Early Childhood, Youth Wellness
Swindells Resource Center of Providence Health & Services	Supports for Children with Special Health Needs
The Swindells Center Providence Health & Services	Resource Center
Tigard-Tualatin School District	K-12 Education, Supports
Tri-County Behavioral Health Providers Association	BH Provider Association
Tuality Health Alliance	Health Plan, Clinics
United Way of Columbia-Willamette	Social Service Programs, Early Childhood, Disability Services
Virginia Garcia Memorial Health Center	Medical Clinic
Wallace Medical Concern	FQHC
Washington County Department of Health and Human Services	Public Health, Social Services
Willamette Dental Group	Dental Clinics

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: Although applicant clearly states that they will fully manage the behavioral health benefit with no delegation of risk, it is unclear if the Integrated Community Network (ICN) and the Integrated Delivery System (IDS) are indeed the applicant or a separate provider, which means delegation.

- If they are programs within the organization, the applicant is clearly taking full responsibility without delegation.
- If they are outside entities, applicant is delegating responsibility for key elements of the behavioral health benefit.

Applicant's intent to manage a global budget is not clear in their response. They say they will manage the budget based on need, but it is unclear if their intent is to continue to "bucket" the behavioral health spend.

Recommendations: Applicant to specify and clarify if ICN and IDS are programs within the applicant's organization or if they are separate. Require applicant to submit a plan for including behavioral health in the global budget.

Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
7	2	3	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

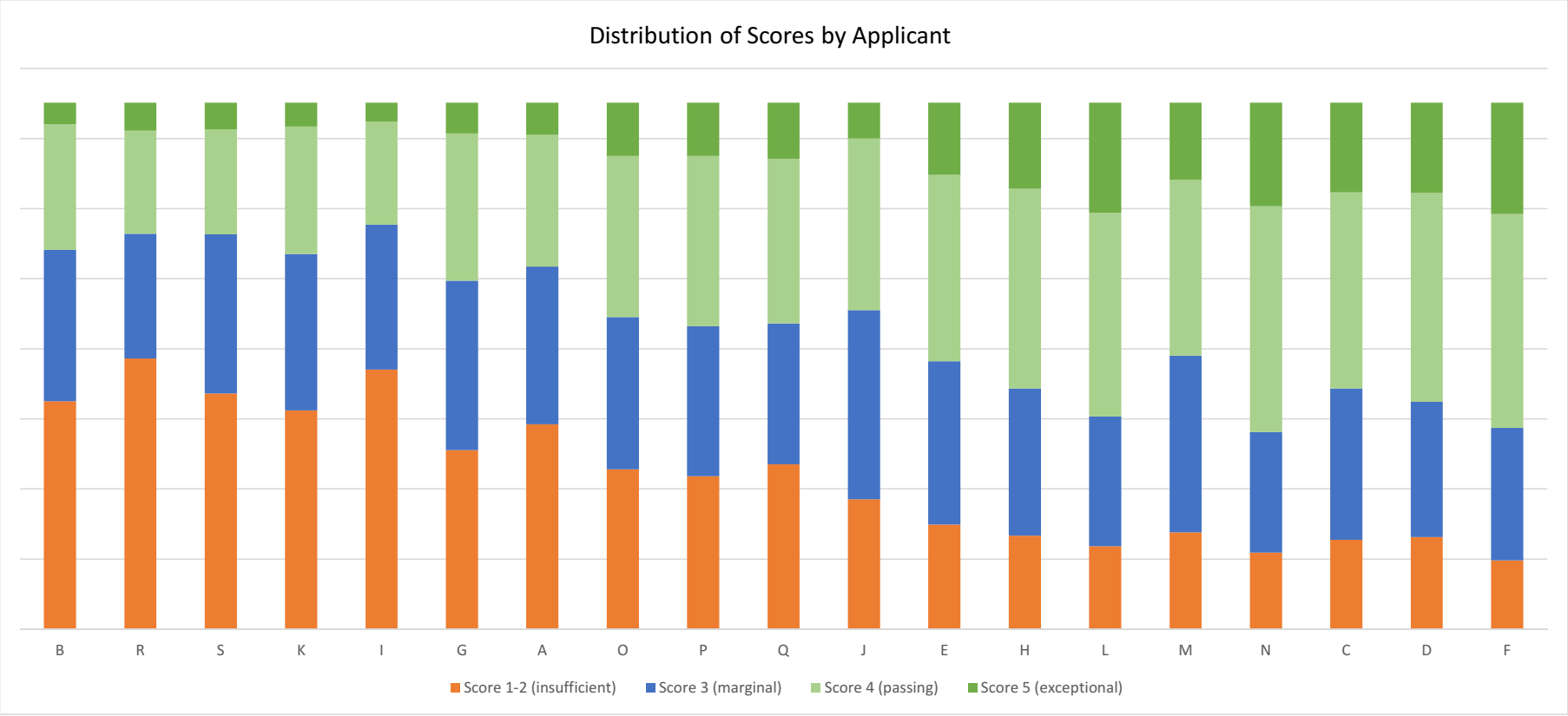
Members with no claims history

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

Pass/Fail by Category

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

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



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

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

Note:

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

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

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

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

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

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

using data as of 5/22/19

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