RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant Q
InterCommunity Health Network Coordinated Care Organization

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 that IHN appears to have adequate experience and capacity for managing financial risks and establishing financial reserves.
- ASU noted no risks.

Service Area Analysis

- IHN is requesting to cover the entirety of Lincoln, Benton, and Linn counties. There are no service area exception requests.
- IHN is the only applicant for Lincoln County, and one of two applicants in Benton and Linn counties. There is low to no risk that IHN's enrollment will be below the minimum threshold or exceed the maximum threshold.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Fail; responses were missing moderate amount of detail. Limited supporting processes for EHR adoption and HIT/VBP. Little detail was provided on the member transition processes.
- Care Coordination and Integration – Fail; responses suggest limited ability to coordinate care for special populations. Lacking engagement plan with tribal health system.
- Clinical and Service Delivery – Fail; responses were high-level, vague and sometime missing entirely. Missing detail for the care coordination questions in the Behavioral Health Covered Services
- Delivery System Transformation – Pass
- Community Engagement – Pass

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

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

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 23, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

InterCommunity Health Plans, Inc.

I have performed a financial evaluation of InterCommunity Health Plans, Inc. ('CCO') based on the materials provided. CCO filed the Restated Articles of Incorporation on March 20, 2019 as a public benefit corporation. CCO is part of the Samaritan Health Services, Inc., holding company system, which includes Samaritan Health Plan. CCO will provide services in Benton, Lincoln, and Linn counties.

The Applicant provided worksheet 'RFA4690-IHNCCO-Att12-UCAA Supplemental Financial Analysis and Proforma Workbook' within their application package. The 'Company Assumptions' tab provides membership totals for desired service area for years 2020, 2021, and 2022, which is further broken down by Best Estimate ('BE') 100%, Minimum ('MIN') 75%, and Maximum ('MAX') 125% of membership.

It is worthy to note that the CCO did not provide the capital and surplus prior reporting year (line 39) amount in tab 'UCAA P and L' for BE, MIN, and MAX, thus understating 'Capital and Surplus End of Reporting Year' line 34 and providing the incorrect RBC and other calculations relating to the P & L. Therefore, the Analyst computed beginning capital and surplus to match the 'UCAA Balance Sheet' 'Total Capital and Surplus' line 25 for all assumptions to arrive at the correct ending capital and surplus.

It is equally important to note differences (approximately 3.6% of C & S) between Total Administrative Costs and Reported Administrative costs as calculated in the 'CCO Administrative Costs' tab line. The CCO did not provide an explanation for this difference. The Analyst was unable to determine how Administrative Service Agreement (variable and fixed) Fees are determined, other than the Compliance portion of the agreement is $5 PMPM.

Analyst recommends explanation for difference between Total Administrative costs and Reported Administrative costs.
Analyst recommends the CCO provide Administrative Service Agreement fee breakdown for fixed and variable. Provide explanation how agreements comply with SSAP 25, arm's length transaction and fees are fair and reasonable.

Based on the review of the information provided and adjusted UCCA application for correct ending capital and surplus, the CCO projects Best Estimate ('BE') RBC of 647.5%, 641.2%, and 649% for year ending 2020, 2021, and 2022, respectively. The RBC and Capital & Surplus meets the minimum requirement. Review of year-end Audited Financial statement for 2017, the CCO had $54.2M in surplus and liquid assets appear to be sufficient.

Under all assumptions (BE, MIN, and MAX), the CCO estimates Net Income for each year. Non-excessive net losses occur when assumptions are stressed at 2%. Excessive Net losses occur when claims are increased by 4% and 6%. BE net loss at 4% is ($8.1M), which is 10.6% of capital and surplus. Again, it appears capital and surplus can absorb any net loss in a single period. Cumulative net losses are excessive under stress testing for 2% (Net loss is 10.6% of C & S), and 4% (Net losses are 33.8% of C & S). It appears that capital & surplus is sufficient to absorb net losses under 2% and 4% assumptions for the entire contract period. RBC remains above 200% for each assumption (BE, MIN, MAX) under stress testing at 2% and 4%.

The CCO appears to have adequate experience and capacity for managing financial risks and establishing financial reserves.

Does the CCO meet the RBC and Capital & Surplus requirements?

Yes. CCO meets the basic RBC, Capital & Surplus, and liquidity requirements under all assumptions and stress testing for 2% and 4% of claims.

Recommendations, Issues, and Additional questions:

- Analyst recommends explanation for difference between Total Administrative costs and Reported Administrative costs.
- Analyst recommends the CCO provide Administrative Service Agreement fee breakdown for fixed and variable. Provide explanation how agreements comply with SSAP 25, as arm's length transaction and fees are fair and reasonable.
- What is the Parent's threshold for infusing capital into IHN CCO in the event the CCO experiences significant losses?

[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**
683,712	622,887	854,640	512,784	91%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$445.68		$459.81	$490.78	-9%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
90%	90%	0%

Cost Trend	
Applicant Assumption	**OHA Assumption**
4.93%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.00%	0.27%

Profit margin and Admin load %

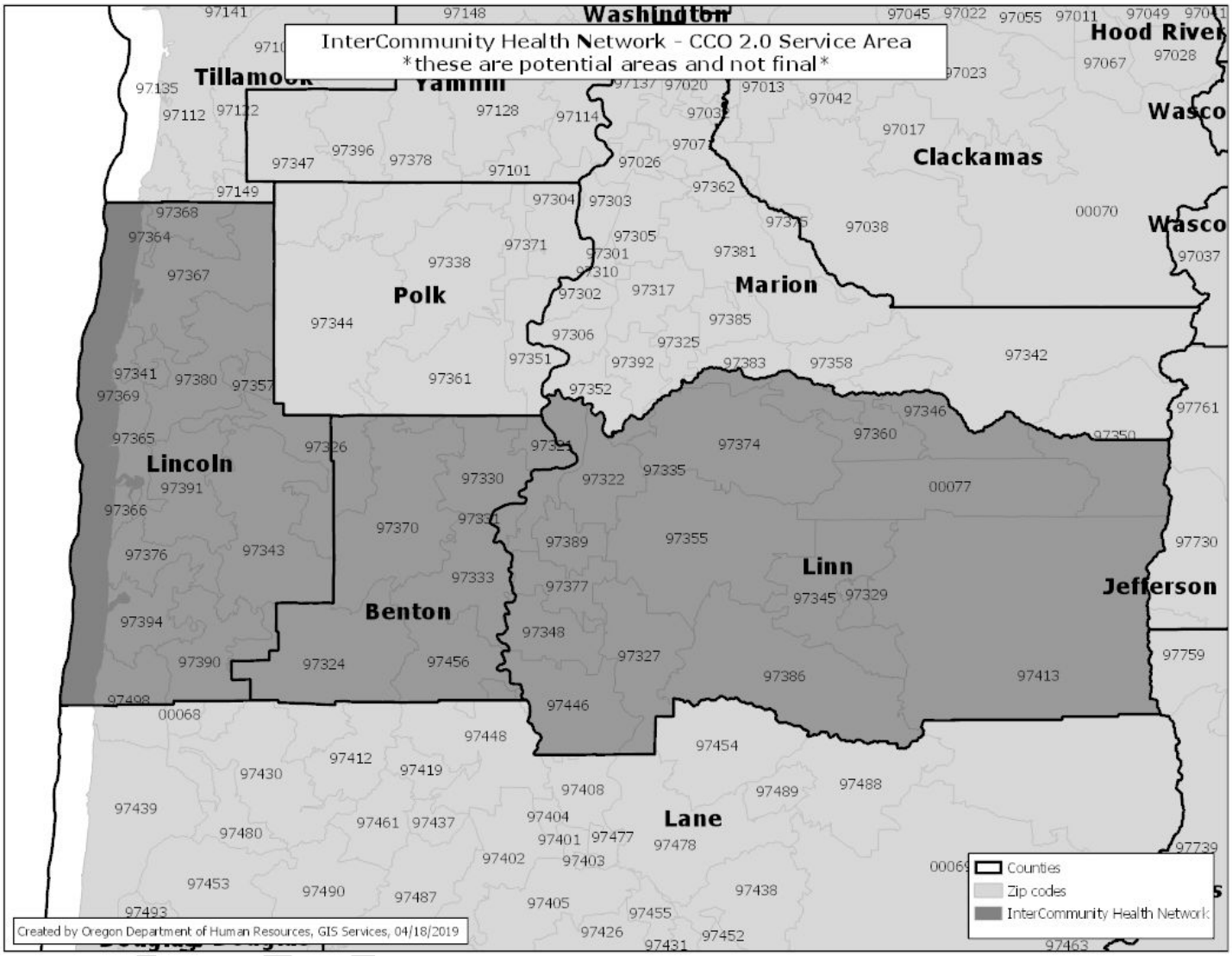
By looking at IHN's historic financial result for periods FY2013-FY2018, the projected BE FY2020's admin load 9.1% appears very high (historic range is 5.6%-8.5%) and the profit margin at 1% appears very low (historic data for FY2018 is 4.5%, for FY2017 is 3.2%).

Risk: none identified

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Lincoln, Benton, and Linn 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
Linn, Benton and Lincoln	-	IHN would be the only applicant to serve the entire counties. Trillium proposes to serve parts of Linn and Marion Polk Coordinated Care proposes to serve parts of Benton.	Even if Trillium and Marion Polk Coordinated Care do not serve parts of Linn and Benton – and therefore more members for IHN to enroll - there's a 1% chance IHN does not receive enough members for their minimum.	No scenarios show enrollment exceeding applicant's maximum	Low risk

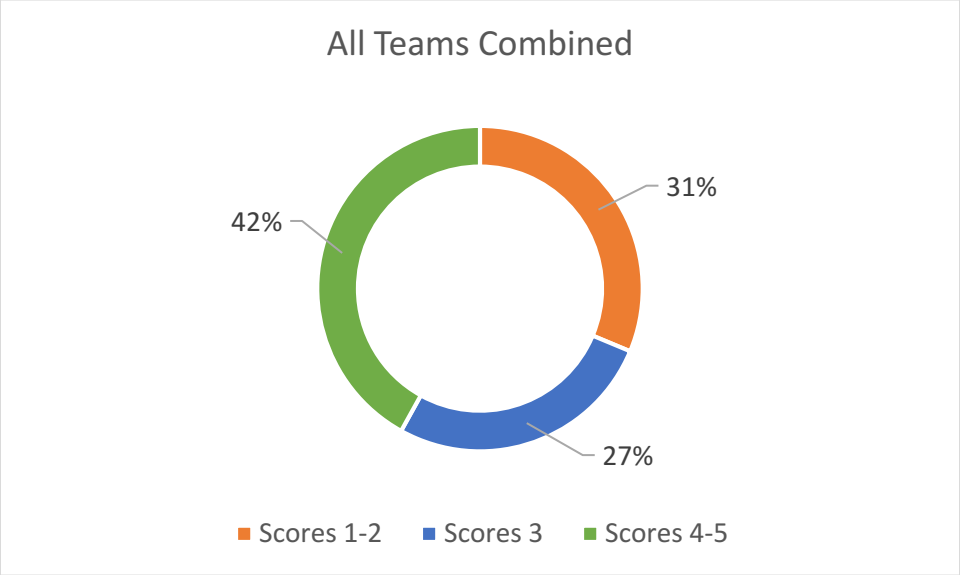
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, IHN is likely to receive approximately 48,954 members out of the 42,732 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.

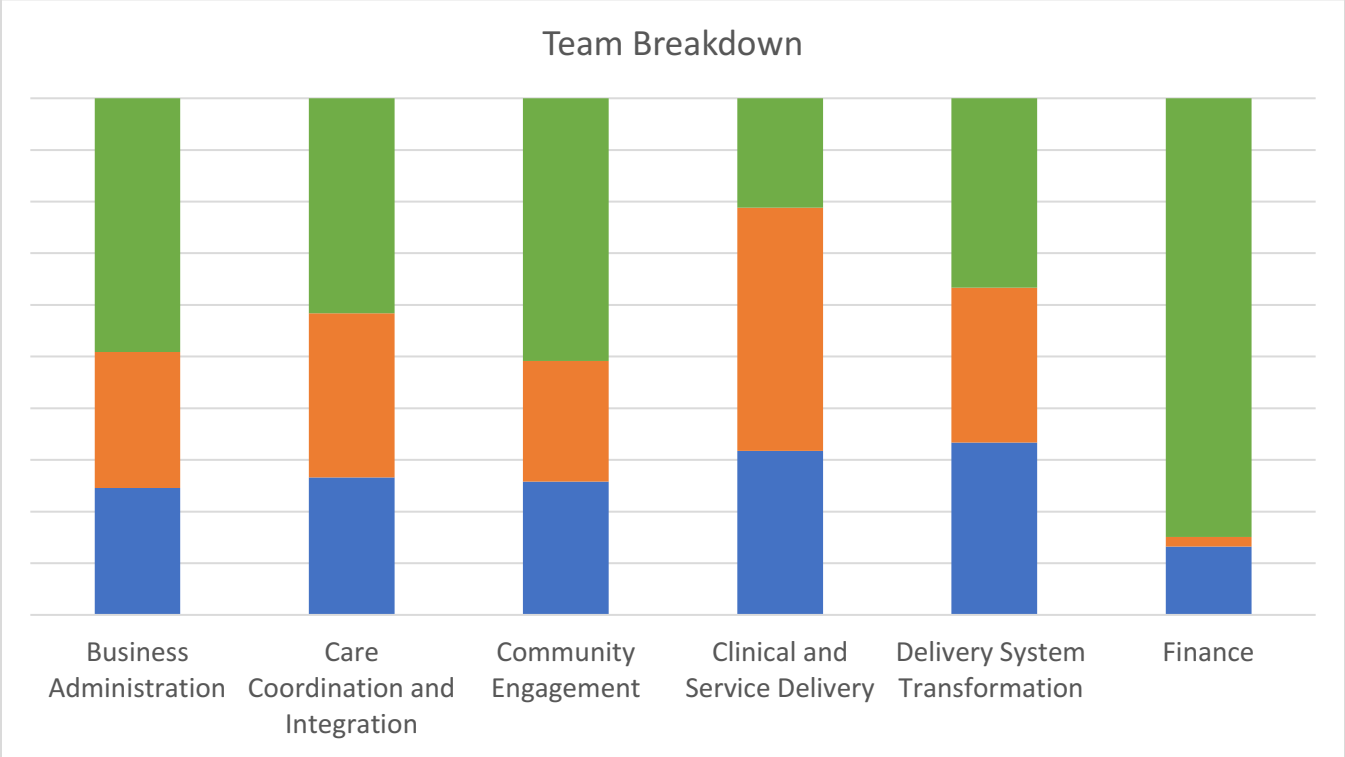
Evaluation Results – Overall Scores

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	FAIL	X		X	X
Care Coordination and Integration	FAIL	X	X	X	X
Clinical and Service Delivery	FAIL	X		X	X
Delivery System Transformation	PASS	X			
Community Engagement	PASS	X		X	

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	1	6	27
Value-Based Payment	6	7	23
Social Determinants of Health	17	26	70
Behavioral Health	46	66	65
Business Operations	165	96	130

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	6	4	23
Cost	11	13	33
Behavioral Health	7	20	28
Value-Based Payment	27	15	14
Business Operations	50	30	17

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	1	1	16	X			
CCO Performance and Operations	0	4	11	X			

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

Deficiency Analysis

Value-Based Payment

There are no concerns regarding value-based payment.

Cost

The care coordination plan did not have rationale for cost-effectiveness.

CCO Performance and Operations

While the strategy and plan was high quality, there was not enough detail to connect this plan to the goals of efficiency, cost, and quality.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Intercommunity Health Network Coordinated Care Organization be given a “pass” for the financial section. Gaps in care coordination cost and connecting strategy to overall plans are not considered an insurmountable barrier.

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	1	5	22	X			
Member Transition	8	6	22	X		X	
Administrative Functions	16	20	27			X	
Health Information Technology	19	10	11	X			X

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

Deficiency Analysis

Administrative Functions

For encounter data section, general lack of detail, missing info on the tools used, no info on frequency of monitoring and missing detail on the encounter validation process. Unclear how Applicant will obtain and monitor Third Party Liability. Pharmacy benefit materials are not easily accessible. Basic functions for Fraud, Waste and Abuse were not described such as how claims data is used for FWA audits or monitoring.

Difficult to tell if these deficiencies are due to missing information or if they are due to missing processes, procedure and infrastructure. Deficiencies due to missing information **could be easily fixed**, deficiencies due to missing processes, technologies or other infrastructure would take a **moderate to high amount of effort** to address, collectively.

Health Information Technology

Significant missing detail. Little detail regarding current operations for EHR, plans to adopt, barriers and mitigation strategies. Also, the option they listed is not feasible (OMUTAP) as that contract just ended. Limited detail on the SDOH sources they would implement for HIT/VBP, no info on actionable key insights or current reports. It also appears as if they lack a connection to outside data sources. There are no responses describing 5-year plans. The response reviewed suggest a limited knowledge and limited supporting processes and infrastructure to address EHR adoption and the creation and sustainment of data-informed VBP models. The deficiencies identified would talk a **moderate to large amount of effort** to adequately address.

Member Transition

The responses in this section were limited in detail. How Applicant would coordinate transfer of care was unclear. Applicant stated that their few case workers would be leading this work but provided little detail on how. This meant that no detail was provided in many responses in this section. Also concerning that only a few case workers would be leading all of the activities that are needed for transferring care from one CCO to another. The deficiencies in this section were unclear as many of the responses were not adequately addressed. If the missing detail is due to missing processes and procedures, then this would require a **moderate to large amount of effort** to address.

Social Determinants of Health

There was a lack of detail on how SDOH-HE data would be collected and analyzed and limited detail on SDOH communication strategies. These deficiencies could be **easily remedied**.

Team Recommendation: **FAIL**

- In general, this Applicant's responses were missing moderate amount of detail.
- Important administrative functions such as encounter data validation, TPL and FWA would take a **moderate to large amount of effort** to collectively stand up, if they are missing.
- Responses to the EHR adoption and HIT/VBP questions suggest a limited knowledge and limited supporting processes and infrastructure to address these processes. The deficiencies identified would talk a **moderate to large amount of effort** to adequately address.
- The member transition deficiencies were difficult to determine as Applicant indicated that their case managers would mange all of the transition activities and very little detail was provided on the transition processes themselves.
- The quality of the answers and multiple sections that likely required **moderate to large amounts of effort** to adequately address led to a team recommendation of FAIL.

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	6	1	14				
Behavioral Health Covered Services	1	12	23			X	
Behavioral Health Benefit	4	3	5	X			
Health Information Exchange	10	7	11	X			
Care Coordination	34	23	19		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 were missing significant details on planned timelines and milestones. Reviewers identified deficiencies in both people and process among the Applicant's proposed plan for developing MOUs with CMHPs. Use of weak language showed a lack of planning and understanding of the fundamentals of this subject. The Applicant's failed to provide a meaningful description of LTSS, DHS and behavioral health relationships.

Behavioral health covered services responses were generally well received, though no process was provided for identifying members ready to transition of lower levels of care. Reviewers expressed a desire for more information on planned timelines for review and updating of care coordination plans as well as processes in place to maintain low caseloads.

Care coordination responses failed to provide information on planned relationships with both tribes and community organization. No reference was made to usage of event notifications; the Applicant provided limited detail on tracking mechanisms and follow up activities. No plan was provided for oral health referrals for special populations.

Care integration responses were generally well received by reviewers who noted lacking detail for plans to engage with tribal populations, Indian health providers and plans/processes for care integration activities as concerns.

Applicant's ability to support Health Information Exchanges (HIE) was unclear from both financial and technical perspectives.

Team Recommendation: **FAIL**

Overall, reviewers felt that the deficiencies identified **could not be easily remedied**. Poor descriptions of how to meet the needs of special populations implied to reviewers that this applicant was not capable of coordinating care for those populations. No description was provided for tools, approaches or plans to identify the correct partners for care coordination. The lack of engagement plans with tribal populations failed to demonstrate the value of the tribal health system.

Clinical and Service Delivery

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	6	12	15	X			
Behavioral Health Covered Services	32	35	17	X		X	
Service Operations	20	14	12	X		X	
Administrative Functions	40	5	0	X		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 were missing a moderate amount of detail. For the network adequacy questions, physical, behavioral and oral health providers were discussed separately however some their ratios appeared to indicate network adequacy gaps and there was no information on how Applicant will address these gaps. The questions in this section are largely unanswered and when they are, it appears as if processes to manage the data are missing. For the grievance and appeal section it appears as if Applicant does not monitor their subcontractors at all, for the appropriate application of medical necessity criteria. Applicant is only using the complaint data and not any of the other G&A data to improve their network.

Although some of the deficiencies noted could be remedied with a small amount of effort, the high-level responses and missing information **suggested deficiencies that would require a moderate to large amount of effort to remedy**.

Behavioral Health Benefit

The responses in this section were missing some detail. There was limited information in the about billing barriers for Duals members. Details on how to assess needs for in-home services, was missing. And the response for Warm handoff billing barriers was also missing certain components. The deficiencies noted would take a **small amount of effort to remedy**.

Behavioral Health Covered Services

The responses in this section were missing a moderate to large amount of detail. For care coordination, no information on how Applicant matches members to different levels of care coordination or if those levels are present in their system. No indication of how members are notified of care coordination services and reports were the only data source used to identify members needing care coordination – no assessment process. The largest concern in this area was care coordination although nearly all responses were vague, at

best. The very vague and sometimes missing responses are suggestive of missing underlying processes, knowledge or other infrastructure and therefore the deficiencies noted are characterized as **moderate to large**.

Service Operations

The responses in this section lacked detail. The answers to the utilization management section had limited detail on policies for appropriate utilization management and there was little detail on how UM was monitored throughout the network. For the pharmacy section, the responses for medication management services was very vague – there appeared to be no processes in place. For the DHS/LTSS questions, responses were missing detail and two questions were missed entirely. Care coordination was not addressed for members receiving LTSS services and it was not clear how Applicant would work with APD or other care delivery systems. The deficiencies in this section are difficult to characterize due to vague and sometimes missing responses, however they are estimated to be **small to moderate sized** provided there are no missing underlying process, knowledge or infrastructure, which **could take additional effort to address**.

Team Recommendation: **FAIL**

- Overall, the responses from this Applicant were high-level, vague and sometime missing entirely.
- The responses in the Administrative functions section were very vague and missing enough information that they were suggestive of deficiencies that would require a **moderate to large amount of effort** to remedy.
- The missing detail for the care coordination questions in the Behavioral Health Covered Services section were also suggestive of missing underlying processes, knowledge or other infrastructure and therefore the **deficiencies noted are characterized as moderate to large**.
- The quality of the responses and the presence of multiple areas requiring **moderate to large amount of effort** to remedy led to a team recommendation of FAIL.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Accountability and Monitoring	6	5	7	X			
Delivery Service Transformation	3	5	4	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 descriptions of quality measures and how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking sufficient information about the role and administration of the reporting program.

Quality Improvement Program – Lacking sufficient information about referrals and prior authorization processes, including coordination of care.

CCO Performance - Lacking sufficient information about the process to continuously improve quality and outcomes while focusing on value and efficiency. Lacking sufficient information about process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REAL-D).

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data collection and how it is incorporated into quality improvement activities. Lacking sufficient plan to collect data by sub-categories (by REAL-D).

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as provider type and oversight.

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 missing details on connecting care coordination processes to ensure continuity of care
- Provide information about the process for communicating standards to providers and subcontractors
- Provide information about process if provider/subcontractor is not meeting targets

Delivery Service Transformation

- Describe the data collected and how it is incorporated into quality improvement activities
- Provide plan for improving the quality of services and outcomes

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	10	14	36	X			
Social Determinants of Health	5	5	10	X			
Community Engagement	4	2	4	X		X	
Governance and Operations	9	10	11				

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

Deficiency Analysis

- Community Engagement Plan did not describe barriers to engagement, no mention of member role in Quality Improvement.
- Insufficient details for aligning CAC population with demographics, limited detail on collaborating with CACs from other CCOs, no reference to reporting governance decisions made on CAC recommendations back to the CAC.
- Community engagement with partners was lacking detail on how to build relationships with stakeholders and lacking detail on which stakeholders have input into decision making besides CAC and how Applicant will engage community to addresses disparities.
- Doesn't include all priorities across CHPs
- Over-reliance on CAC to elevate member voice
- No mention of plan for engaging with tribes/tribal committees
- No mention of which publicly-funded partners were involved in development of the application, or agreements with county governments.
- No explicit role for the CAC and tribes in HRS CBI decisions
- No reference to how Applicant will ensure an equitable process when awarding the SDOH funding and insufficient detail on how projects will be evaluated and outcomes shared.
- Insufficient detail on how member engagement and care planning is culturally or linguistically appropriate

Team Recommendation: **PASS**

- Develop a more robust plan for involving non-CAC member voice and non-CAC community voice in decision making
- Develop a detailed plan for engaging for tribes
- Develop a strategy for engaging CACs from other CCOs
- Develop explicit role for the CAC and tribes in HRS CBI decisions
- Develop mechanism for accountability of governance to the CAC, including sharing of decisions back to the CAC
- Ensure sufficient strategies and capacity to successfully engage engaging communities to address disparities
- Develop a process that is equitable when awarding funding for SDOH-HE projects, including how projects will be evaluated and outcomes will be broadly shared

Community Engagement – Community Letters of Support

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

Organization Name	Type
ABC House	Child Abuse Intervention Center serving Benton and Linn Counties.
Advantage Dental	Dental Clinics
Albany InReach Services	Medical, BH, Dental Clinics
Albany Partnership for Housing and Community Service	Housing Services
Benton County Health Department	Public Health and BH
CAC Chair - Tyra Jansson	CAC
Capitol Dental	Dental Clinics
Community Health Centers of Benton and Linn Counties	Medical, BH, Dental Clinics
Community Helping Addicts Negotiate Change Effectively (CHANCE)	BH, SUD
Community Services Consortium	Social Programs, Supports
Corvallis School District	K-12 Education, Supports
Early Learning Hub of Linn, Benton & Lincoln Counties	Early Learning Hub
Heart of the Valley Birth and Beyond: Community Doula Program	THW Workforce
Legal Aid Services of Oregon	Legal Aid
Lincoln County Health and Human Services	Public Health, BH, SUD
Linn Benton Health Equity Alliance (LBHEA)	Health Equity Research, Advocacy, Programs
Linn Benton Lincoln Education Service District	K-12 Education, Supports
Linn County Department of Health Services	Public Health, BH, SUD, DD
Morrison Child and Family Services	Family, child BH and SUD
ODS Community Dental	Dental Clinics
Olalla Center	Services for children and families in poverty with high mental, social, emotional, physical and basic needs
Old Mill Center for Children and Families	Preschool, mental health, early intervention and parent support for children birth to 18 and their families.
Oregon West Cascades Council of Governments, Ride Line	Senior and Dsiability Services, NEMT
Samaritan Health Services	Hopsital, Medical Clinics
Signs of Victory	Homeless shelter, food bank
Siletz Community Health Clinic, Confederated Tribe of Siletz Indians	Tribal Government, Medical, Dental, BH

Traditional Health Worker Hub and the Benton County Health Navigation Team	THW Workforce
Tree Relief Nursery	Releif Nursery
Trillium Family Services	BH, Children and Families
Willamette Dental Group	Dental Clinics
Willamette Neighborhood Housing Services (WNHS)	Housing Services
Willamette Nutrition Source	Food, Nutrition, Education

Behavioral Health Policy Assessment

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

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

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

No additional comments were received.

Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
6	6	0	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

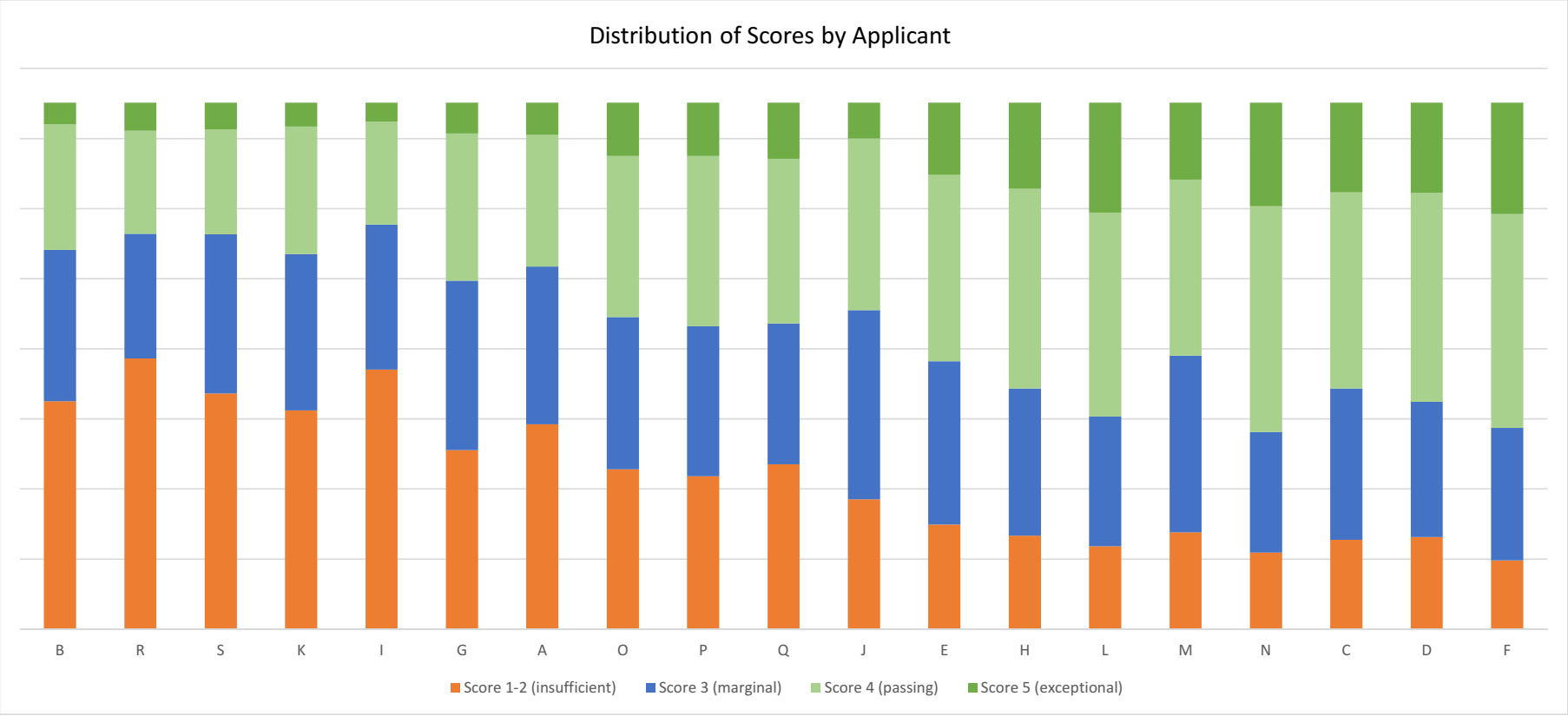
Members with no claims history

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

Pass/Fail by Category

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

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



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

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

Note:

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

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

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

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

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

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

using data as of 5/22/19

CONFIDENTIAL UNTIL 7/9/2019