RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant E
Jackson Care Connect

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 no potential sources of additional capital listed in the information received.
- ASU raised concerns about a severe loss risk based on historic financial results.

Service Area Analysis

- Jackson CareConnect is requesting to serve Jackson County. There is no service area exception requested.
- Jackson CareConnect is one of three 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 – Fail; responses missing minor to moderate amount of detail specific to Administrative and Behavioral Health Benefit.
- Delivery System Transformation – Fail; missing information about data collection, prior auth and referral systems, and quality oversight. Lack of detail about REALD, SUD, workforce development, and PCPCH oversight.
- Community Engagement – Pass

Community Letters of Support

- 46 letters of support were submitted from various provider groups and local entities

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

Jackson CareConnect'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

Jackson County CCO, LLC, d.b.a., Jackson Care Connect (JCC)

I have performed a review of the Jackson County CCO that includes pro forma financial information, audited financials, Articles of Incorporation, and biographical affidavits.

JCC appears to meet OHA's RBC, Liquidity, and Premium to Surplus Leverage Ratio requirements (as defined by the checklist) per the Pro Forma Statements generated under the Best Enrollment Estimates (Ideal). These Ideal ratio estimates are based on net income projections for the 2020 – 2022 where no annual net losses are expected. This expectation appears unrealistic because the immediate prior history for JCC and CareOregon, Inc. have shown that both entities had significant net operating losses for the prior two years (2016-17) per their audited financial statements and OHA internal financial online filings. An explanation of how they will be able to change their results from operations under the new CCO rates should be requested.

For RBC, the company projections exceed the 200% standard in all but 2020 for the Maximum enrollment projection, which is 195%. There appears to be sufficient financial resources to be able to handle results from operations that are below the projections for their best estimate and minimum estimates of enrollment.

The applicant appears to have sufficient assets to meet current liability obligations for the Best Estimate (Ideal), Minimum Estimate, and Maximum for Years 2020 to 2022. However, the range of claims cost increases tested that generated acceptable liquidity ratios (100% or greater) was quite narrow from 0% to 4% when compared with recent healthcare insurance experience where claims costs are often underestimated and exceed expected inflation estimates per DFR calculations. Also, if the "other assets" are removed from

the calculation (due to unknown type and liquidity), they may have just enough to cover liabilities and would be dependent on positive cash flow from operations from their anticipated results, but may be more reliant on cash flow from operations under negative deviations from their projections.

In addition, the analyst notes that if you increase the claims cost estimate just 2% for those scenarios calculated net losses are generated for every condition tested and if you increase the claims cost estimate 4% the RBC ratio generated from the Ideal estimates drop below 200% for 2020.

A capital infusion/contributions could be used to improve surplus or 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, and there is a little 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 JCC were reviewed and no material concern was noted, via the consolidated statements of CareOregon, Inc.. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in the years from 2015 and 2016, but had a small net loss in 2017 of $1,934,095. JCC reported net incomes of $9,865,219 in 2015 and $1,061,102 in 2016. Total net assets was $29.6 million in 2015 and changed to $28.7 million in 2017. DFR calculated a ratio of total current assets to total current liabilities of 262.7%, in 2017. This is well above the considered "ideal benchmark" of 200%, and the current health insurance market average, which was 175.4% at 12/31/2018, also they have more assets than liabilities. As a result, JCC is not dependent upon positive cash flow to maintain their current liabilities.

JCC paid $12.4 million in 2017 for administrative services, to CareOregon, Inc..

No concern(s) was associated with the review of the biographical affidavits.

The Articles and Amended Articles 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**
356,357	302,567	672,372	201,712	85%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$434.39		$447.43	$457.26	-5%

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

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.41%	3.40%

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

JCC's market share is reasonably consistent with current market share.

Profit margin

Applicant projected 0.9% profit margin for FY2020 under the BE scenario. However, based on its financial history, the applicant incurred -1.4% and -0.3% loss for FY2017 and FY2018 respectively.

From JCC's FY2018 Exhibit L reporting, OHA financial analyst noted that though the reported net loss is only $0.4M, however, this loss figure is after including a $9.6M gain from its sub capitated arrangements (the applicant delegates PH, BH, DH and NEMT services/risks to other risk accepting entities by paying sub capitation) which represents the loss incurred by the RAEs. If we factor in the loss of the RAEs, then JCC's loss for FY2018 would be over $10M (which translates to -7.0%'s profit margin).

From the business perspective, RAEs won't forever absorb such huge loss and as a normal reaction would request JCC to increase the sub capitation rate. If this negative profitability trend continues, JCC is expected to incur severe loss in future years similar to FY2018's level, which means its current capital level could easily be exhausted within 1.5 years without further capital contribution from its parent company CareOregon (which is also the largest RAE who is subcapitated for JCC's PH and BH service).

Risk: Severe loss risk based on historic financial result

Recommendation: Request JCC provide explanation of how it would significantly improve its profitability from 7%'s loss in FY2018 (including RAEs' experience) to 0.9% profit in FY2020.

JCC 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.

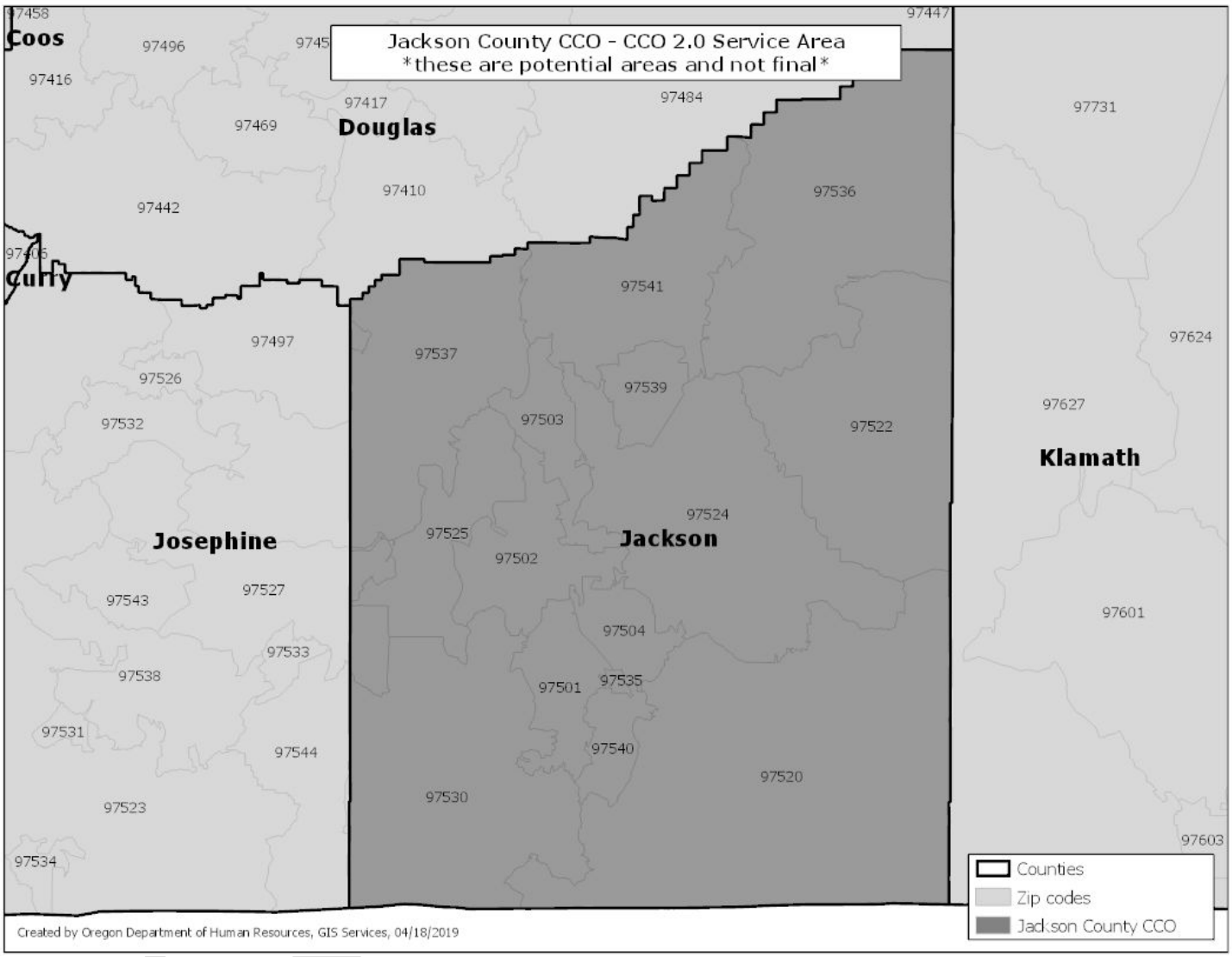
JCC 2018 reported net loss is only $0.4M; however, this loss figure is after including a $9.6M gain from its sub capitated arrangements. After reflecting RAE losses, JCC's loss for FY2018 would be over $10M (-7.0% margin). If this negative trend continues, JCC would soon exhaust C&S absent any further capital contribution. It is also worth noting that a $13.5M transfer out of capital was recorded in 2018.

- Recommend OHA request information from JCC regarding these losses and capital withdrawals and their financial consequences for 2019 and future years. Follow up on information as circumstances warrant.
- Suggest OHA look into DCBS statement that, "no potential sources of additional capital were listed in the information received."

Service Area Analysis

Requested Service Area

Applicant is requesting to serve the entirety of Jackson county.



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
Jackson	-	Serves only Jackson county, with Primary Health and AllCare also serving Jackson	No scenarios show enrollment below applicant's minimum	No scenarios show enrollment exceeding applicant's maximum	Low risk

Additional Analyses on High Risk Areas

Southwest Oregon

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

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

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

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

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

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

Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Jackson Care Connect is likely to receive approximately 9,299 members out of the 16,809 minimum required.

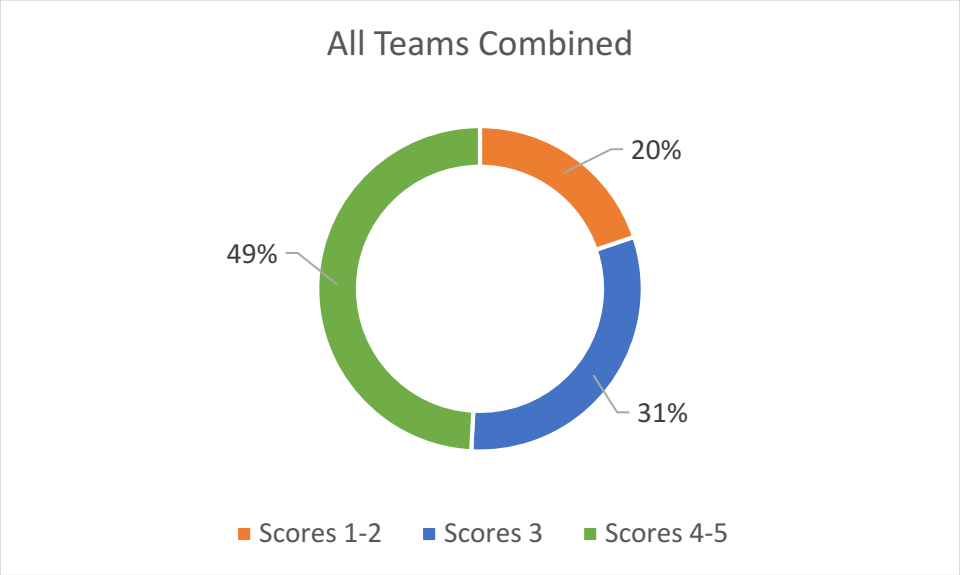
Note: the allocation test is based off the April 22, 2019 DSN submission. Applicants may expand their provider networks after contract award, increasing the likelihood of member match, and as such this projection should be considered only an approximation based on the available data. Special Populations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

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

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

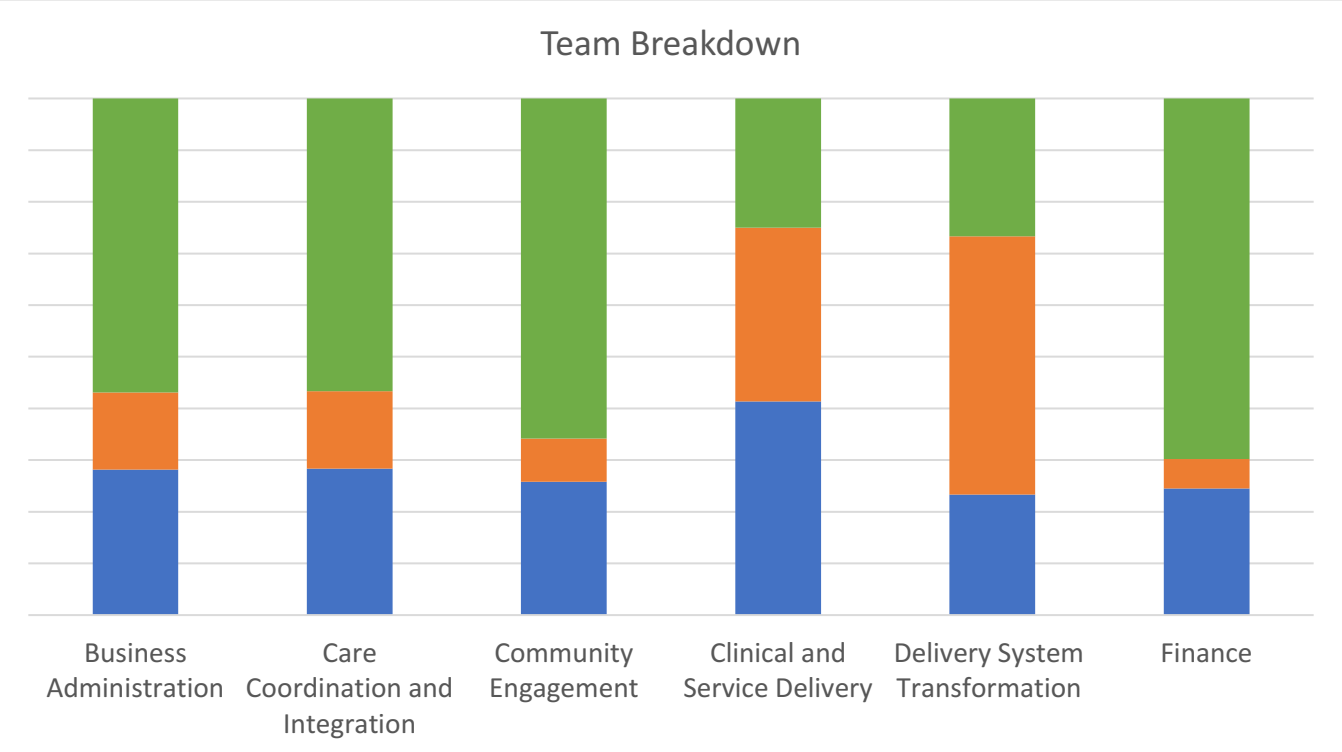
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Value-Based Payment	1	10	25
Cost	2	10	22
Social Determinants of Health	11	32	70
Business Operations	85	99	207
Behavioral Health	50	82	45

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	3	4	26
Cost	9	18	30
Value-Based Payment	17	10	29
Business Operations	23	32	42
Behavioral Health	17	16	22

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	4	16				
CCO Performance and Operations	0	5	10				
Cost	3	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

Jackson Care Connect's application was lacking detail and explanation on PMPM ranges for PCPCH, specifically as to why $0 was included in the range. However, other aspects of value-based payment were adequate.

CCO Performance and Operations

No specific aspects of CCO performance and operations were inadequate, but more detail would be beneficial.

Cost

Cost aspects of JCC's application were generally good, but specific areas would benefit from more detail and/or planning. When discussing care coordination, incorporation of social supports was not mentioned. Cost containment answers mentioned current activities but did not mention if these activities would be continued and if there was a contingency plan for if their current practices ineffectively contain costs in the future. There was insufficient detail explaining how proposed strategies would accomplish desired goals. Lastly, it was unclear if Jackson Care Connect is integrating behavioral health financing with physical health financing.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Jackson Care Connect be given a "pass" for the financial section. The deficiencies noted in the cost section should be **relatively simple** for JCC to correct.

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
Health Information Technology	4	6	30				
Social Determinants of Health	1	8	19				
Member Transition	3	12	21				
Administrative Functions	17	21	25	X		X	

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

Deficiency Analysis

Administrative Functions

Largely unresponsive to Third Party Liabilities question. Responses for encounter data were missing the capacity, tools, monitoring processes and frequency of monitoring for all claims including Medicare. Responses for FWA were high level but majority of components addressed. Missing pharmacy hours of operation and how they will provide information on pharmacy benefit to members. TPL and encounter data processes and procedures would require a **moderate amount of effort** to implement if not already present. The other deficiencies **could be remedied quickly**.

Health Information Technology

The responses in this section were mostly responsive. There was detail missing on how new data sources will be incorporated, mitigation strategies and the types of reports that are utilized. Also, the 5 year plans were missing but all deficiencies are considered **relatively easy to resolve**.

Member Transition

There is no detail on warm handoff and transition activities, continuity of care for medical case management was not addressed and the data reception plan was missing some components. All deficiencies are considered **relatively easy to resolve**.

Social Determinants of Health

Limited details on policies that promote diversity and missing some detail on their health equity training – who will provide this training, how often, etc. Applicant is reactive in responding to needs of those with disabilities – monitoring complaints – but should establish some proactive processes to address these member's needs.

Team Recommendation: **PASS**

- This Applicant's responses were largely responsive to questions and only minor deficiencies noted, with the exceptions mentioned above.
- Recommend that OHA confirm that Applicant has TPL and encounter data validation processes in place or feasible plans for them. Also recommend that Applicant readdress the TPL and encounter data questions to provide sufficient evidence those processes are applied.

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	1	3	17				
Health Information Exchange	0	6	22				
Behavioral Health Covered Services	6	10	20	X			
Care Coordination	14	26	36	X			
Behavioral Health Benefit	5	4	3			X	

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

Deficiency Analysis

Applicant's responses on behavioral health benefit plans were focused on historical efforts and included limited information on how these tasks would be performed moving forward. Applicant failed to provide an explanation of current or future monitoring efforts intended to identify gaps in workforce capacity across the delivery system. Workforce capacity analysis was focused on a limited number of provider types indicating a process deficiency. Applicant scored well in behavioral health covered services but failed to include detail on outreach for high-needs members as well as substance use disorder in their explanation of treatment planning.

Care coordination activities have been identified as immature. Applicant provided no detail on coordination activities for dual eligible populations. Tribal populations were not included in the Applicant's discussion of crisis management plans, and these plans did not contain enough information about partners and partner agreements. Applicant failed to define the process by which coordination efforts with partners would occur on an ongoing basis. Beyond these issues the applicant provided limited responses on:

- How they will form relationships with DHS – this is a heavier lift to resolve
    - Applicant confused APD staff with APD providers. Reviewers worried this demonstrated a misunderstanding of the current system.
- Planned oral health and wellness activities

Team Recommendation: **PASS**

Care integration responses were well received; however, additional detail on how care coordination and record sharing / monitoring was desired.

Applicant's ability to support Health Information Exchanges (HIE) was clearly demonstrated but lacked a robust assessment of where providers are currently at in their adoption of HIE. Plans to increase HIE adoption were presented, but methods of execution were not provided.

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
Administrative Functions	17	11	17			X	
Behavioral Health Benefit	8	20	5				
Behavioral Health Covered Services	27	44	13	X			
Service Operations	18	11	17				

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 largely responsive but missing detail. Monitoring of network adequacy unclear; unclear how improvements would be made; more discussion needed on PCP but not on other categories; accountability process unclear or seemed indirect; deficiencies in linguistic access monitoring – they were waiting for complaints instead of being more proactive. The deficiencies noted (additional detail and processes needed) could be remedied with a **small amount of effort**.

Behavioral Health Benefit

The responses in this section were largely responsive but missing detail. No clear process for warm handoffs, just stated they would occur. No barriers identified for warm handoffs, did not indicate what the applicant does to ensure access to services or how they play a role; more discussion about providers than members. The deficiencies noted (additional detail and processes needed) could be remedied with a **small amount of effort**.

Behavioral Health Covered Services

The responses in this section were missing a moderate amount of detail and some components were not addressed at all. Did not address peer support; no discussion of the family role; no discussion of assessment of pre- or post-pregnancy assessment; no detail about how care coordination is performed (specific methods and mechanisms); outreach is limited to the welcome packet. Applicant combines answers to multiple questions. Wraparound service responses are lacking a lot of detail. The deficiencies identified in this section (peer support not addressed at all and missing large amount of detail on care coordination) would require a **moderate to large amount of effort to remedy**.

Service Operations

Responses in this section were missing moderate amount of detail and some components were no addressed. No discussion of monitoring or process for utilization monitoring; no discussion of access to

pharmacy services or hospital services; lacking detail on PA and PA timelines; no detail and incomplete responses on DHS LTC. The deficiencies identified in this section (moderate amounts of missing detail, missing fundamental processes) would take a **small to moderate amount of time to remedy**.

Team Recommendation: **FAIL**

- The responses from this Applicant were missing minor to moderate amount of detail.
- The deficiencies noted in the Administrative and Behavior Health Benefit sections were estimated to take a **small amount of effort to remedy**.
- The deficiencies identified in the Behavioral Health Covered Benefit section (peer support not addressed at all and missing large amount of detail on care coordination) were more foundational gaps and would require a **moderate to large amount of effort to remedy**.
- The deficiencies identified in this section (moderate amounts of missing detail, missing fundamental processes) would take a **small to moderate amount of time to remedy**.
- The quality of the answers and the presence of many small and multiple moderate deficiencies led to a team recommendation of FAIL.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Delivery Service Transformation	2	3	7				
Accountability and Monitoring	13	4	1			X	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 the system/software used for quality measurement and reporting, the process used to track performance and quality expectations, and the tool used to push data out to various providers. Lacking sufficient information about how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking sufficient information about the external programs, who administers these programs or the purpose/roles of these programs. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

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

CCO Performance - Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services by population sub-category (by REAL-D).

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide details describing data collection and analysis by sub-categories (by REAL-D). Lacking sufficient information about plan for improving quality of services and outcomes. Lacking information about identifying and filling workforce gaps, including lack of SUD services in the community.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as number of providers by tier levels, member assignment stats by provider type, and system oversight.

Team Recommendation: **FAIL**

The responses provided by this applicant are insufficient. The following items are missing from the responses:

Accountability and Monitoring

- Missing information about the applicant's ability to collect electronic and other data to support performance benchmarks
- Missing details about the prior authorization system and referral processes to support care coordination and continuity of care
- Missing structure of quality oversight
- Implementation concerns about system of referral and prior authorization, and how the processes support care coordination and continuity of care

Delivery Service Transformation

- Missing detail in quality improvement plan specific to REALD, SUD, and workforce development
- Missing detail about PCPCH tiers and oversight

Community Engagement

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Community Engagement	0	2	8	X			
Governance and Operations	0	6	24			X	
Social Determinants of Health	1	6	13			X	
Community Engagement Plan	9	17	34				

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

Deficiency Analysis

- No mention of how the community engaged on the actual application development
- Not enough detail on COI policy; not clear if self-disclosure of COI recuses them from vote
- Lack of detail overall or mechanism for ensuring an equitable process for spending
- No culturally specific providers or THWs identified
- No description or detail included about projects
- Did not explicitly include allocation of funds to overcome barriers to engagement, did not describe how the barriers would be addressed through their work.
- No strategies for how to recruit from "traditionally underserved communities" as stated in application
- No engagement of tribes

Team Recommendation: **PASS**

- Improve and strengthen COI policy
- Consider how to make the process more equitable so that it isn't just about transparency

Community Engagement – Community Letters of Support

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

Organization Name	Type	Notes
ACCESS	Community Action Agency	Social Services/Supports
Addictions Recovery Center	BH, SUD, Education	Critical Clinical Providers
Advantage Dental	Dental Clinics	Dental Care Organizations
Asante Health System	Hospitals, Medical Clinics, Primary Care	Critical Clinical Providers
Ashland YMCA	Family Fitness, Wellness	Wellness
Capitol Dental Care	Dental Clinics	Dental Care Organizations
City of Medford	Local Government	Broad Community Collaboratives/Partners
ColumbiaCare Services Inc.	Outpatient Services, Supported Employment, Intensive Case Management, Facility-based Crisis Respite and Resolution, Supported Housing, Rental Assistance	Critical Clinical Providers
Compass House	BH, Homeless and Housing Services	Social Services/Supports
Continuum of Care	Homeless Services, Housing	Housing
Eagle Point School	Education	Education
Family Connection	Early Childhood Services	Social Services/Supports
Family Nurturing Center	Early Childhood and Family Services	Social Services/Supports
Housing Authority of Jackson County	Local Housing Authority	Housing
Jackson County Mental Health	BH, SUD	Safety Net Providers
Jackson County Sheriff Nathan Sickler	Local Law Enforcement	Broad Community Collaboratives/Partners
Jackson Elementary School	Education	Education
JCC Community Advisory Council	CAC	Community Stakeholders
JCC Youth Advisory Council	CAC, Youth	Community Stakeholders
Jefferson Regional Health Alliance	Regional Health Initiative Collaboration	Broad Community Collaboratives/Partners
Kairos	Family, Children, Teen BH	Critical Clinical Providers
Kid Time Children's Museum	Early Childhood Programs	Housing
Kids Unlimited	Youth recreation, health, nutrition, BH support services	Education
LaClinica Health	FQHC	Safety Net Providers

Community Letters of Support

Organization Name	Type	Notes
Linguava	Interpreter Services	Health Equity/Language Access
Maslow Project	Homeless Services, Families and Children	Social Services/Supports
MercyFlights	Ambulance Service	Critical Clinical Providers
OnTrack Rogue Valley	SUD	Critical Clinical Providers
Oregon DHS-Aging and People with Disabilities	Public Senior and Disabled Services	Housing
Passport to Languages	Interpreter Services	Health Equity/Language Access
Phoenix High School	Education	Education
Phoenix-Talent Schools	Early Childhood Programs, Education	Education
PrimeCare	Medical Clinics	Critical Clinical Providers
Providence Medford Medical Center	Hospital, Medical Clinics	Critical Clinical Providers
Rogue Community Health	Medical Clinic	Safety Net Providers
Rogue Retreat	Homeless Services, Housing	Housing
Rogue Valley Transportation District	NEMT	Transportation
Rogue Valley YMCA	Family Fitness, Wellness	Wellness
RVCOG Deaf & Medical Providers Workgroup	Disability Services Workgroup	Health Equity/Language Access
SO Health-E Coalition	Health Equity Coalition	Health Equity/Language Access
Southern Oregon Early Learning Services	Early Learning	Early Learning Services
Southern Oregon Head Start	Early Learning, Preschool	Early Learning Services
Southern Oregon Pediatrics	Pediatric Clinic	Critical Clinical Providers
Southern Oregon Success	Family Health, Early Childhood, Education, Youth Services	Broad Community Collaboratives/Partners
Willamette Dental Group	Dental Clinics	Dental Care Organizations

Behavioral Health Policy Assessment

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

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

Deficiencies: Applicant is not clear on if they're integrating BH financing with physical health. Applicant does not address that how they will not provide a capitation or how they will ensure that BH is not carved out.

Recommendations: Require applicant to submit a plan for including behavioral health in the global budget and not "bucketing" the behavioral health spending.

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
2	8	1	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.

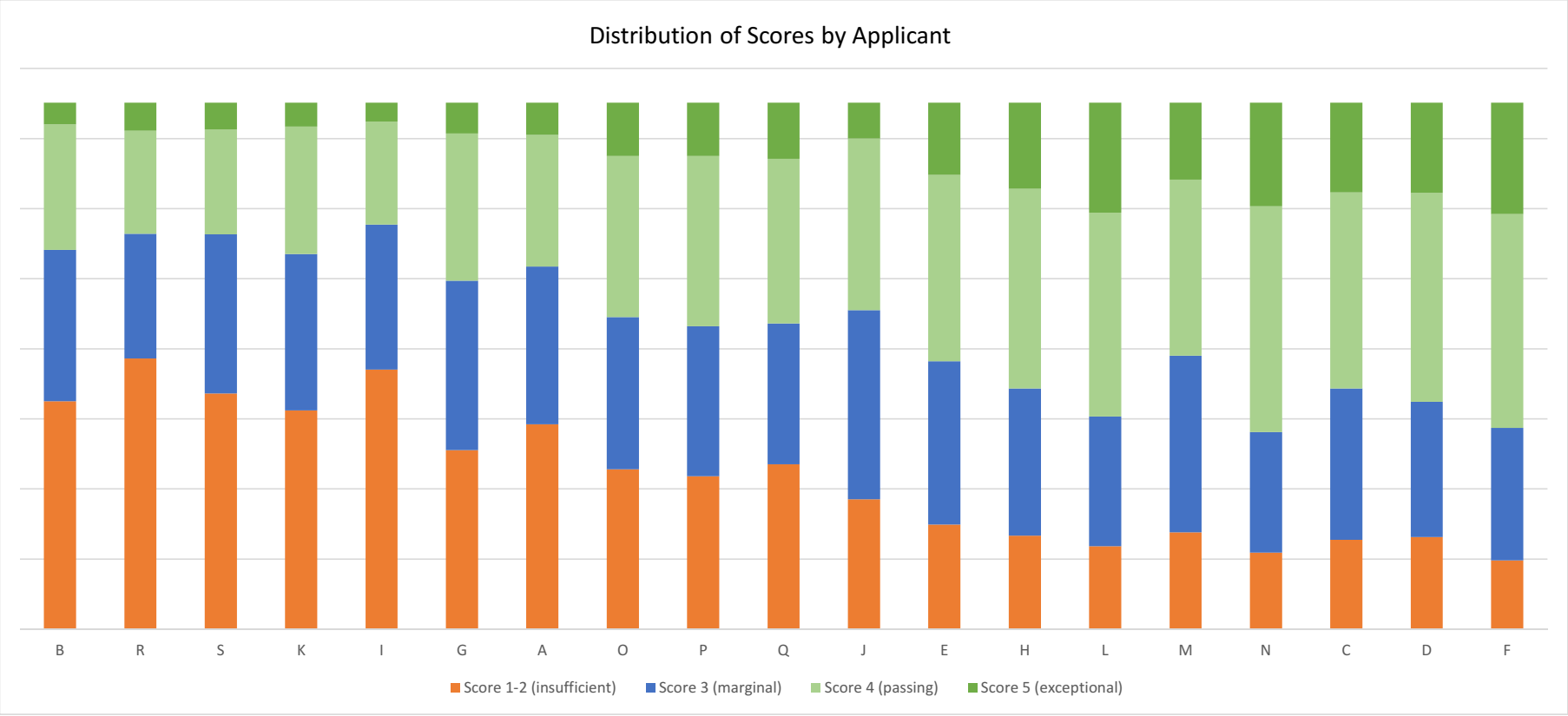
Members with no claims history

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