RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant H
PacificSource Community Solutions – Central Oregon

CONFIDENTIAL UNTIL 7/9/19

Evaluation Overview

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

Criteria Development

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

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

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

Passing Score

Team Analysis

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

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

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

Evaluation Results: Policy Alignment

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

Evaluation Results: Informational Assessment

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

Ex:

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

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

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

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

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

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

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

Executive Summary

Financial Analysis

- PSCS – CO is a CCO division of PSCSCCO. All four PSCS divisions are potentially sharing resources. The resource allocation method is unclear.
- DCBS performed the financial evaluation and found results to be reasonable for projections provided.
- ASU raised concerns about capital funding and multiple CCOs under PSCS, specifically that C&S could be redundantly recorded across these four applications.

Service Area Analysis

- PSCS – CO is requesting to serve Crook, Deschutes, Jefferson, and Klamath Counties. They are requesting a service area exception to serve only part of Klamath County.
- PSCS – CO received sufficient scores to grant the exception request for Klamath County.
- PSCS – CO is the only applicant in this service area.

Evaluation Results – Team Recommendations

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

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

PSCS – CO'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 28, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: **Oregon Health Authority CCO 2.0 – DFR Financial**

Review **PacificSource Community Solutions (PSCS) – Central Oregon CCO**

I have performed a review of PacificSource Community Solutions – Central Oregon, that includes pro forma financial information, audited financials, Articles of Incorporation, biographical affidavits, and corporate narratives related to operations and holding company transactions and affiliations.

PacificSource Community Solutions – Central Oregon is one of four separate CCOs managed by the PacificSource group of companies, and more specifically, PacificSource Community Solutions (PSCS). This is a well-established and successful CCO with current operations that is expanding its geographic service area. PSCS is applying for expansion of their operations under the umbrella of the single entity of PSCS. As part of the PacificSource holding company system, which includes health insurers, PacificSource Health Plans (NAIC #54976) and PacificSource Community Health Plans (NAIC #12595), PSCS may have access to additional parental resources.

Upon review of the CCO application submission for Central Oregon, the results appear to be reasonable for projections provided.

As PSCS is expanding their operations from just the Central Oregon and Columbia Gorge areas into Marion & Polk Counties and into Lane County, resources must be mutually shared/allocated to each of the four (4) divisional CCO operations of the company. Information presented appears to indicate that the resources are wholly and exclusively available to each of the four (4) divisions to the exclusion of the other three (3) divisions. While the company is able to recognize synergetic benefits from diversifying their risk, those

resources must be mutually available to all four (4) divisions unless some allocation process is established. As such, the Analyst reviewed the pro forma financial statements as presented by the company indicating that the Applicant may have exclusive and unallocated access to the company's entire resources.

NOTED for CONSIDERATION:

Resource information provided by the Applicant appears to report that all of PSCS' resources would be wholly and exclusively available to the Central Oregon operations and thus would not be available to the other three PSCSCCO applicants. While the Company would be able to recognize synergetic benefits from diversifying their risk, the Analyst believes that those resources are mutually available to all four (4) operations and thus should not be illustrated as being wholly and exclusively available to only one (1) operation.

Note: This analysis would be substantially different if the Applicant was to be reviewed using only the resources exclusively allocated to the Applicant it alone. Ratios such as Premiums to Surplus, Liquidity Ratio, and RBC & ACL calculations would be significantly different on a resource allocation basis.

There is concern that by using a single entity to operate four (4) different CCO's, but present the financial information as "broken up" between each entity, that the applicant may not have the financial resources available to operate such a large business entity. OHA should ensure that if a contract is offered, that there is a separate legal entity per location with dedicated Capital & Surplus, with calculated RBC amounts per entity. Otherwise, they will need to file a consolidated financial statement for each of the operating areas, with aggregated RBC (ACL) calculations. Doing a consolidated statement provides for the appropriate risk assessment of the operations, but would appear to not provide the clarity and transparency the OHA is looking for in the financial statement presentation for each CCO. Based upon the total C&S provided, they have an aggregate amount in excess of $200 million, which DCBS is unsure how they could raise those types of funds to contribute without being an immediate financial detriment to their insurance companies.

DCBS would consider the financial presentation in the Pro-Forma for all four of the applicant CCO's to be incorrect, misleading and not viable to allow for an assessment of the company for a CCO contract.

Using a combined RBC calculation from the numbers provided (which may include duplications for Asset Risk, which should be a very minor portion of the ACL calculation for RBC) would give the company in their Best Enrollment projection an RBC of 166.5% as of 12/31/2020 at the best guess, or 145.4% under the lowest C&S amount provided. Those values would not meet the OHA standards.

As such, without the Applicant providing allocated resource data, the Analyst reviewed the pro forma financial statements as presented by the Company, indicating that the Applicant has exclusive and unallocated access to the Company's entire CCO resources.

A complete review could not be conducted given the lack of scenario data provided, as noted periodically in the Analyst Calcs worksheet and in the review conclusions below.

RBC Review/Enrollment Projections:

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 100%, Minimum ('MIN') 84%, and Maximum ('MAX') 138%.

The Applicant is able to maintain an adequate RBC at all three levels of enrollment (Best Estimate, Minimum, and Maximum), and all Claims +2%, +4%, +6% projections, and combined enrollment/claims deviation projections for all three years, beginning with 2020, through 2022.

At Best Estimate, the applicant would not see a reduction in RBC down to the 200% level until claims hit 11% higher than projected in the first year, and 12% in the second year, and 13% in the third.

That being said, changes in enrollment, either up or down, do not appear to significantly impact profitability of the company.

At no point in these scenarios are the losses 20% of C&S, or anywhere close to 50% of C&S. The CCO met the basic capital and surplus and RBC requirements under all presented scenarios.

BE MM Years 1-3: Net losses are greater than 5% of C&S if claims cost are 4% or 6% higher, but not at 2% higher.

5% of Surplus:	**2,613,895**	**2,785,617**	**2,964,892**
+2% Claims	**(1,896,933)**	**(1,930,479)**	**(1,964,079)**
20% of Surplus:	**10,455,581**	**11,142,468**	**11,859,568**
+4% Claims	**(7,083,312)**	**(7,295,390)**	**(7,513,657)**
50% of Surplus:	**26,138,954**	**27,856,169**	**29,648,919**
+6% Claims	**(12,269,691)**	**(12,660,301)**	**(13,063,235)**

The pro forma financials included a profit and loss statement for estimated enrollment, minimum enrollment, and maximum enrollment. The three enrollment scenarios include an RBC projection. PSCS – Central Oregon projected an RBC of nearly two to three times the minimum requirement for the CCOs within all three scenarios, for all three years.

Additionally, the Assumptions that have been used by the Company for their "ideal" or "best estimate" scenario appear to be right on target, within 1-2% of enrollment the capitation rate, and loss ratio.

NOTE, however, the in-house OHA Actuarial Analysis indicated that some of the capitation rate assumptions are unexpected, in that they are not as well aligned as expected. In this case, PSCS – Central Oregon looks as though it may be assuming too much income per member. The Applicant assumed a rate of $28.76 HIGHER than OHA, per member, per month, which can add up to substantial differences in revenue when matched against claims costs.

They suggest rerunning projections by using the OHA capitation rate assumption and a 90% loss ratio. This is based on getting 2% less income than expected, plus an expected 88% loss ratio. Using this adjustment would put the company's projections actually closer to the +2% as a baseline. As shown above, this would generate net losses from operations, but the losses would be small in consideration to their C&S position, that could still meet the RBC requirements. If the four CCO applicants, though, have net losses, the aggregate losses may put a greater strain on the financial position that the company may not be able to withstand through the full five year CCO contract.

Liquidity Review:

The Applicant appears to have sufficient assets to meet their liability obligations without reliance on positive cash flow from operations under each of the three scenarios. It does not appear that claims increases impact liquidity down to the 100% threshold until upwards of 21-23% of an increase in claims costs is projected. As shown below:

Expected Membership and Claims = ≈223+% (top line in graph)

Minimum Membership and Claims = ≈246+%

Maximum Membership and Claims = ≈200+%

Liquidity Ratio (Liquid Assets/Current Liabilities)	calculated	223%	227%	231%
At 2% increase in claims costs (BE):	calculated	212%	216%	219%
At 4% increase in claims costs (BE):	calculated	200%	204%	208%
At 6% increase in claims costs (BE):	calculated	189%	192%	196%
At 21% increase in claims costs (BE):	calculated	102%	105%	109%
At 22% increase in claims costs (BE):	calculated	96%	100%	103%
At 23% increase in claims costs (BE):	calculated	91%	94%	97%
At MINIMUM MM – expected claims and enrollment	calculated	247%	250%	254%
At MAXIMUM MM - expected claims and enrollment	calculated	200%	204%	207%

Additionally, the Applicant appears to have parental resources available for further capitalization as needed. However, the assets available could be limited, though, and with four CCO applicants within the organization, and the resources may be more strained and limited than if done under a single application.

Net Income Review:

Net income was positive for each of the first three years under the Best Estimate scenarios.

Net Income (BE MM):	**Year1=$3,289,446**	**Year2=$3,434,431**	**Year3=$3,585,499**
Net Income (MIN MM):	**Year1=$2,926,205**	**Year2=$3,053,464**	**Year3=$3,186,016**
Net Income (MAX MM):	**Year1=$4,099,565**	**Year2=$4,284,084**	**Year3=$4,476,447**

However, in all cases, for all three years, an increase of just 2% in claims costs results in a net loss for the year, even with liquidity intact.

Net Loss (BE MM):	**Year1=($1,896,933)**	**Year2=($1,930,479)**	**Year3=($1,964,079)**
Net Loss (MIN MM):	**Year1=($1,370,194)**	**Year2=($1,390,944)**	**Year3=($1,411,491)**
Net Loss (MAX MM):	**Year1=($3,071,692)**	**Year2=($3,133,778)**	**Year3=($3,196,488)**

An increase of 4% (and 6%) in claims costs, for all three years, and all three scenarios, showed net losses, even with liquidity and RBC intact.

Net Loss (BE MM):	**Year1=($7,083,312)**	**Year2= ($7,295,390)**	**Year3=($7,513,657)**
Net Loss (MIN MM):	**Year1=($5,666,593)**	**Year2=($5,835,351)**	**Year3=($6,008,998)**
Net Loss (MAX MM):	**Year1=($10,242,949)**	**Year2=($10,551,641)**	**Year3=($10,869,424)**

Net Loss (BE MM	**Year1=($12,269,691)**	**Year2=($12,660,301)**	**Year3=($13,063,235)**
Net Loss (BE MM	**Year1=($12,269,691)**	**Year2=($12,660,301)**	**Year3=($13,063,235)**
Net Loss (BE MM	**Year1=($12,269,691)**	**Year2=($12,660,301)**	**Year3=($13,063,235)**

A Net Loss occurs between 1% - 2%, is between a 1.26%-1.30% increase in expected claims, under the best estimate scenario. The point at which a Net Loss occurs is below the given scenario of 2% increase in claims costs. The Company is well capitalized and set to absorb losses, should they occur. However, significant claims costs could be a risk to liquidity and their ability to pay. Changes in claims costs, even at 2%, do impact profitability of the company.

PREMIUM to SURPLUS

The Applicant's Premium to Surplus ratio is:

Expected Membership & Claims +0%: 5.3:1, 5.2:1, and 5.0:1 for each year, respectively

Minimum Membership & Claims +0%: 4.5:1, 4.4:1, and 4.3:1 for each year, respectively

Maximum Membership & Claims +0%: 6.6:1, 6.4:1, and 6.2:1for each year, respectively

Data was not provided, nor calculated, for any of the +2%, +4% nor +6% scenarios.

These are within the acceptable range and indicate that they are able to continue growth and underwrite new policies.

OTHER

The audited financials for PSCS were reviewed and no material concern was noted. An unqualified opinion was issued for each of the three audits provided. The Company was profitable in each of the three years from 2015 through 2017 and reported net income between $7.5M and $12.0M in each year. Total capital and surplus was $46.3, $47.6M, and $35.8M at year-end 2015, 2016, and 2017, respectively.

NOTE: This is for PSCS as a WHOLE.

The Articles of Incorporation were reviewed and no concern was noted. The Articles of Incorporation provided were in fact Articles of Merger, delineating the process of the merger between Conners Group (CG) and PacificSource Community Solutions, Inc. (PCSI), a then wholly-owned subsidiary of the former, resulting in PacificSource Community Solutions (PSCS), a non-profit corporation. Exhibit A is the Agreement and Plan of Merger, which states that the Articles of Incorporation, Bylaws, and Board of Directors and Officers of CG remained in place, except for the name of the new non-profit entity.

They were filed with the Oregon Secretary of State Corporation Division on June 27, 2016. The Articles of Merger were filed on December 30, 2016, and were accepted as filed. No issue or concern.

The biographical affidavits / Resumes were reviewed and no concern was associated with the or Board of Directors members. Every Director or Officer included a statement about regulatory issues that the PSG was subject to through both CMS and DFR, but they did not disqualify anyone from serving in any way. There was only one other disclosure that again, has no bearing on their ability to be appointed. They were recently reviewed in depth via the DFR examination process, revealing no anomalies, records, or other concerns, and they qualify to serve on PSCS's board pursuant to ORS 414.625(2)(o).

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**
576,000	572,724	790,104	480,000	99%	none

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$490.94		$511.32	$482.56	2%

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

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

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

PacificSource Central's service area in Klamath is in service area 4, which is at lower capitation rate. PSCSC's application may mistakenly use the same rate as in service area 2.

PacificSource applicants may be reporting partially combined balance sheets in their pro formas. This would effectively quadruple-count most of their 12/31/2018 C&S, which would in turn inflate the projected RBC

ratios. ASU agrees with DCBS that if all applicants' RBC was combined, and only one of the reported C&S figures was used, the aggregate RBC level as of 12/31/2020 would be around 145% to 165%.

- Recommend OHA clarify with PS the extent to which C&S is "shared" (i.e. redundantly recorded) across these four applications.
- If C&S is mostly quadruple-counted, suggest OHA consider denying one or both new applications unless additional capital is contributed to get to a total of 200%.
    - For example, denying PSCS - Lane application would result in approximately 200% combined RBC for remaining three CCOs in absence of any additional capital. Similar result holds true if only PSCS – Marion Polk application is denied.
- Suggest OHA consider whether a consolidated pool of capital is acceptable, or whether two to four separately financed entities would be preferable.

Admin load % and profit margin assumption

In the FY2020 projection under the BE MM scenario, three of the four PSCS CCOs (Columbia Gorge, Central Oregon, Marion & Polk) projected high admin load ratios (9.2%, 9.3%, 10%, respectively), which is way above two existing CCOs (Columbia Gorge, Central Oregon)'s admin ratio in the past. From FY2013 to FY2018, PSCSG and PSCSC's admin load ratio ranges between 6.1% to 7.9%.

Capital requirement

PSCS - Gorge and PSCS - Central currently report balance sheet at the consolidated level showing the two entities share the same resources, and their total C&S at end of FY2018 is $43.6M, while $9M of it was goodwill.

Per the applications submitted, the four CCOs' resources are wholly and exclusively available to each of the four divisions, and the aggregated amount of C&S for four CCOs would be up to $198M.

This means that the parent company PSCS needs contribute additional $163M into the four CCOs at the beginning of or during 2020. The capital funding is questionable given the large dollar amount.

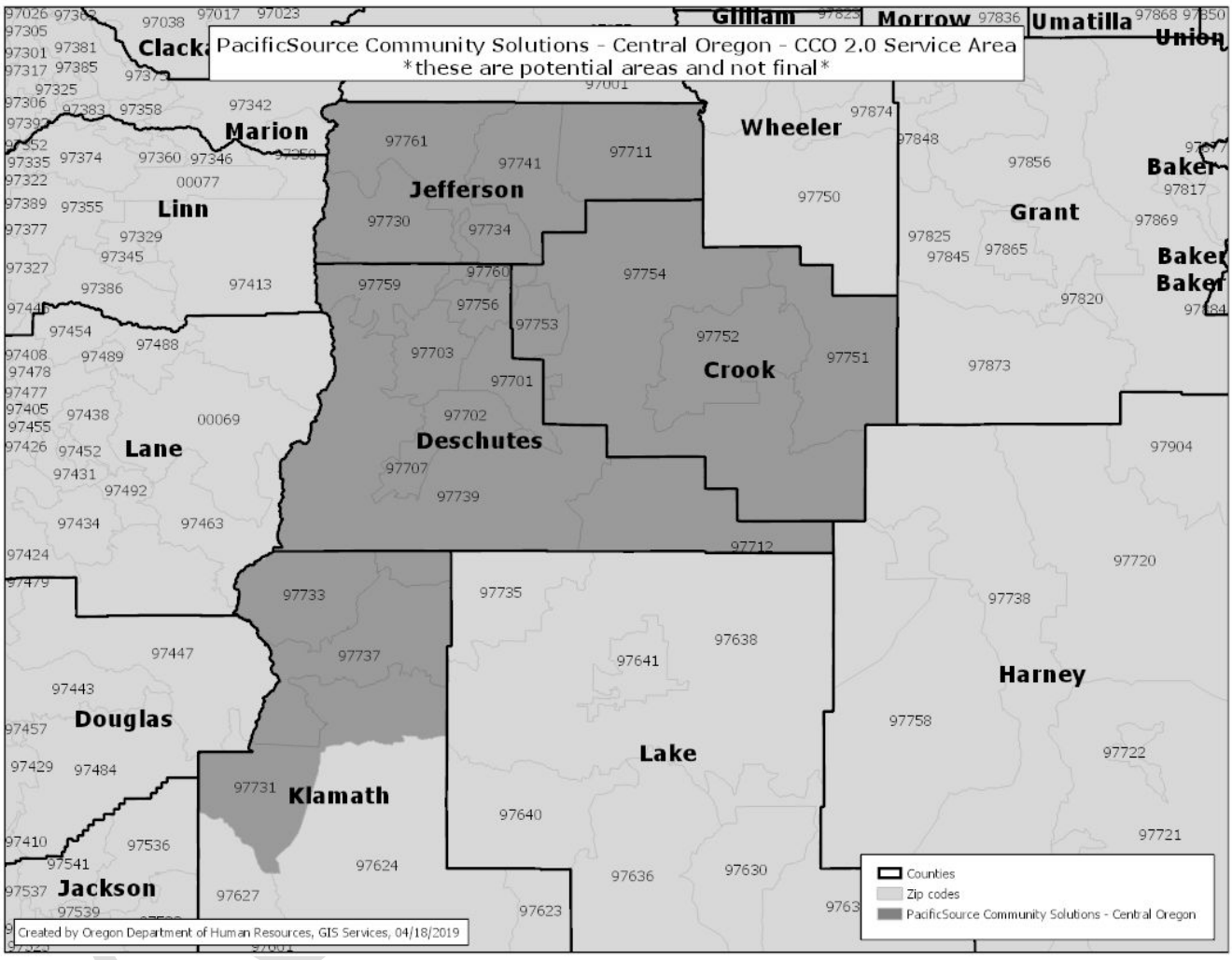
Risk: questionable capital funding

Recommendation: Request PSCS to provide detailed plan of the capital source; or do not award more than 2 PacificSource applications.

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Jefferson, Crook and Deschutes counties, and partial Klamath county. PacificSource Central is the only Applicant requesting to cover the northern portion of Klamath county. The request is aligned with the Applicant's current coverage area.



Full County Coverage Exception Request Evaluation Scores

Evaluation Team	Scores 1-2	Scores 3
Business Administration	1	29
Care Coordination and Integration	2	28
Community Engagement	3	12
Clinical and Service Delivery	3	30
Delivery System Transformation	0	12
Finance	0	0

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

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.

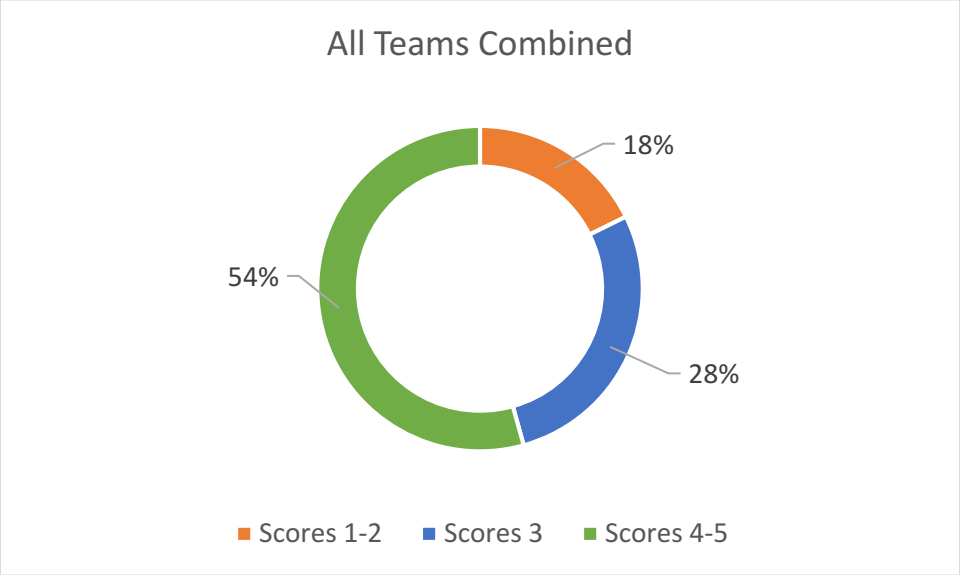
Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Deschutes, Jefferson, Crook	Klamath	No modeling performed. Pacific Source Central would be the only CCO serving these counties. A significant number of Open Card members would have to join the applicant, or a significant number of current members would have to leave in order for the applicant's enrollment to fall outside of their min-max range.			

Member Allocation Projection

No member allocation tests performed. PacificSource – Central would be the only CCO serving these counties.

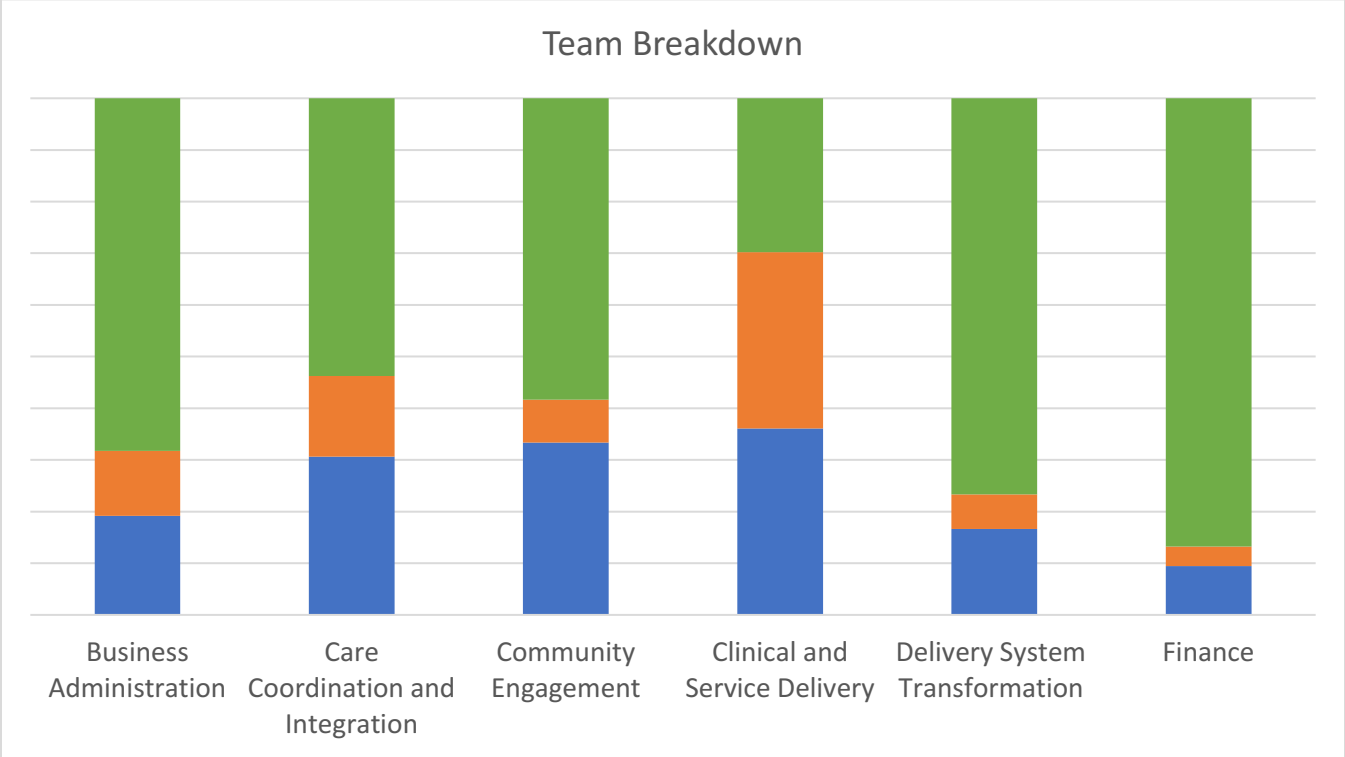
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

Evaluation Team	Recommendation	Lacks Detail	People	Process	Tech
Finance	PASS				
Business Administration	PASS				
Care Coordination and Integration	PASS	X			
Clinical and Service Delivery	PASS	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**
Value-Based Payment	1	3	32
Cost	2	3	29
Social Determinants of Health	10	31	72
Business Operations	84	110	197
Behavioral Health	36	63	78

Evaluation Results: Informational Assessment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	3	8	46
Social Determinants of Health	1	7	25
Value-Based Payment	2	12	42
Behavioral Health	5	20	30
Business Operations	19	30	48

Finance

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Value-Based Payment	0	1	19				
CCO Performance and Operations	1	0	14				
Cost	1	4	13				

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

Deficiency Analysis

Value-Based Payment

PSCS Central Oregon received a passing grade from all members of the financial review team.

CCO Performance and Operations

PSCSS Central Oregon had no significant deficiencies related to CCO performance and operations.

Cost

There were no deficiencies identified related to cost.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that PacificSource Community Solutions – Central Oregon be given a “pass” for the financial section.

Business Administration

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Member Transition	4	4	28				
Social Determinants of Health	2	6	20				
Health Information Technology	7	5	28				
Administrative Functions	8	17	38				

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 are largely responsive and provide adequate detail, with the exception of Third Party Liability – there is no mention of how the Applicant will receive TPL info promptly, how they will verify TPL and how often they will confirm Medicare coverage for their members.

Health Information Technology

The responses in this section were largely responsive and provided adequate detail. EHR plans that covered the entire 5-year contact were missing, however, this deficiency could be remedied with **a small amount of effort.**

Member Transition

The responses in this section were largely responsive and provided adequate detail, with few exceptions: warm handoff/transition activities were missing; continuity of care was missing for prior authorizations, prescriptions and case management; validation process was missing for transferring members. These deficiencies **can be remedied relatively quickly**.

Social Determinants of Health

The responses in this section were largely responsive and provided adequate detail. There was limited detail on the communication strategy for SDOH-HE and a strategy for addressing diversity in leadership and professional was not addressed however, these are deficiencies that **can be remedied relatively quickly**.

Team Recommendation: **PASS**

- With very few exceptions, the responses provided by this Applicant were responsive and adequately detailed.
- Recommendation to obtain more detailed answers from Applicant on their TPL processes.
- Recommendation to obtain more detailed answers from Applicant that address the missing info in the Member Transition section.

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	1	5	22				
Behavioral Health Covered Services	2	10	24	X			
Care Coordination	20	29	27	X			
Behavioral Health Benefit	3	6	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 lacked detail on expected milestones and timelines. No dates were provided with respect to finalization of MOUs with Community Mental Health Programs. More detail was requested on expansion of staff capacity and planned training for staff. These deficiencies were identified as requiring **little additional effort**.

Behavioral health covered services responses included no information on how individualized care plans would be jointly shared with Medicare Advantage plans. Applicant failed to provide information on person-centered planning. Detail was lacking on the applicant's plans to support adolescents. Applicant did not provide an explanation of staff accountability with respect to supported employment services.

Care coordination generally lacked detail or missed required components. Applicant provided no detail of planned crisis management, and failed to mention plans for oral wellness or preventative services. Limited detail was provided in the following areas:

- Plans for coordination between dual eligible populations and Medicare Advantage plans
- Plans to address or expand provision of language and culturally-specific services.
- Coordination of care across systems
- Plans to monitor care coordination efforts.

Team Recommendation: **PASS**

Care integration responses were well received; however, additional detail on how person-centered services will be offered is desired.

Applicant's ability to support Health Information Exchanges (HIE) was clearly demonstrated but lacked a robust explanation of how hospital event notifications will be provided if the State subscription enabling these services ends. Concerns on sustainability of these efforts were expressed by reviewers.

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	7	8	18			X	
Service Operations	14	18	14				
Behavioral Health Covered Services	23	38	23	X			
Administrative Functions	27	11	7	X			

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

Deficiency Analysis

Administrative Functions

All answers in this section contained generalized content, fairly generic information and not a lot of detail. There was no mention of how they will ensure member access to services, response doesn't mention access to out-of-area providers and strategies for using grievance and appeal data to ensure medical necessity criteria are being applied properly are missing. The deficiencies identified in this section (missing information and processes) **could be remedied relatively quickly**.

Behavioral Health Benefit

Responses in this section are missing detail. No clear process for in-home services; access and capacity are not addressed and there is no indication of how services are monitored. The deficiencies identified in this section would take a **small amount of effort to remedy**.

Behavioral Health Covered Services

Responses in this section were missing small to moderate amounts of detail and some questions were not answered at all. No mention of communication to members; did not answer 11.E.2.f or g; did not mention in-home assessment for services; did no provide a description of how they will provide crisis services for members with SPMI; used age as a population category – this is not really a category. "Aged" is used which can be considered disrespectful. The deficiencies identified in this section would take **a small amount of effort to remedy**.

Service Operations

Lacking detail on how utilization will be monitored, Applicant doesn't address different targeted member populations; there is little detail on how they communicate pharmacy benefits or pharmacy utilization

controls to their members. The deficiencies identified in this section would take a **small amount of effort to remedy.**

Team Recommendation: **PASS**

- The responses from this Applicant were missing small to moderate amounts of information and some answers were missing entirely in one section.
- All of the deficiencies were estimated to be resolvable with **small amount of effort** or additional information.
- The quality of the answers and deficiencies requiring only smaller level of effort to remedy, led to a team recommendation of PASS.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Accountability and Monitoring	1	1	16	X			
Delivery Service Transformation	1	4	7	X			

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Applicant failed to provide details describing external programs, their purpose and who administers them. 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 the data infrastructure and a plan for using accountability metrics to incentivize improvements.

CCO Performance – Applicant failed to provide information about continuous improvement while focusing on value and efficiency. Lacking sufficient information about the measure by data source and the process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REALD).

Delivery Service Transformation

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

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as the number of assigned members by provider type and tier level, oversight, and engagement of potential new PCPCH providers. Lacking sufficient information about monitoring the non-PCPCH model to ensure fidelity. Lacking sufficient information about care coordination, evidence for success, effective wellness and prevention, and emphasis on whole person care. Lacking sufficient information about the “community governance model”.

Team Recommendation: **PASS**

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

Accountability and Monitoring

- Describe external accountability program
- Describe grievance/appeals process and how the information is communicated with providers
- Describe data infrastructure and plan for metrics, associated incentives

Delivery Service Transformation

- Provide information about the number of assigned members by provider type or how oversight of the PCPCH system works
- Describe the "community governance model"

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	7	16	37	X		X	
Community Engagement	0	4	6	X			
Social Determinants of Health	1	8	11				
Governance and Operations	2	12	16	X			

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

Deficiency Analysis

- Doesn't specifically mention how they'd collaborate with other the CACs if relevant
- Barriers to communication engagement, but limited strategies for overcoming barriers or and no strategy for allocating funds
- Need more robust strategy for elevating member voice
- Strategies to align demographics with CAC didn't include culturally appropriate strategies
- Limited meaningful tribal engagement with the board and in HRS spending
- Lacks detail in engaging with the CAC as part of engaging with members in care planning
- Doesn't provide information about existing agreements
- Only describes a general model for community engagement/addressing disparities, but no details

Team Recommendation: **PASS**

- Include Klamath agencies and organizations
- Meaningfully engage tribes in CEP and in HRS
- Ensuring clear strategies to overcome barrier to engagement, and including allocation of funds
- Needs a clear process for how they will align CAC with ORS
- Clearly detail how the Health Council helps with community engagement, and what other mechanisms they use, because the Health Council isn't sufficient
- Need to ensure they have a plan in place for awarding funds, including details on their equitable/transparent process, how they will evaluate and share outcomes

Community Engagement – Community Letters of Support

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

Organization Name	Type
Advantage Dental	Dental Clinics
Best Care	BH, SUD
Bethlehem Inn, United Way	Homeless Shelter, Services
Capitol Dental	Dental Clinics
Central Oregon Health Council	PSCS Central Oregon governing and oversight body
Central Oregon IPA	Provider Association - IPA
Central Oregon Pediatric Associates	Pediatric Medical
Crook Count Health Department	Local Public Health
Deschutes County Health Services	CMHP
Family Access Network	Family, children education supports
High Desert ESD	Regional K-12 early childhood services
Jefferson County Public Health	Local Public Health
Klamath County Board of Commissioners	Local Government
LaPine Community Health Center	Medical Clinics
Mosaic Medical	FQHC
Mountain Star	Family, children early childhood services, education
Neighbor Impact	Homeless services, food distribution, Head Start
ODS	Dental Clinics
Pacific Crest Affordable Housing	Housing
St. Charles Health System	Hospital, Medical Clinics
United Way Deschutes County	Health, Education, Financial Stability Services
Willamette Dental Group	Dental Clinics

Behavioral Health Policy Assessment

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

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

Deficiencies: Applicant reports they do not carve out the behavioral health benefit or delegate services. They do state that they have "executed VBP arrangements that involve risk sharing," however they also state the applicant "retains responsibility for ensuring our members receive medically appropriate and necessary covered services"

Regarding behavioral health covered services, Applicant has very limited, if any, detail on person-centered planning.

Recommendations: Require Applicant to provide details and statements articulating ownership of benefit.

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
3	2	7	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.

Full County Coverage Exception Request - Full Text

PSCS respectfully proposes to serve less than a full county, consistent with the current boundary of the existing PSCS CCO that serves Central Oregon. Specifically, we propose that our service area cover residents who reside in these zip codes in northern Klamath County: 97731, 97733, 97737, and 97739.

(1) Serving these northern Klamath County residents will allow us to achieve the transformation goals of CCO 2.0 more effectively than county-wide coverage in the following areas:

Community engagement, governance, and accountability

In partnership with the Central Oregon Health Council (Health Council), our community governance structure provides for enhanced community engagement opportunities. Representatives from southern Deschutes County (i.e.: La Pine), which borders northern Klamath County, serve on the Health Council Board, Clinical Advisory Panel (CAP), Community Advisory Committee (CAC), and Community Health Improvement Plan (CHP) workgroups. The Health Council Board and the CAC meet at least annually in southern Deschutes County to engage with the community in public meetings. We have a strong relationship with the regional Federally Qualified Health Center (FQHC), La Pine Community Health Center. We contract with this FQHC system to serve southern Deschutes County and northern Klamath County. Their clinic sites are within 1-20 miles of all Klamath County zip codes we currently serve and propose to continue to serve in this Application.

The FQHC runs a School-Based Health Center in one of the Klamath County zip codes we serve, which is the only site of care for residents in the town of Gilchrist, and the FQHC is very active in Health Council subcommittees as well as in the development of the CHA and CHP. Klamath County residents that live south of Crescent participate in CCO governance and community engagement to the south with Cascade Health Alliance due to the natural geographical divide. We are proposing to serve Central Oregon as a cohesive region, which includes the communities of northern Klamath County, and is consistent with our existing regional approach to community engagement, governance, and accountability. The Klamath County Commissioners support our application and desire to retain the current CCO service area boundaries in CCO 2.0, because residents in northern Klamath County benefit from receiving care in our service area, due to geographic proximity, and because of our commitment to provide the same quality of care to members in rural and frontier areas as those in urban areas.

Behavioral Health integration and access

The FQHC, discussed above, offers integrated behavioral health services and employs Behavioral Health Consultants in their clinics. Members have shared positive feedback about their services on member satisfaction surveys, regarding access to all services, including behavioral health. The clinics also provide walk-in services after regular business hours. Additionally, the FQHC offers the only health care services available in zip code 97737. In our 2016 Access Study, their consumer quantitative results were also positive: their assigned members rated access more favorably than members across the region as a whole. In addition,

Deschutes County Health Services operates a clinic in southern Deschutes County and provides public health, behavioral health, and safety net services to members in northern Klamath County. Residents in northern Klamath County benefit from receiving care in our Service Area due to geographic proximity and ease of access. Similarly, residents south of the Klamath County zip codes we are proposing to serve benefit from receiving care and ease of access in the southern part of the County, due to their geographic proximity. CCO members that reside in northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship, particularly during inclement weather.

Social Determinants of Health and Health Equity

Both the FQHC discussed above and Deschutes County Health Services serve individuals seeking care in northern Klamath County, regardless of insurance status or any other factor, to ensure equitable access. Both organizations participate actively in Health Council committees as well as in the development and implementation of the regional CHA and CHP. Both organizations screen for SDOH factors, such as transportation and food insecurity, within their patient population and connect members to such services. CCO members in northern Klamath County have interacted far more, if not completely, with providers and community-based organizations in the PSCS CCO versus Cascade Health Alliance. The model currently in place addresses SDOH-HE factors that are unique to northern Klamath County residents that, based on geography, naturally identify more with Deschutes County than southern Klamath County.

Value-Based Payments and cost containment

PSCS already contracts with the providers that serve the zip codes in northern Klamath County that we propose to serve. Both the FQHC discussed above and Deschutes County Health Services have been parties to value-based payment arrangements with the CCO for over five years. We have also provided funding to the FQHC to increase Patient Centered Primary Care Home (PCPCH) tiers and to integrate behavioral health services in their clinics. These agreements have proven effective for both parties in expanding access, containing cost, and improving quality. In addition, some providers have satellite offices located in the zip codes in northern Klamath County, but their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in the rest of Klamath County are based in Klamath Falls. Residents of northern Klamath County would have to travel over an hour to reach services in Klamath Falls, which is a hardship particularly during inclement weather. As discussed above, members residing in these four zip codes in northern Klamath are already being served by providers in southern Deschutes County and Bend. We will continue to explore the possibility of expanding value-based payments and further cost containment measures with these other providers; however, PSCS already has significant such payments and measures in place with the main providers in northern Klamath County.

Financial viability

Our request to retain the existing boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or risk. Instead, it is driven by our ability to best serve a community. We have existing contractual arrangements to serve members in northern Klamath County and make no decisions about them on a financial basis based on county lines. We do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of provider rate setting. We have made investments to expand access to residents of southern Deschutes County and northern Klamath County, based on emergency department utilization and the request of the FQHC, which serves members on a walk-in basis if they can accommodate the level of care without sending members to Bend. Any residents of southern Deschutes County or northern Klamath County who need a higher level of care than can be provided in a primary care setting are referred by their provider to Bend and not to Klamath Falls.

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

Northern Klamath County residents in zip codes 97731, 97733, 97737, and 97739 tend to have patterns of care that take them to Deschutes County because it is significantly closer, geographically, than seeking services in Klamath County. We have been serving this community for over five years. This partial county service area will promote ease of access and expanded access for members, improve continuity of care for our members, increase meaningful provider interaction, and reinforce current patterns of travel that align with utilization of health care services, employment, and social services. As discussed above, PSCS already contracts with the providers that serve the four zip codes listed above. Some providers have satellite offices located in the zip codes in northern Klamath County, but their main offices are in southern Deschutes County (i.e.: La Pine) or Bend. The majority of providers in Klamath County are based in Klamath Falls. CCO members residing in northern Klamath County are already being served by providers in southern Deschutes County and Bend. With respect to referral patterns associated with provider affiliations, providers in southern Klamath County refer to the Sky Lakes Medical Center in Klamath Falls. In contrast, providers in northern Klamath County refer to providers available in La Pine and Bend.

There are no services available in Klamath Falls that are not available in Bend. Because Bend is a larger community than Klamath Falls, more services are available in the Central Oregon region than the southern Klamath Falls region.

CCO members in northern Klamath County have interacted far more, if not completely, with providers and communities in the Central Oregon CCO than with the Klamath County CCO. The model currently in place has been effective in addressing and providing appropriate access with more meaningful provider interaction opportunities and less travel restrictions than heading south to Klamath County. Community members in northern Klamath County naturally, based on geography, identify and more easily connect to services in

Deschutes County than southern Klamath County. Based on this same rationale, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.

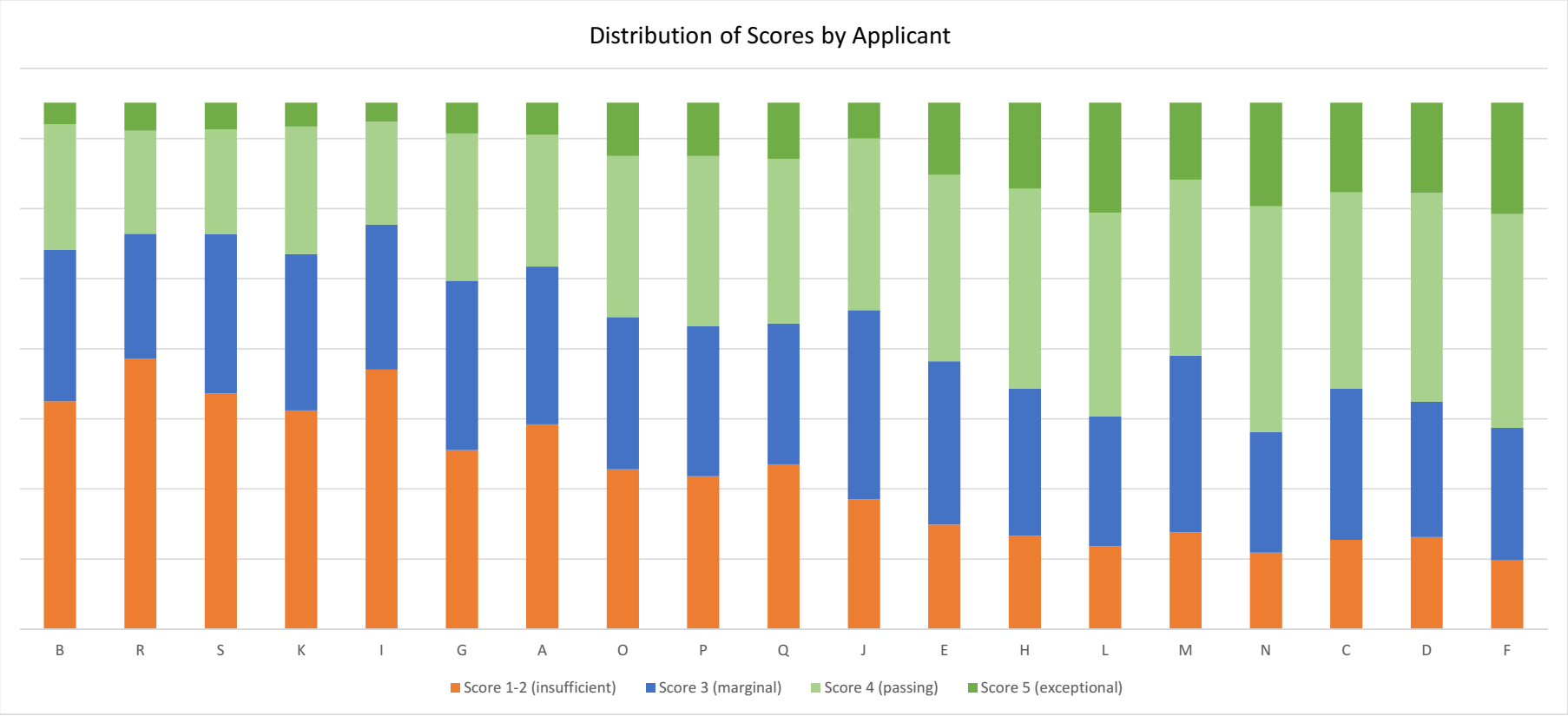
(3) The exception request is not designed to minimize financial risk and does not create adverse selection, e.g. by red-lining high-risk areas.

Our request to retain the existing CCO boundary and serve northern Klamath County versus the entirety of Klamath County is not driven by financial viability or designed to minimize risk. Instead, it is driven by our ability to best serve a community that naturally fits within the Central Oregon definition and service region. We have existing contractual arrangements to serve members in northern Klamath County and make no decisions about them on a financial basis based on county lines. We do not evaluate the cost or trends associated with these members separately from the rest of our membership for purposes of provider rate setting, and our proposal to the OHA does not create adverse selection. As discussed above, consistent with this assertion, CMS has also issued preliminary approval of our request to serve northern Klamath County (along with the rest of Central Oregon) with our Medicare Advantage plan on a partial county basis.

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