

RFA 4690-19

CCO 2.0

Final Evaluation Report

Applicant D

PacificSource Community Solutions - Lane

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

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
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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
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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
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Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

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Ex:

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

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

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

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

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

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

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

Executive Summary

Financial Analysis

- PSCS – Lane County is a CCO division of PSCSCCO. All four PSCS divisions are potentially sharing capital 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 – Lane County is requesting to serve Lane County, with no service area exception request.
- PSCS – Lane County is one of three applicants in this service area. High risk (74%) that PSCS – Lane County will not meet minimum enrollment required if all three applicants are awarded. Lower risk (23%) if PSCS is one of two applicants awarded.

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

- 29 letters received from various provider types and local entities

Evaluation Results: Policy Alignment

The responses from PSCS – Lane County 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 – Lane County'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) – Lane County CCO

I have performed a review of PacificSource Community Solutions – Lane County, 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 – Lane County is one of four separate CCOs managed by the PacificSource group of companies, and more specifically, PacificSource Community Solutions, a successful CCO. PacificSource Community Solutions is well-established as a CCO, and 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 Lane County, 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 synergistic 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 131.3% 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.

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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') 26%, Minimum ('MIN') 12%, and Maximum ('MAX') 120%.

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 30% higher than projected in each year.

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

Losses do surpass 5% of surplus at a 4% increase at BE, at 6% for MIN, and at only 2% for MAX. None of the scenarios surpass 20% of C&S, or anywhere close to 50% of C&S, except for a 6% increase in claims costs at the maximum enrollment, Years 1-3, at which point it exceeds 20%. The CCO met the basic capital and surplus and RBC requirements under all presented scenarios.

BE MM Years 1-3:

5% of Surplus:	2,458,493	2,566,077	2,678,098
+2% Claims	(245,416)	(239,537)	(232,959)
20% of Surplus:	9,833,971	10,264,309	10,712,392
+4% Claims	(2,557,223)	(2,630,765)	(2,706,333)
50% of Surplus:	24,584,926	25,660,772	26,780,980
+6% Claims	(4,869,031)	(5,021,994)	(5,179,708)

MIN MM Years 1-3:

5% of Surplus:	2,433,444	2,514,758	2,599,231
+2% Claims	481,315	504,851	529,439
20% of Surplus:	9,733,777	10,059,033	10,396,926
+4% Claims	(602,795)	(616,576)	(630,587)
50% of Surplus:	24,334,443	25,147,582	25,992,314
+6% Claims	(1,686,904)	(1,738,002)	(1,790,614)

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MAX MM Years 1-3:

5% of Surplus:	4,759,514	5,051,710	5,357,315
+2% Claims	(5,352,351)	(5,470,551)	(5,590,534)
20% of Surplus:	19,038,057	20,206,842	21,429,261
+4% Claims	(16,291,528)	(16,785,024)	(17,293,165)
50% of Surplus:	47,595,143	50,517,104	53,573,153
+6% Claims	(27,230,704)	(28,099,498)	(28,995,797)

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 – Lane County projected an RBC of 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 2-3% of the capitation rate, and loss ratio. OHA is assuming a 2% lower enrollment rate, based on capacity, but did not note any concern with the assumptions used.

The in-house DRF Actuary assessment assumed PSCSL would get about 25% market share based on a cursory analysis, and that their Lane County provider network is of comparable size to its competitor. PSCS – Lane County also projected claims to be viable at no less than 12% of the Lane County market (perhaps because they have other CCO areas over which they can spread fixed costs).

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. They maintain a liquidity ratio of at least 100% in each year at the “best estimate” scenario with no deviation in claims. It does not appear that claims increases impact liquidity down to the 100% threshold until upwards of 43-44% of an increase in claims costs is projected, which is significant, and not likely. In Year 2 and Year 3, claims would need to surpass 44-45% for liquidity to fall under 100%.

EXPECTED MEMBERSHIP and CLAIMS

Liquidity Ratio (Liquid Assets/Current Liabilities)	387%	385%	384%
At 2% increase in claims costs:	373%	372%	371%
At 4% increase in claims costs:	360%	358%	358%
At 6% increase in claims costs:	346%	345%	345%
At 42% increase in claims costs:	104%	106%	109%
At 43% increase in claims costs:	97%	100%	102%
At 44% increase in claims costs:	90%	93%	95%

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Additionally, the Applicant appears to have resources available for further capitalization as needed. However, the assets available could be limited, though, 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, Minimum, and Maximum enrollment scenarios.

Net Income (BE MM): Year1=\$2,066,392 Year2=\$2,151,692 Year3=\$2,240,416

Net Income (MIN MM): Year1=\$1,565,425 Year2=\$1,626,277 Year3=\$1,689,465

Net Income (MAX MM): Year1=\$5,586,825 Year2=\$5,843,922 Year3=\$6,112,097

An increase of 2% in claims costs still resulted in Net Income for the Minimum Enrollment only, in all three years, but resulted in a Net Loss for the Best Estimate and Maximum Enrollment.

Net Income (BE MM): Year1=(\$ 245,416) Year2=(\$ 239,537) Year3=(\$ 232,959)

Net Income (MIN MM): Year1= \$ 481,315 Year2= \$ 504,851 Year3= \$ 529,439

Net Income (MAX MM): Year1=(\$5,352,351) Year2=(\$5,470,551) Year3=(\$5,590,534)

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=(\$ 2,557,223) Year2=(\$ 2,630,765) Year3=(\$ 2,706,333)

Net Loss (MIN MM): Year1=(\$ 602,795) Year2=(\$ 616,576) Year3=(\$ 630,587)

Net Loss (MAX MM): Year1=(\$16,291,528) Year2=(\$16,785,024) Year3=(\$17,293,165)

Net Loss (BE MM) Year1=(\$ 4,869,031) Year2=(\$ 5,021,994) Year3=(\$ 5,179,708)

Net Loss (MIN MM) Year1=(\$ 1,686,904) Year2=(\$ 1,738,002) Year3=(\$ 1,790,614)

Net Loss (MAX MM) Year1=(\$27,230,704) Year2=(\$28,099,498) Year3=(\$28,995,797)

A Net Loss occurs between 1.0% - 3.2%. The point at which a Net Loss occurs is between the given scenarios of a 0% and a 4% increase in claims costs. The company appears to be 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.

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Changes in claims costs, even at 2%, do impact profitability/net income of the company. The break-even point is between a 2.75% and 3.2% increase in claims.

PREMIUM to SURPLUS

The Applicant's Premium to Surplus ratio is:

Expected Membership & Claims +0%: 2.6:1, 2.6:1, and 2.6:1 for each year, respectively

Minimum Membership & Claims +0%: 1.3:1, 1.3:1, and 1.3:1 for each year, respectively

Maximum Membership & Claims +0%: 6.4:1, 6.2:1, and 6.0:1 for 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 Connors 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

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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).

[End of summary]

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ASU Analysis of Applicant Financial Assumptions

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

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary. The focus of this review is the reasonability of projected numbers stated in Applicant's Balance Sheet and P&L pro formas (BE MM scenario) by comparing to the most recent year's Exhibit L financial results of PacificSource Community Solutions (FY2018) as they share the same parent company.

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
252,000	148,066	1,179,600	120,000	59%	none
Capitation Rate					
Applicant Assumption	Applicant Stated the Rate used	Applicant Assumption with 0 Maternity	OHA/Optumas Rate Assumption	Compare	
\$502.50		\$512.87	\$490.78	2%	
Loss Ratio					
Applicant Assumption	Recent OHA History	Difference			
89%	92%	-3%			
Cost Trend					
Applicant Assumption	OHA Assumption				
3.40%	3.40%				
Population Trend					
Applicant Assumption	OHA Assumption				
0.27%	0.27%				

PacificSource - Lane competes with 2 other applicants, one currently fully covered the service county. OHA assume that PacificSource - Lane will get 15% of the market share. PacificSource - Lane's best estimate is 26% of the market share.

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.

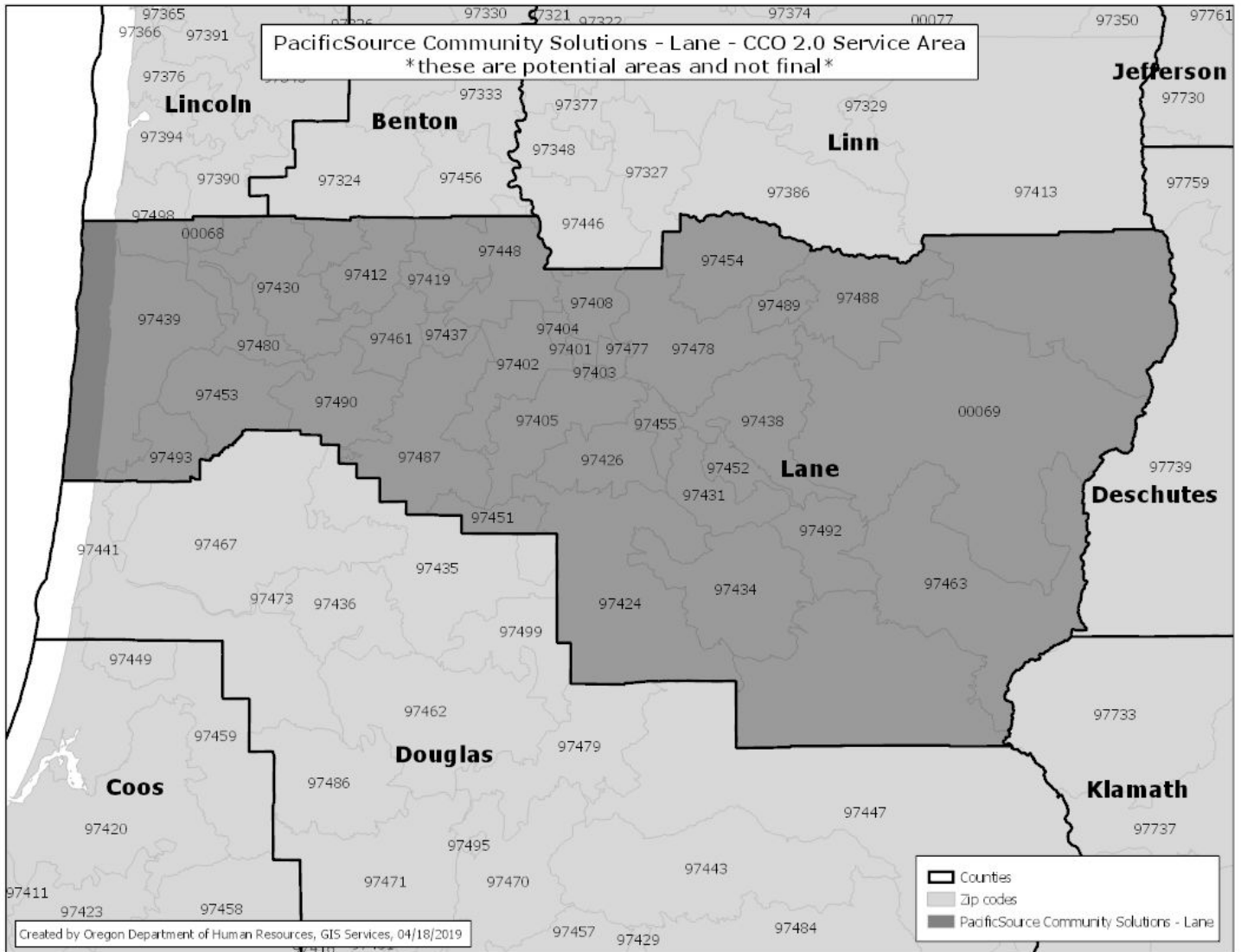
Risk: questionable capital funding

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 Lane 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
Lane	-	Two other CCOs propose serving all of Lane County: Trillium and West Central CCO	74% chance that Pacific Source Lane does not receive enough members.	No scenarios show enrollment exceeding applicant's maximum	High risk

Additional Analyses on High Risk Areas

Lane County

Three applicants have proposed to serve Lane County members, which contains nearly 103,400 members.

Applicant	Minimum threshold
Pacific Source Lane CCO	10,000
West Central CCO	35,200
Trillium CCO*	42,500

*Note: Trillium CCO's min and max reflect all proposed service areas, including Lane County and the Portland metro area.

Over 21,000 members in Lane County are in open-card. Assuming these individuals remain in open-card, 82,400 members remain to be allocated to the applicants. If Trillium CCO does not serve the Portland metro area and must attract all their members from Lane County, the sum of all three applicants' minimum thresholds is 87,700 which exceeds the number of non-open-card members in the county. The only scenario in which all three applicants meet their minimum threshold is if 5,300 – or a quarter – of open-cards are willing to join a CCO.

The table below outlines different scenarios and the impacts on each Lane County applicant, as modeled by the Monte Carlo simulations which rely on at most 35% of CCO enrollees opting to leave their CCO and move to another.

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Scenario description	Impact on Pacific Source Lane	Impact on West Central CCO	Impact on Trillium
All three applicants awarded	74% chance the applicant does not meet their minimum threshold. (See Findings table above)	100% chance the applicant does not meet their minimum threshold. (See Findings table above).	Because Trillium currently serves Lane County, it is likely that a significant share of enrollees remain with Trillium.
Trillium and Pacific Source Lane awarded	23% chance the applicant does not meet their minimum threshold.	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.
Trillium and West Central awarded	Not awarded in this scenario	100% chance the applicant does not meet their minimum.	Projected enrollment falls within the applicant's parameters.
Pacific Source Lane and West Central awarded	Projected enrollment falls within the applicant's parameters.	2% chance the applicant does not meet their minimum threshold	Not awarded in this scenario
Only Pacific Source Lane awarded	Projected enrollment falls within the applicant's parameters.	Not awarded in this scenario	Not awarded in this scenario
Only West Central awarded	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.	Not awarded in this scenario
Only Trillium awarded	Not awarded in this scenario	Not awarded in this scenario	Projected enrollment falls within the applicant's parameters.

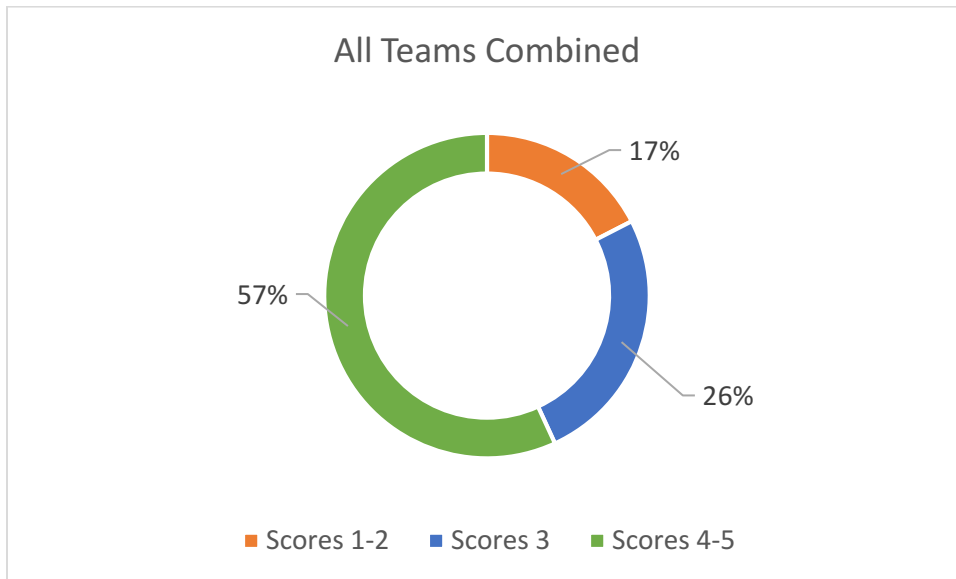
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, PSCS – Lane is likely to receive approximately 14,596 members out of the 10,000 minimum required.

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

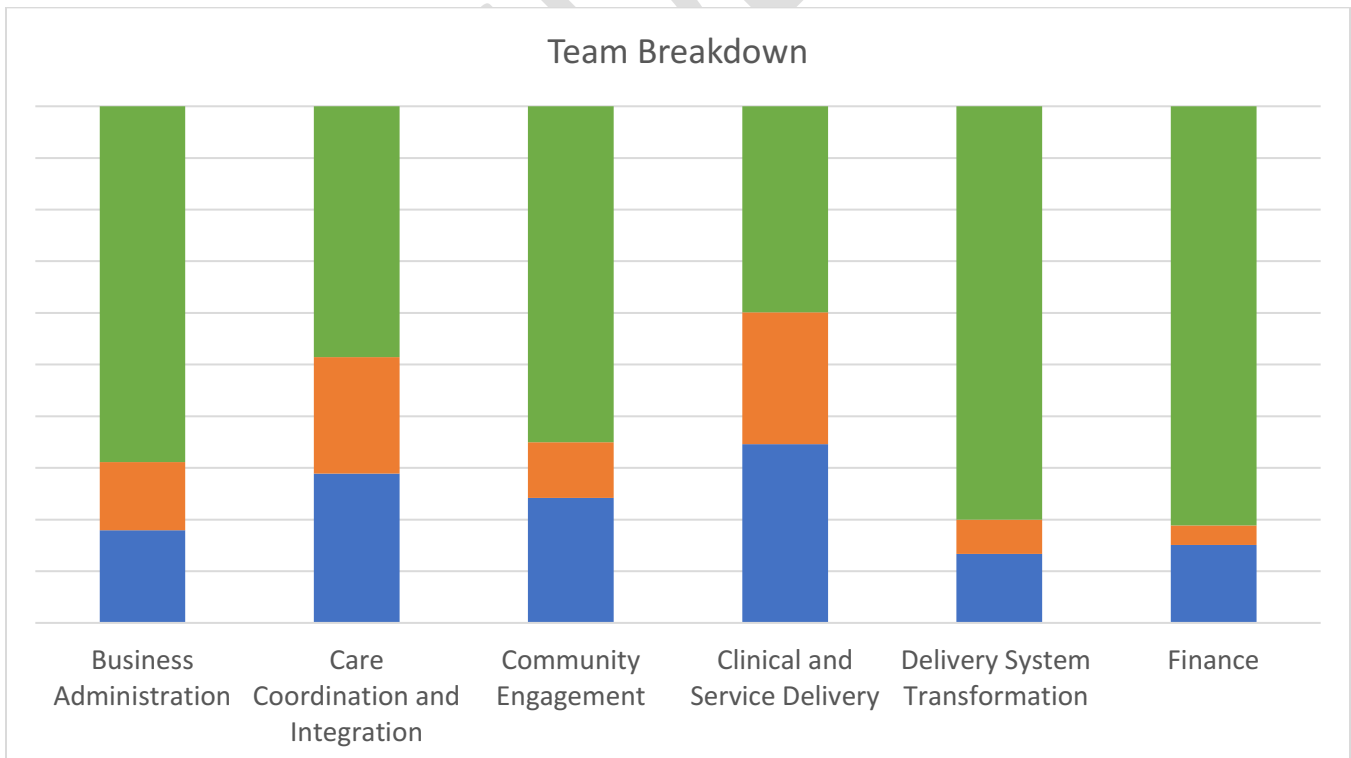
Evaluation Results – Overall Scores

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



Scoring by Team

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



Overall Team Recommendations

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

Evaluation Team	Recommendation	Lacks Detail	People	Process	Tech
Finance	PASS				
Business Administration	PASS	X			
Care Coordination and Integration	PASS	X		X	
Clinical and Service Delivery	PASS	X			
Delivery System Transformation	PASS	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	2	33
Cost	2	5	27
Social Determinants of Health	8	21	84
Business Operations	90	104	197
Behavioral Health	30	61	86

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
Value-Based Payment	1	10	45
Cost	3	10	44
Social Determinants of Health	3	7	23
Behavioral Health	4	21	30
Business Operations	18	28	51

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	2	12				
Cost	1	5	12				

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

Deficiency Analysis

Value-Based Payment

There were no significant deficiencies regarding value-based payments.

CCO Performance and Operations

There were no significant deficiencies regarding CCO performance and operations.

Cost

There were no significant deficiencies regarding cost.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that PacificSource Community Solutions – Lane receive a “pass” for the financial section. PSCS - Lane had no notable deficiencies in any of the categories.

Business Administration

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Social Determinants of Health	1	2	25				
Member Transition	4	4	28	X			
Health Information Technology	9	3	28				
Administrative Functions	8	21	34				

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

Deficiency Analysis

Administrative Functions

This section was largely responsive and only missing detail on Medicare TPL monitoring – specifically how will the Applicant receive and verify this information. This deficiency **can be resolved relatively quickly**.

Health Information Technology

All components present except missing 5-year plans for E.H.R adoption, missing detail and mitigation strategies for oral health providers and requested staffing model was missing in one area – **all deficiencies could be resolved relatively quickly**.

Member Transition

Missing some detail – specifically how prescription prior authorizations will be handled during transition, no clear warm handoff activities were mentioned and there appeared to be no validation process for data being exchanged. All deficiencies **could be resolved relatively quickly**.

Social Determinants of Health

This section was largely responsive - only missing some detail on what a modified communications strategy would look like and how SDOH data will be collected. All deficiencies **can be resolved relatively quickly**.

Team Recommendation: **PASS**

- Vast majority of answers were responsive to questions and only missing smaller amounts of detail. All deficiencies identified were considered to be **easily remedied**.
- Recommendation that member transition deficiencies be addressed – more specifics needed on how Applicant plans to handle prescription prior authorizations, data validation processes and what types of warm handoff activities they will offer.

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Care Coordination and Integration

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Care Integration	2	2	17				
Health Information Exchange	0	9	19				
Behavioral Health Benefit	4	1	7				
Behavioral Health Covered Services	2	14	20	X		X	
Care Coordination	31	24	21	X		X	

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

Deficiency Analysis

Applicant failed to provide dates and milestones for local behavioral health benefit plans. Plans to reduce barriers to service for behavioral health covered services were not detailed. Process description, communication, and engagement plans for these activities were non-definitive.

Care coordination activities have been identified as needing additional development. Applicant provided no detail on coordination activities for dual eligible populations. Beyond these issues the applicant provided limited responses on:

- How they will form relationships with DHS – this is a **heavier lift to resolve**
- Current crisis management programs
- Current cross-system collaboration efforts
- Engagement and follow up with members as part of the care coordination process.
- Clear statement on the details of MOU as it relates to care coordination. It is unclear how formalized these relationships with other organizations currently are.

Team Recommendation: **PASS**

Care integration responses were generally well received; however, limited detail was provided on the qualifications of providers to address the needs of the SPMI population. Detail was subsequently missing on the content of agreements with providers to meet the needs of this population.

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.

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	4	8	21				
Service Operations	7	15	24				
Behavioral Health Covered Services	19	36	29	X			
Administrative Functions	23	13	9	X			

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

Deficiency Analysis

Administrative Functions

Responses are largely responsive but missing some detail. Lacking detail on how they're calculating FTE, response focused on complaints but not the entire grievance system; concerns about process and delegation of monitoring activities; need more information about how delegated entities are performing. Deficiencies identified (missing detail) require a **small effort to remedy**.

Behavioral Health Benefit

Responses are largely responsive but missing some detail. More detail needed on strategies for in-home services; plan was to make a plan but no timelines; heavy reliance on governance council. Deficiencies identified (missing detail) require a **small effort to remedy**.

Behavioral Health Covered Services

Responses are largely responsive but missing some detail. Inappropriate term ("aged") used; no detail about communicating to members besides saying they would conduct "outreach"; didn't include family role in planning; lacking detail of plan. Discuss staff training as an existing process but did not provide detail on what it included. Deficiencies identified (missing detail) require a **small effort to remedy**.

Service Operations

Responses are largely responsive but missing detail and some components were not addressed at all. Did not address four models, no description of how services provided in different settings; no discussion of PA timelines; did not discuss the process for what the utilization management review would result in. Deficiencies noted (missing details and processes) would require a **small effort to remedy**.

Team Recommendation: **PASS**

- The answers were largely responsive and missing smaller amounts of detail.
- The deficiencies identified (needing some additional detail) required a **small effort to remedy**.
- The quality of the responses and the identification of deficiencies requiring only **small amount of effort to remedy** led to a team recommendation of PASS.

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Delivery System Transformation

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

Category	1-2	3	4-5	Lacks Detail	People	Process	Tech
Accountability and Monitoring	0	2	16	X			
Delivery Service Transformation	2	2	8	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 a sufficient description of the external programs and who administers these programs. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Response is missing a description of “staffing” experience.

CCO Performance – Applicant failed to provide specific description of measures aims and quality indicators. Lack of sufficient details describing data collection and analysis by sub-categories (by REALD).

Delivery Service Transformation:

Provision of Covered Services – Applicant failed to provide a comprehensive analysis plan, including details describing data collection and analysis by sub-categories (by REALD). Lacking sufficient information about member and workforce engagement. Lacking sufficient information on utilization of existing resources and gap identification, including services specific to SPMI.

Transforming Models of Care – Applicant failed to provide details describing PCPCH, such as the number of assigned members by provider type, oversight, and new provider engagement. Lacking description of 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

- Description of the external programs and who administers these programs.
- Describe how complaint/grievance information is shared and communicated with providers

Delivery Service Transformation

- Details about the PCPCH system of care 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 Plan	6	13	41				
Social Determinants of Health	1	6	13	X			
Community Engagement	2	2	6			X	
Governance and Operations	4	8	18				

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

Deficiency Analysis

- Did not describe how community input informs decision-making
- Did not describe any of their projects for community engagement
- Did not discuss tribes in terms of their CAC or health council for meaningful engagement
- Not very detailed or lengthy list of SDOH engaged partners; there are many other partners not engaged that were identified in earlier tables
- No mention of language access, plain language, or language considerations beyond CLAS anywhere outside of the clinic (e.g., initial contact, care planning, etc.)
- No engagement of providers, not clear about any specific outcomes of “training” for providers – how does this change how they do business or conduct their work?
- Did not describe how they engage the community beyond the Health Council; didn’t explain how they address disparities
- Unclear of what county government agencies they have agreements with
- Did not list actual criteria, just plan for developing criteria
- Spending plan didn’t include info on how they would ensure an equitable process
- Missing info about how outcomes would be shared
- Missing COI policy

Team Recommendation: **PASS**

- Engage tribes in a more meaningful way
- Improve engagement around SDOH partners
- More explicit plan for how input can better inform decision-making (especially the two-way communication)
- Address language access outside of the clinic walls – OHA to provide TA specific to CLAS
- Health Council cannot be only means of community engagement – need more inclusive means of engagement; especially around identifying and addressing health disparities. Opportunity for OHA TA.
- Consider how to ensure funding is distributed in a more equitable way
- Develop explicit plan for how outcomes would be shared

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Community Engagement – Community Letters of Support

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

Organization Name	Type
Advantage Dental	Dental Clinics
Capitol Dental	Dental Clinics
Centro Latino Americano	Translation and Interpretation, Social Services, Alcohol and Addictions, Community Mental Health, C.A.R.E. Youth and Family Services, Youth Mentoring
Community Health Centers of Lane County	FQHC
Cornerstone Community Housing	Housing
Direction Service	Family Support agency, youth with disabilities
Lane Early Learning Alliance	Early Learning Hub
Early Childhood CARES	Early intervention and early childhood special education to infants, toddlers and preschool age children
Food for Lane County	Food Bank, Nutrition, Education
Homes for Good Housing Agency	County Housing agency
Lane County Health and Human Services	Local Public Health and LMHA, CMHP
Lane Education Service District	k-12 education supports
Laurel Hill Center	BH, SUD
Live Healthy Lane	Community Wellness Initiative Collaboration
Looking Glass Community Services	BH, SUD, Residential Treatment, Crisis Response, Runaway and Homeless services, Education and vocational services,
McKenzie Willamette Medical Center	Hospital, Medical Clinics
Northwest Health partners, LLC	Provider Group - CIN
Options Counseling and Family Services	BH, family Services
Oregon Medical Group	Provider Group
Planned Parenthood	Medical Clinic
LCOG Senior and Disability Services	Senior and Disability Service
Serenity Lane	SUD, BH
ShelterCare	Homeless Services, housing, Medical Clinics, BH
Slocum	Specialty Provider - Orthopedics
South Lane Mental Health	BH, crisis services, sud, supported housing
Sponsors, Inc.	Housing. Employment. Counseling. Mentorship.
The Trauma Healing Project	Trauma prevention
Willamette Family Inc.	Medical Clinics, BH, SUD

Behavioral Health Policy Assessment

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

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

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

No additional recommendations were provided.

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Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

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Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate $0.5 \leq \text{ICC} < 0.75$	Good $0.75 \leq \text{ICC} < 0.9$	Excellent ≥ 0.90
2	6	4	0

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

Team Analysis Meetings

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

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Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

- Members who choose to disenroll from a CCO: The percent of current CCO members who opt to leave their current CCO (when the current CCO is also a CCO 2.0 Applicant)
 - o Minimum: 1%
 - o Maximum: 35%
 - o Mode: 11%
- The percent of members who leave their existing CCO and migrate to a new Applicant
 - o The percentage ranges vary depending on the number of Applicants
 - o 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
 - o Minimum: 0%
 - o Maximum: 40%
 - o Mode: 20%
- For those current Open Card members who enroll with a CCO
 - o 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. This assumes all current applicants are awarded a contract.

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

CCO Applicants	As reported on Financial pro forma:		Converted to # of members	
	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%

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

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

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

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Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

Members with no claims history

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

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

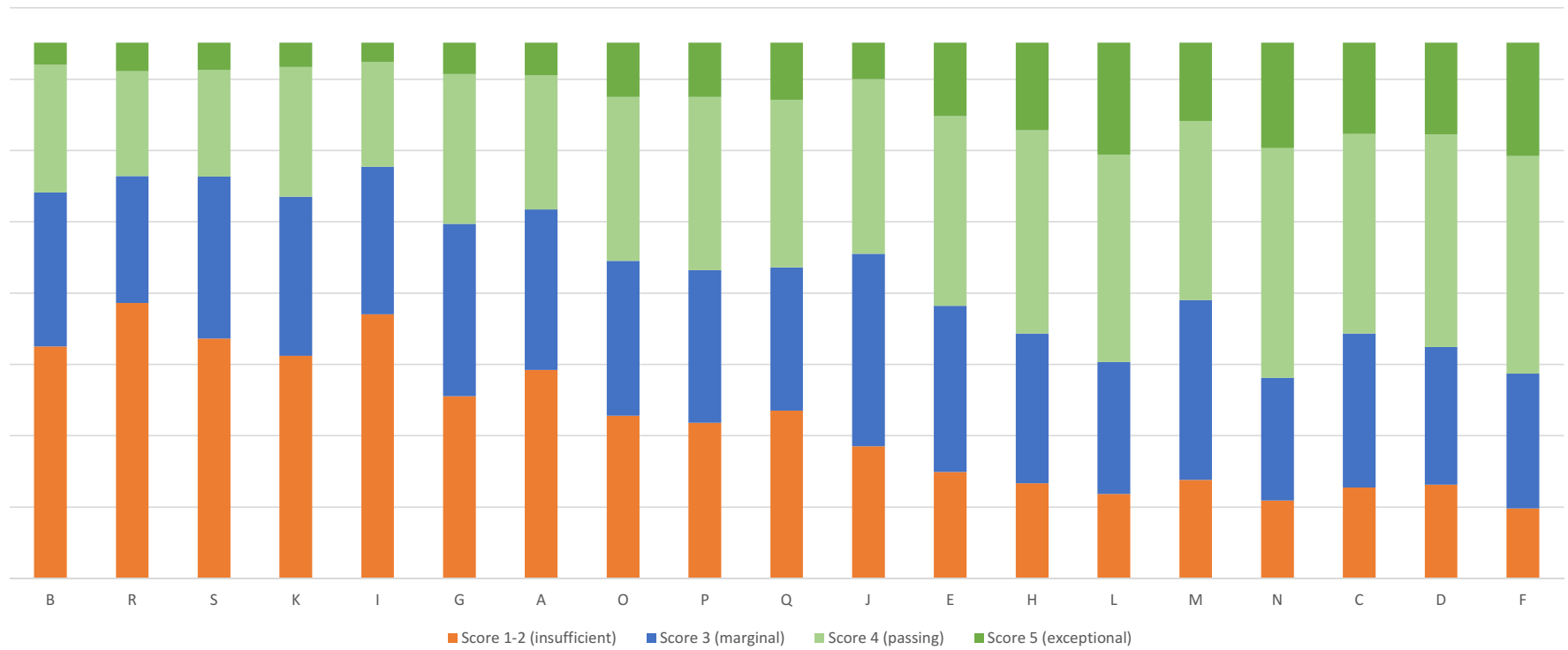
CC - Care Coordination and Integration

CE - Community Engagement

CSD - Clinical and Service Delivery

DST - Delivery System Transformation

Distribution of Scores by Applicant



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/ FY2018	FY2020 (**)	FY2018	Increase (decrease)	% as FY2020/ FY2018
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
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

15,000 max

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 service 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