RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant G
Umpqua Health Alliance, LLC

CONFIDENTIAL UNTIL 7/9/19

Evaluation Overview

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

Criteria Development

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

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

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

Passing Score

Team Analysis

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

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

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

Evaluation Results: Policy Alignment

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

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

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

Evaluation Results: Informational Assessment

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

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

Strong Fail		Weak Fail	Weak Pass		Strong Pass

Contents

Reviewing the Final Evaluation Report

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

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

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

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

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

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

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

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

The table also shows whether the deficiencies were related to:

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

Ex:

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

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

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

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

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

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

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

Executive Summary

Financial Analysis

- DCBS financial review found that the pro-forma results appear to be reasonable for projections provided.
- ASU raised concerns that the projected C&S level is not supported by guaranteed funding

Service Area Analysis

- Umpqua Health Alliance is requesting to serve Douglas County. There is no service area exception requested.
- Umpqua Health Alliance is one of two applicants in this service area. There is low or no risk that the applicant will fail to meet minimum enrollment or exceed maximum enrollment.

Evaluation Results – Team Recommendations

- Finance – Pass
- Business Administration – Fail; some details missing in Administrative sections. Response were limited, incomplete or not responsive in the HIT, Member Transitions and SDOH-HE sections.
- Care Coordination and Integration – Fail; missing specific plans and monitoring for dual eligible populations, children, and members with BH needs. Missing information about HIE planning.
- Clinical and Service Delivery – Fail; missing a small to moderate amount of detail some questions were not addressed at all. Requires moderate to large effort to remedy.
- Delivery System Transformation – Pass
- Community Engagement – Fail; response did not adequately address THW, community engagement.

Community Letters of Support

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

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

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

Financial Analysis

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

Division of Financial Regulation

M E M O R A N D U M

May 29, 2019

To: Ryan Keeling

From: [redacted]

Subject: CCO2.0 Financial Review

Umpqua Health Alliance, LLC (UHA) CCO

I have performed a financial evaluation of UHA application for their Douglas County operations based on the materials provided. UHA is an existing CCO, operating in the above county since 01/01/2005.

UHA is part of a **holding company system** in which it is 100% owned by Umpqua Health, LLC (UH). Umpqua Health, LLC is owned 50% by Douglas County Individual Practice Assoc., Inc. and 50% by Mercy Medical Center, Inc., the ultimate controlling persons.

PROFORMA REVIEW

The pro-forma results provided appear to be reasonable for projections provided.

Complete review could not be conducted given the lack of scenario data provided as noted in review conclusions below. Only Claims +0% scenarios provided complete scenario data.

ENROLLMENT:

The CCO provided the membership percentage assumptions for Best Estimate ('BE') 100% (343,388 Member Months), Minimum ('MIN') 75% (257,541 Member Months), and Maximum ('MAX') 125% (429,235 Member Months).

CAPITAL AND SURPLUS: (C&S) appears to be sufficient to absorb net losses within the 3 years referencing the information provided in this review, with all other estimated amounts remaining the same for each scenario. Their BE for 2020 started at $14.5M C&S and they would need to lose $12.0M to be at the minimum C&S of

$2.5M. Claims would need to increase 10% in order for C&S to be reduced to $2.5M all else remaining the same in the first year.

RBC:

RBC was above the OHA required 200% in all scenarios and all years, presented for Best Estimate (BE), Minimum (MIN), and Maximum (MAX) Estimates, being 213.4%, 285.1%, & 321.9%, respectively. If UHA incurs a 2% increase in claims then it would fall below 200% in the first year and at 4% in the first and second year from the BE estimates provided.

RBC calculations was not provided by Applicant for any of the +6% scenarios.

NET INCOME:

Per the estimates provided, UHA would operate at a **net income** for all three years for all three enrollment scenarios at Claims +0%. In a stress environment, if claims cost are approximately 2% higher, with all other items remaining the same, UHA would incur a net loss in the first year only across all enrollment scenarios. At 4%, UHA would experiences losses in all scenarios. Even at a net loss generated, UHA would have sufficient capital & surplus to absorb the losses and meet the RBC requirements under each of their best, minimum and maximum enrollment numbers for the three-year period presented.

LIQUIDITY:

For the years 2020-2022 the **liquidity** ratios for the period noted would be 113%, 125%, & 139% under the Best Estimate, noting that the higher the ratio the better the ability of the Company to pay off its obligations in a timely manner. The applicant shows adequate liquid assets to meet the needs of the company as estimated at this time.

UHA has noted that if needed they would be able to obtain capital from their parent, Umpqua and their providers Mercy Medical and DCIPA, LLC. Financials from the parent and providers was not provided to DCBS for verification that funds are available if needed to UHA. UHA starts to fall below the 100% liquidity benchmark at 3%-5%-7% for each year under the Best Estimate scenario.

[End of summary]

Additional analysis from DCBS not included in summary memo:

The documentation received did not include the financial statement of the ultimate parent Umpqua Health, LLC, to determine if they have sufficient means to provide capital to UHA if needed.

- May benefit analysis to obtain most recent financial statement of Umpqua and the current owners Mercy Medical and DCIPA. LLC as they were noted above as being able to provide capital if needed.

Is the company profitable if claims costs are 2% higher?

Not in the first year (2020) but in the following two (2021-2022)

	2020	2021	2022
BE: Net Income Claims +2%	($35,296)	$280,198	$116,883
MIN Net Inc Claims +2%	($26,397)	$210,135	$87,635
MAX Net Inc Claims +2%	($44,120)	$210,135	$146,104

Is the company profitable if claims costs are 4% higher?

No – Net Losses in all three estimated years 2020 – 2022.

BE: Net Income Claims +4%	($2,657,034)	($2,430,679)	($2,686,163)
MIN Net Inc Claims +4%	($1,992,700)	($1,823,023)	($2,014,650)
MAX Net Inc Claims +4%	($3,321,292)	($3,038,349)	($3,357,704)

Is the company profitable if claims costs are 6% higher? No

Applicant did not provide a 6% stress test. Net Income with Claims increasing +4% the company showed a Net Loss position in all positions. No further work deemed warranted.

[End of summary]

Additional detail regarding Umpqua's financial position and liquidity in stress tested scenarios is available on request but was not included in this summary memo.

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**
343,388	309,049	429,000	258,000	90%	

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$433.17	$463.13	$445.80	$457.26	-5%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
86%	88%	-2%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.39%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
0.23%	0.23%

Umpqua assumes a membership decrease in year 2022. Umpqua Best Estimate is 100% market share. Their current market share is 90%. OHA assumes 90% market share. Lower MLR assumption.

Profit margin

Projected profit margin is only 1.7% for FY2020 under the BE scenario, which is relatively low compared to UHA's profitability history reported in the prior years FY2013-FY2018: 8.7%, 19.7%, 8.9%, 6.5%, 2.6%, and 3.5%.

Capital and Surplus

Under the BE scenario, UHA projected to start FY2020 with a beginning C&S balance of $10M and contribute another $2M within a year, however, the C&S balance at end of FY2018 per Exhibit L was only $6M.

A $6M capital infusion is needed to reach the projected C&S level, and it is unknown whether the parent company has the available fund to increase the capital level by end of FY2020.

Risk: Projected C&S level is not supported by guaranteed funding

Recommendation: Request UHA to provide detailed plan to show the availability of extra capital infusion.

Liability balance

Projected liability balance at end of FY2020 is only 73% of reported balance at end of FY2018, however this balance is consistent with FY2017 ending liability, so still deemed to be reasonable.

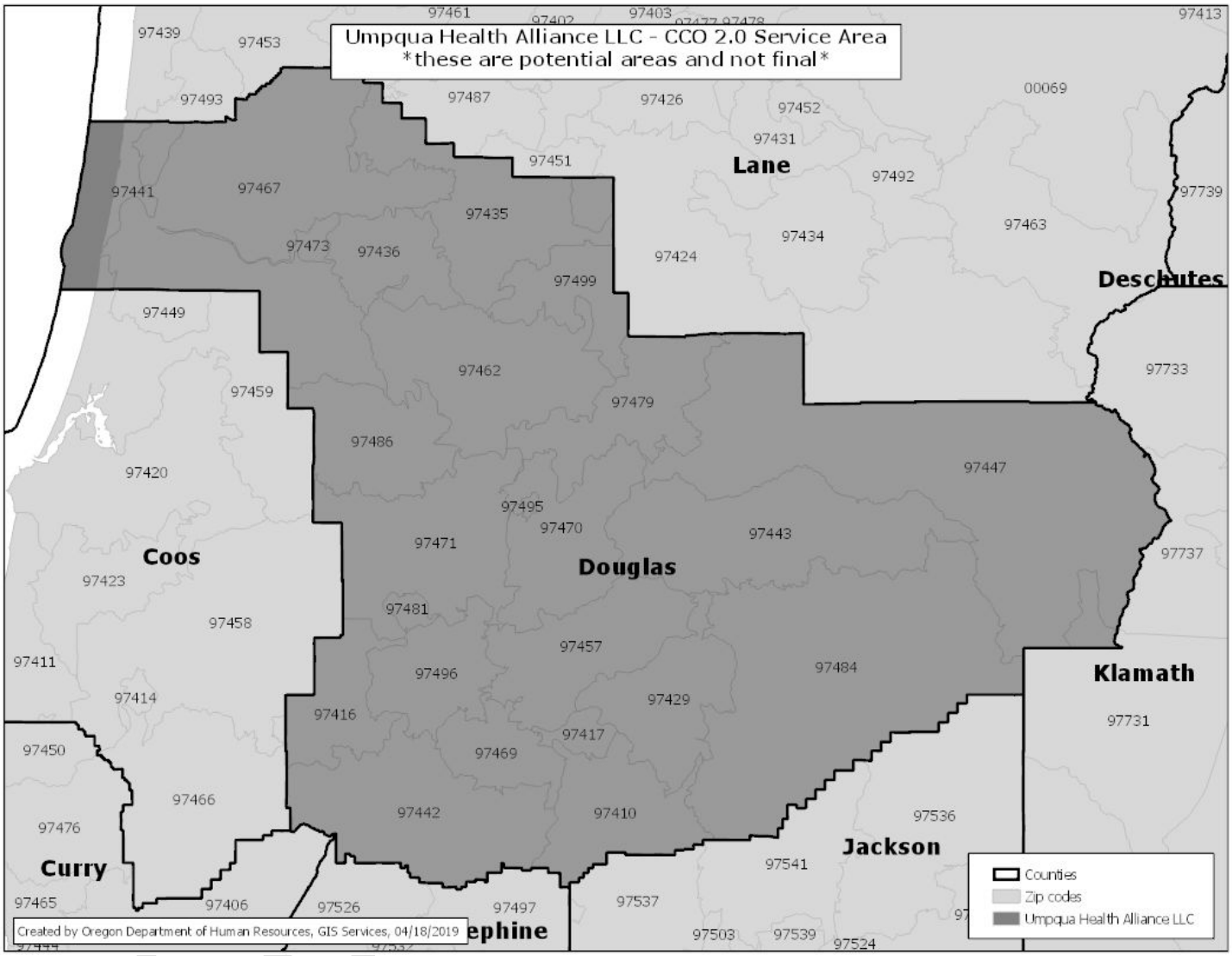
UHA has paid $13.3 M in dividends in 2017, and $5.4 M in 2018, against net income of $2.7 M and $4.6 M. Anticipated 1/1/2020 C&S is $9.9 M, with another $2 M planned contribution in 2020, as compared with $5.8 M outstanding C&S as of 12/31/2018.

- Suggest OHA require minimum capital of ~$13 million as of 1/1/2020 (estimated 200% RBC ratio).

Service Area Analysis

Requested Service Area

Applicant is requesting to serve the entirety of Douglas 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
Douglas	-	Umpqua Health Alliance would be the only CCO serving the entirety of Douglas County. Primary Health, All Care, and Trillium propose to serve parts of Douglas County.	2% chance Umpqua does not meet their minimum. Umpqua Health Alliance currently has 26,000 members and has reported a minimum threshold of 21,500.	No scenarios show enrollment exceeding applicant's maximum	Low risk

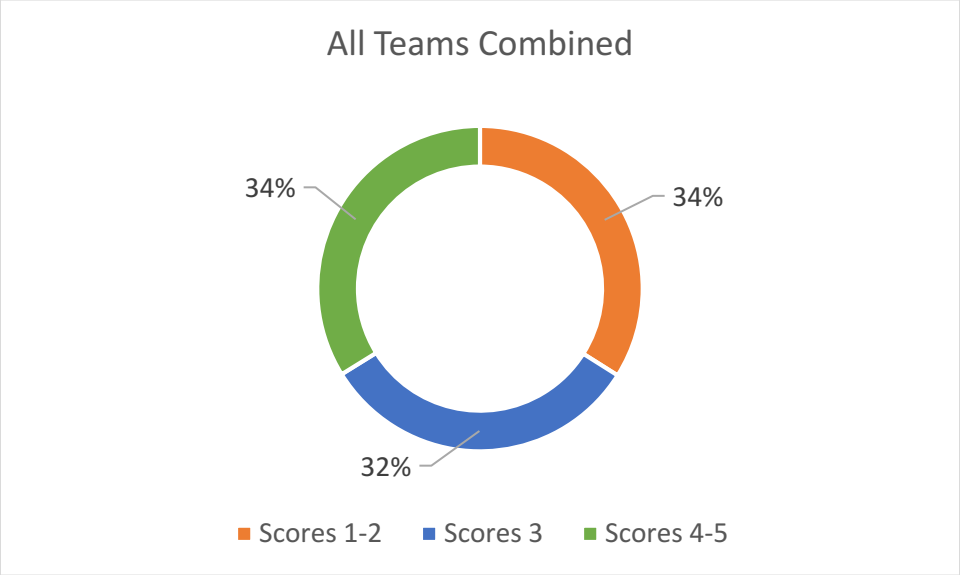
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Umpqua Health Alliance is likely to receive approximately 24,837 members out of the 21,500 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.

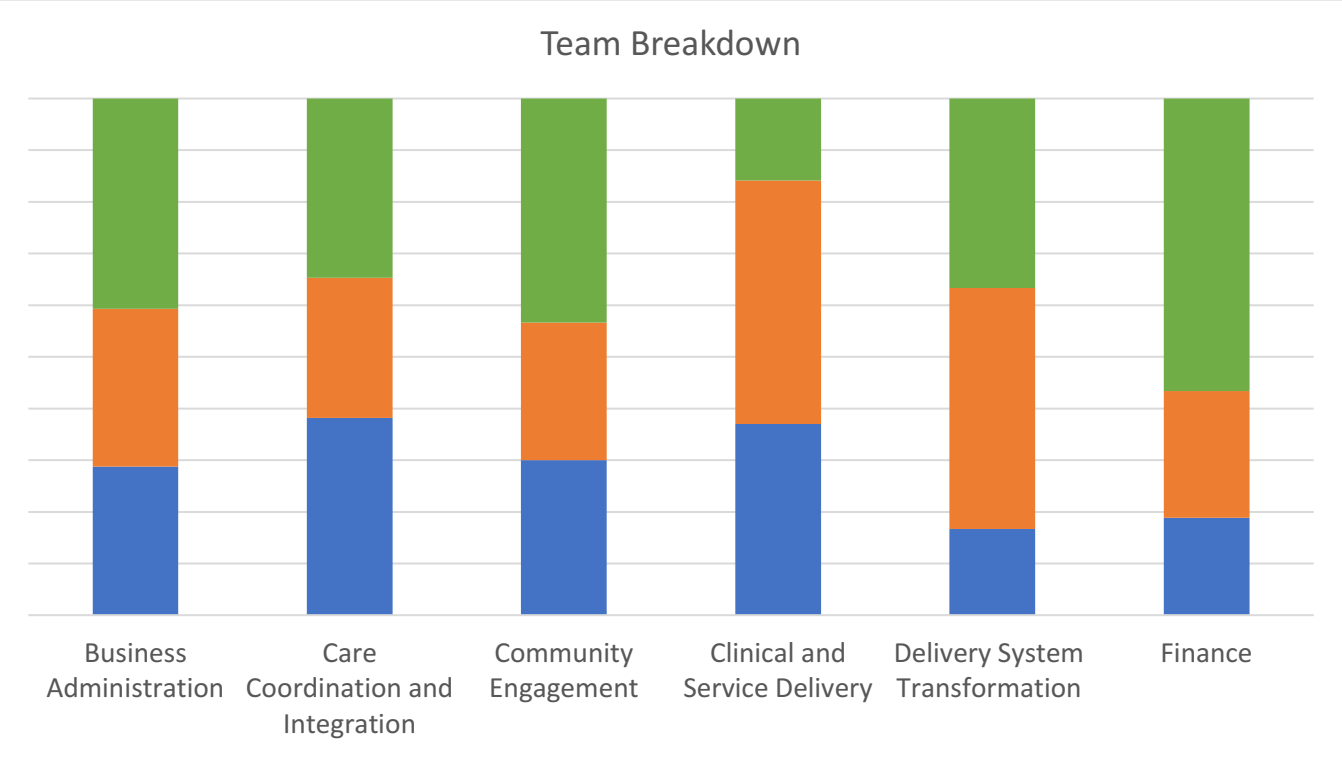
Evaluation Results – Overall Scores

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

Evaluation Results: Policy Alignment

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

Policy Areas	**1-2**	**3**	**4-5**
Cost	6	5	23
Social Determinants of Health	27	36	50
Business Operations	137	124	130
Behavioral Health	70	67	40
Value-Based Payment	15	10	11

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**
Business Operations	19	26	52
Cost	12	16	29
Social Determinants of Health	14	4	15
Behavioral Health	16	20	19
Value-Based Payment	21	19	16

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
CCO Performance and Operations	2	2	11	x			
Value-Based Payment	5	4	11	x		x	
Cost	6	4	8	x		x	

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

Deficiency Analysis

CCO Performance and Operations

Umpqua had sufficient responses regarding performance and operations. However, details were limited, and more robust efforts are needed to evaluate HRS and SDOH programs and investment strategies.

Value-Based Payment

The PCPCH funding plan may be sufficient, but there was not enough information regarding the rationale for decisions, or regarding what components are provided. There was also insufficient detail relating to new VBPs for targeted care delivery areas. Applicant may already be meeting high level VBP targets, but the application lacked detail on this topic. Overall, the Applicant may be sufficient in value-based payment, but this aspect of the application lacked a sufficient explanation within each response.

Cost

No demonstration for evaluating the cost-effectiveness or programs or interventions. No demonstration linking payments to quality, and while there are strategies regarding cost containment, there was no evidence provided of the effectiveness of these strategies.

Team Recommendation: **PASS**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Umpqua Health Alliance, LLC be given a “pass” for the financial section. The financial team has the impression that noted deficiencies were related to detail of answers given, and that addressing said deficiencies should be manageable for UHA. Cost and VBP sections were lacking detail. Lastly, concerns were raised regarding cost containment and investment strategies.

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
Administrative Functions	9	17	37	X		X	
Social Determinants of Health	6	10	12	X	X	X	
Health Information Technology	18	10	12	X		X	X
Member Transition	18	11	7	X		X	

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

Deficiency Analysis

Administrative Functions

Clear majority of answers were responsive but pharmacy and some Third Party Liability questions lacked detail. Pharmacy network was poorly described and reasons why it meets CCO needs were not addressed. Pharmacy was missing detail on how formulary changes and pharmacy benefits in general will be communicated. There is limited detail on how Applicant will identify members with Medicare and how frequently member coverage is reviewed. All deficiencies **could be addressed relatively quickly**.

Health Information Technology

Most answers in this section were missing detail and some were missing answers entirely. EHR adoption questions lacked detail on current operations and future plans. No indication of how providers would be trained, how new data sources would be integrated.

Questions addressing how HIT would be used for VBP and population health management failed to address how Applicant will support contracted providers with VBP arrangements and how Applicant would use HIT for population management. Very little detail on how VBP reports are used in Applicant network and how they would be shared with providers – no evidence of an overall plan for VBP that addressed all 5 years of the contract.

Member Transition

Clear majority of answers lacked detail and were missing some components. Detail missing included how care coordination will work during the transition period, what the warm handoff/transition activities will be. Missing detail on data will be transferred to receiving CCOs and any HIPPA considerations. Description of transition activities only include those members transferring in, not for members transferring out. Details

missing on how members with special needs will be identified. No indication of how continuity of care will be maintained with regard to prior auths, prescriptions, treatment plans, case management or transportation services. Details lacking on how Applicant will help members in the transition process, to understand their coverage.

Social Determinants of Health

Clear majority of answers in this section were missing at least some detail. There was no info on existing diversity policies, how diverse personnel would be recruited or retained. Appears to be a lack of understanding about what health equity is – a non-discrimination policy is pointed to as evidence of a health equity policy. A description of how the Applicant will collect and analyze SDOH-HE data is missing. There is no description of limitations or concerns about collecting or analyzing REAL-D data. Applicant would benefit from a language access plan and subject matter expertise.

Team Recommendation: **FAIL**

- Answers were responsive with some details missing in Administrative sections but were limited, incomplete or not responsive in the HIT, Member Transitions and SDOH-HE sections.
- The HIT section, covering E.H.R adoption and HIT for VBP and populations management was missing a large amount of detail. The missing information could be due to missing infrastructure, personnel, processes or any combination of these, but tends to suggest some larger gaps in infrastructure that would require a **significant amount of effort to remedy.**
- The member transition section was lacking a large amount of detail on the transition process including how care coordination, continuity of care, warm handoffs and data sharing will function. The absence of so many essential transition processes suggests that solution to address these gaps would require a **significant amount of effort to remedy.**
- The SDOH-HE section was missing detail and information regarding diversity in the workforce and strategies to ensure longevity of workforce diversity. The applicant does not appear to grasp the definition of health equity and demonstrates an incomplete understanding of how to ensure access to services for members with languages other than English. Applicant did not provide information on how SDOH-HE data would be collected and analyzed and what challenges there might be collecting and analyzing REAL-D data. The missing information in the section and incomplete understanding of health equity, suggests larger gaps in the Applicant's system that will require **at least a moderate amount of effort to remedy.**

This Applicant's responses were limited, incomplete and sometimes missing entirely for 3 of 4 sections. The identification of multiple items needing significant effort to correct, and the overall quality of the responses provided, pointed to a FAIL recommendation.

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
Behavioral Health Benefit	1	2	9	X		X	
Care Integration	2	5	14				
Behavioral Health Covered Services	6	15	15	X		X	
Care Coordination	27	29	20	X		X	
Health Information Exchange	11	15	2	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 planned efforts to support workforce capacity. A deficiency was also noted in the Applicant's description of processes relating to covered services. Description of plans surrounding behavioral health covered services lacked clear strategies for addressing high-needs populations including provision of initial assessments. Applicant challenged aspects of care coordination requirements, describing them as not in rule (11.E.3). Responses in this section lacked detail on the following points:

- Person-centered training
- Trauma-informed care
- Member engagement during transitions.

Team Recommendation: **FAIL**

Care coordination plans included no specific plans for dual eligible populations, children or members with behavioral health needs. Description of current agreements with behavioral health services partners was not provided. Applicant failed to demonstrate how other agencies and family members would be involved in care planning. Limited detail was provided in the Applicant's description of behavioral health partnerships and planned monitoring activities surrounding member care plans do not meet OHA requirements.

Care integration responses were generally well received; however, additional detail on plans for referrals and information sharing was requested. Additionally, a description of qualifications needed to provide services to members of special-needs population should be provided.

Applicant's ability to support Health Information Exchanges (HIE) was not clearly demonstrated. Responses regarding HIE were folded into responses on Electronic Health Records (EHR). Details on hospital event notifications were not provided. Roadmap documentation was high-level and failed to provide a clear description of planned activities.

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
Service Operations	16	18	12			X	
Behavioral Health Benefit	12	17	4			X	
Administrative Functions	23	13	9			X	
Behavioral Health Covered Services	47	29	8	X			

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

Deficiency Analysis

Administrative Functions

The responses were in this section were missing a moderate amount of detail. The network adequacy response did not include BH; Applicant didn't indicate how they calculate FTE; the methodology used to analyze capacity was missing; how Applicant would use the grievance and appeal data to improve their system was unclear; Applicant did not appear to use their G&A data to monitor for the correct application of medical necessity criteria. The deficiencies identified (missing detail about how BH adequacy and FTE's are calculated, creating processes to use G&A data to monitor for correct application of PA criteria and improvements in the network) were estimated to require a **small amount of effort**.

Behavioral Health Benefit

No clear process for warm handoffs and no barriers were discussed in this section. These deficiencies are estimated to take a **small amount of effort to remedy**.

Behavioral Health Covered Services

The responses in this section were missing a moderate amount of detail. There were no processes mentioned for matching a person's level of needs with correct level of services. There is a high barrier to access care coordination services - members have to receive, complete and return something in the mail – this is difficult to do for those who are struggling. Some answers appear provider-centric rather than member-centric -ex: Agency policy is to connect people with teams of care instead of a certain provider. Monitoring of services was not addressed. The SUD services questions addressed only women in with SUD post-partum but not at other stages of pregnancy. Only talked about OHA sponsored PCIT when addressing the question about dyadic therapies and didn't mention any of the other dyadic therapies that are used. The many deficiencies noted in this section are estimated to take a **smaller amount of effort to address**, but collectively they would require a **moderate level of effort to adequately remedy**.

Service Operations

The responses in this section are lacking a small to moderate amount of detail and some responses are missing entirely. Detail on access to care and determining medical necessity is missing. There are no timelines for prior authorization included. There is no mention of any data sources or monitoring processes to ensure access to services. There does not appear to be a process for requesting out-of-state services and it is unclear how Applicant will provide access to LTSS services and no info was provided on the four models. The deficiencies in this section range from small to moderate but collectively would take at least a **moderate amount of effort to remedy**.

Team Recommendation: **FAIL**

- The responses from this Applicant were missing a small to moderate amount of detail and there were some questions that were not addressed at all.
- The deficiencies identified would take **a small to moderate amount of effort** to remedy however the sheer number of deficiencies identified indicates that collectively, they would require a **moderate to large amount of effort to remedy**.
- The quality of the response and large total number of deficiencies led to a team recommendation of FAIL.

Delivery System Transformation

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Delivery Service Transformation	3	4	5	X		X	
Accountability and Monitoring	11	1	6	X		X	

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Applicant failed to provide details describing the measurement and reporting system, specifically the measures and how they are reported, how the system provides data to stakeholders, and how standards and expectations are communicated and enforced with providers and sub-contractors. Lack of sufficient information about the purpose of the external program and how it is administered. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Applicant failed to provide details describing data systems and process, such as collecting data, performance benchmarks, and using the data to incentivize quality care. Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination across the delivery system. Lacking sufficient information about the process for communicating and enforcing expectations with providers.

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

Delivery Service Transformation

Provision of Covered Services – Applicant failed to provide comprehensive analysis, including details describing data collection and analysis by sub-categories (by REAL-D).

Transforming Models of Care – Applicant failed to provide details describing oversight of PCPCH and engagement of potential new PCPCH providers.

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 plan for quality improvement
- Provide details about the connection of staff to parts of the organization and roles
- Describe process for identifying and improving gaps

Delivery Service Transformation

- Describe PCPCH system by tier level, oversight, and new provider engagement

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	2	2	6	X	X		
Community Engagement Plan	15	16	29		X		
Governance and Operations	9	9	12			X	
Social Determinants of Health	6	9	5	X		X	

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

Deficiency Analysis

- Doesn't include agencies or organizations in Douglas county
- Applicant notes that CHA/CHP is main means for community engagement which is not sufficient
- Member voice is not elevated appropriately
- Not clear how they were defining members or if it was the appropriate way to measure (physical services report)
- Not clear how the CAC and board work together or how input is shared with the CCO governance other than through public comment.
- Really only spoke to member engagement and barriers for the CAC members
- Majority of the parties listed are not SDOH-HE partners
- No substantive information around member engagement on Quality Improvement; QI efforts are mostly only grievance driven – no role for members is described
- Lacks detail in how members are engaged in their own care planning
- No information about how the CAC members were selected or how the community is represented.
- No mention of how they've addressed or plan to address regional, cultural, socioeconomic and racial disparities in health care

Team Recommendation: **FAIL**

- Need to partner with THW organizations
- Need to address Douglas county representation
- Needs TA on how to address health disparities through community engagement
- Needs to ensure CAC is aligned with statute
- Need to ensure that the CCO board is meaningfully engaging back with the CAC

Community Engagement – Community Letters of Support

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

Organization Name	Type
Adapt	BH, SUD, Supported Housing
Advantage Dental	Dental Clinics
Bari Isaacson, LPC	BH Provider
Batters Persons Advocacy	DV, SA Victim Services
Canyonville Farmer's Market	Food, Nutrition
Centria Autism	ABA Provider
CHI Mercy Health Medical Center	Hospital
DCIPA	Provider Association - IPA
Douglas C.A.R.E.S.	Child Abuse Response and Evaluation Services
Douglas County Commissioners	Local Government
Douglas Public Health Network	Local Public Health Organization
Matt Newey, LPC	BH Provider
Meals on Wheels Roseburg	Senior Meals
NAMI	BH Alliance
NeighborWorks Umpqua	Housing, Community Wellness, Food, Education
Oregon Surgery Center, Mercy Medical Center	Specialty Provider
Phoenix School	Education
Rep. Gary Leif	Elected Official
Roseburg Anesthesiology Specialists	Specialty Provider
Sen. Dallas Heard	Elected Official
Serenity Lane	BH, SUD
South-Central Early Learning Hub	Early Learning Hub
Southern Oregon Neuropsychological Clinic	Specialty Provider
StillPointe Counseling Service	BH Provider
Trillium Family Services	Children's BH Res Provider
Umpqua Community Veg Education Group	Food, Nutrition, Education
Umpqua Health Harvard	Medical Clinic
Umpqua Health Newton Creek	Medical Clinic, Urgent Care
Umpqua Valley Breastfeeding Coalition	Education, THW - Certified Lactation Educator training
Valiant Seed	Housing, Homelessness, Veterans
Valley Ridge Family Medicine	Medical Clinic
YMCA Douglas County	Family Fitness club

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 did not demonstrate a plan for evaluating cost-effectiveness of applicant programs and interventions, focused on efficiency without explanation of definition, type or value of efficiency and did not demonstrate link of payments to quality.

Applicant states plan to move services in house and not put a cap on them, however, details of how they will monitor this and ensure full responsibility is missing.

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
6	5	1	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

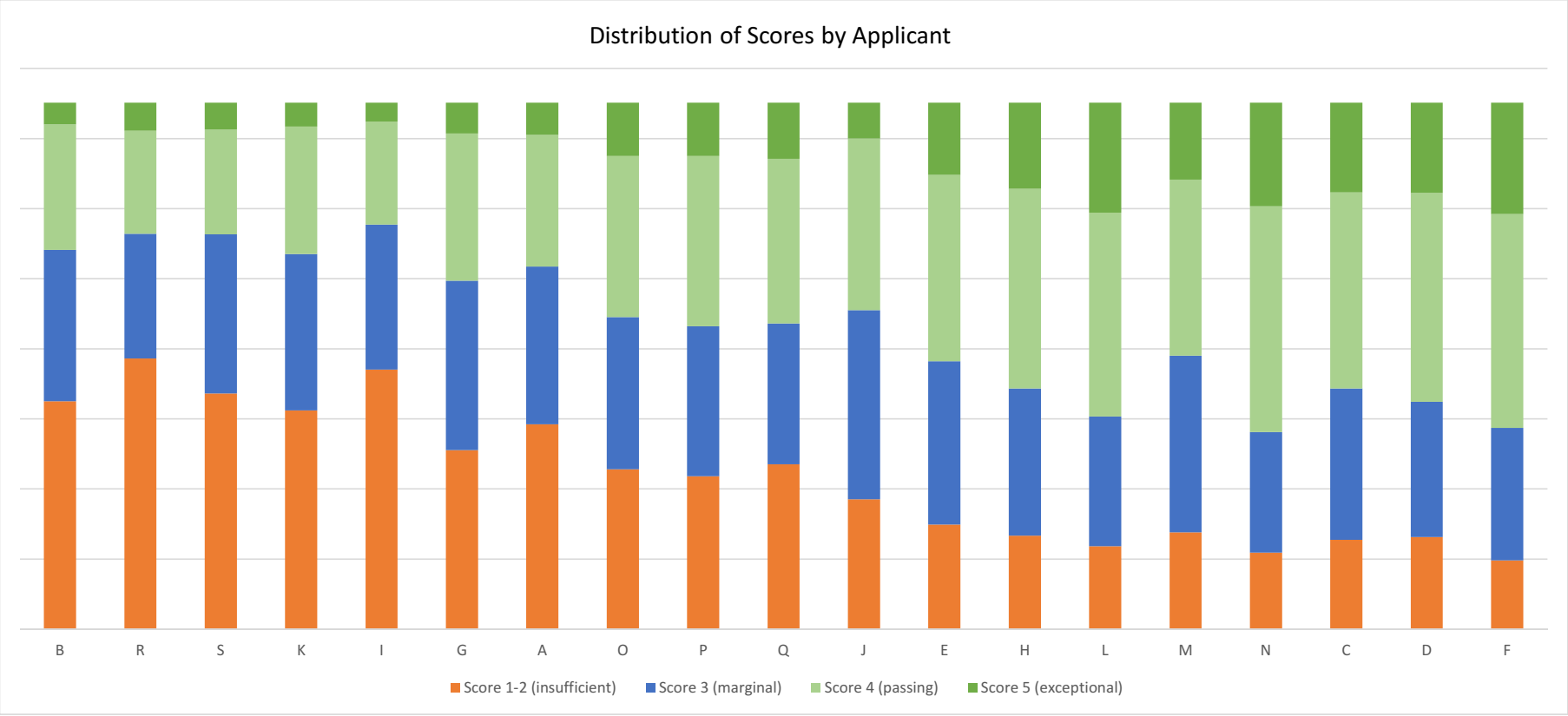
Members with no claims history

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

Pass/Fail by Category

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

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



Comparison of RFA Applicant Pro Forma Submissions to 2018 Exhibit L

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

Note:

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

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

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

Preliminary Member Allocation Results

CONFIDENTIAL UNTIL 7/9/2019

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

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

using data as of 5/22/19

CONFIDENTIAL UNTIL 7/9/2019