RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant B
West Central Coordinated Care Organization, 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

- WCCCO seeks an exemption from SAP and NAIC reporting for 2020 in order to allow sufficient time for hiring and training personnel.
- DCBS performed the financial evaluation and found results to be reasonable for projections provided; however, there is little financial protection from any negative deviations in their results.
- ASU raised concerns about capital funding and multiple CCOs under Moda.

Service Area Analysis

- WCCO is requesting to serve Lane County, with no service area exception request.
- High risk that WCCO will not meet minimum enrolment required if three CCOs are awarded in this service area, or if two CCOs area awarded and one is the incumbent.

Evaluation Results – Team Recommendations

- Finance – Fail; incomplete response, did not demonstrate how they will perform cost containment activities
- Business Administration – Fail; responses were limited, incomplete or not responsive. Requires significant effort to correct deficiencies.
- Care Coordination and Integration – Fail; no detail provided about encouraging preventive services, transition of care activities, or performance expectations.
- Clinical and Service Delivery – Fail; responses lacking in detail regarding administrative functions, SPMI and LTC services. Requires significant effort to correct deficiencies.
- Delivery System Transformation – Fail; responses missing significant details about reporting system and service improvement plan.
- Community Engagement – Fail; response did not adequately address culturally-specific organizations, member engagement plan.

Community Letters of Support

- 15 letters of support were received from various provider groups

Evaluation Results: Policy Alignment

The responses from WCCO show strong alignment with policy objectives in VBP, Social Determinants of Health, and Behavioral Health; and weak alignment with Cost and Business Operations objectives.

Evaluation Results: Informational Assessment

WCCO's responses to informational questions scored higher in VBP, Social Determinants of Health, and Behavioral Health; and scored lower in Cost and Business Operations objectives.

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 29, 2019

To: Ryan Keeling, Chief Analyst

From: [redacted]

Subject: CCO2.0 Financial Review

WCCCO=West Central CCO

I have performed a financial evaluation of West Central CCO (WCCCO) application for their Lane County operations based on the materials provided. WCCCO is a newly formed CCO and would begin operations 01/01/2020.

As part of the Oregon Dental Group holding company system, which includes health insurers, Oregon Dental Service (NAIC=54941) and Moda Health Plan, Inc. (NAIC-47098), WCCCO may have access to additional parental resources.

The results provided appear to be reasonable for projections provided, but leave little financial protection from any negative deviations in their results.

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') 50% (528,000 Member Months), Minimum ('MIN') 75% (422,400 Member Months), and Maximum ('MAX') 105% (1,108,800 Member Months). Concerns surrounding Applicant's membership assumptions were communicated by OHA in:

*Applicant assumed Applicant would get 50% of the County's populations even though there was a new CCO and another CCO currently operating in that county. Even Applicant's Minimum exceeded OHA's estimates.

*The enrollment needed to ensure sustainability of the Applicant.

Such concerns seem warranted given the review below.

RBC:
The applicant is under-funded at the start as beginning operations with an estimated 159% RBC to start 2020. RBC, prepared by the Applicant, projects Best Estimate ('BE') RBC of 183.1%, 204.6%, and 228.7% for year-ending 2020, 2021, and 2022, respectively. They follow a similar pattern for their minimum enrollment estimate, with 2020 RBC of 196.0%, then 2021 and 2022 exceeding 200%. Under their maximum enrollment estimate, they will have 220.5% RBC in 2020, meeting the benchmark, and then increasing RBC to 279.5% in 2021 and 339.1% in 2022.

The applicant would not meet the RBC requirements in any year across all enrollment projections for Claims +2%, +4% projections. RBC calculations was not provided by Applicant for any of the +6% scenarios.

The company is dependent upon profitable results from operations to meet the requirements, and there is little margin for negative deviations without broaching the minimum RBC requirement of 200%.

To breach the 200% RBC threshold, Claims would need to:
decrease at least -7.27% for Expected Membership & Claims +0% scenario;
decrease at least -0.15% for Minimum Membership & Claims +0% scenario;
increase at most +0.72% for Maximum Membership & Claims +0% scenario;
Data was not provided for any of the +2%, +4% nor +6% scenarios.

MINIMUM CAPITAL AND SURPLUS:
The CCO met the basic capital and surplus requirements under all Claims +0% and Claims +2% scenarios but did not for all Claims +4%. Claims +6% was not presented.

NET INCOME:
To breach the Net Loss threshold of $0, claims would need to increase roughly:
0.87% for Expected Membership scenario;
0.27% for Minimum Membership scenario;
2.12% for Maximum Membership scenario.

This is a very small cushion for financial protection for any negative deviations, especially as they are dependent upon net income and positive financial results from operations to meet the required RBC percentage.

LIQUIDITY:
The applicant appears to have sufficient assets to cover their liability obligations without requiring positive cash flow from operations on scenarios where data was provided. Applicant maintained liquidity ratio roughly:
169+% for Expected Membership & Claims +0% scenario;
173+% for Minimum Membership & Claims +0% scenario;
182+% for Maximum Membership & Claims +0% scenario;
Data was not provided for any of the +2%, +4% nor +6% scenarios.

To breach the 100% liquidity benchmark, the claims cost have to rise to:
6+% for Expected Membership scenario;

7+% for Minimum Membership scenario;
7+% for Maximum Membership scenario.

PREMIUM TO SURPLUS:
The Applicant's Premium to Surplus ratio is:
13.9-16.7:1 for Expected Membership & Claims +0% scenario;
15.2-15.4:1 for Minimum Membership & Claims +0% scenario;
09.6-14.3:1 for Maximum Membership & Claims +0% scenario;
Data was not provided for any of the +2%, +4% nor +6% scenarios.

Mitigating the above concerns is the fact that the Applicant appears to have parental resources available for further capitalization as needed. The assets available, though, are limited, and with three CCO applicants within the organization, the resources may be more strained and limited than if done under a single application.

As funding from other owners was yet to be determined, it is unclear if beginning C&S ($13.1M) was to be the total C&S to be later allocated between the multiple owners or if that was to be ODSCH's contribution and the other owners were to contribute "additional funds – yet to be determined." Applicant increased their beginning C&S to $28M for their Maximum Enrollment Scenarios.

The second situation would alleviate the starting RBC issues noted above but analysis was performed based on the first situation, as that was all the information provided. Any additional funds contributed by the other owners would only improve the overall analysis of the Applicant.

Applicant increased their beginning C&S to $28M for their Maximum Enrollment Scenarios, skewing ratio analysis on these scenarios.

It would be prudent to ensure that EOCCO, NWCCO and WCCCO are setup as separate legal entities and are not combining their assets and C&S in a single entity, while breaking out the premiums, claims cost and authorized control level by geographic contract. Doing so would show that each CCO may have sufficient assets and surplus for a location, but may not have enough when combined into the actual single entity that is bearing all of the risk.

[End of summary]

ASU Analysis of Applicant Financial Assumptions

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

As DCBS has performed a detailed review of applicant's pro forma and related application items, this is a high-level review based on the DCBS review summary.

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 EOCCO (FY2018) as they share the same parent company, Moda.

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**
528,000	345,488	1,108,800	422,400	65%	**Too low**

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$484.90	$483.42	$496.45	$490.78	-1%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
90%	92%	-2%

Cost Trend	
Applicant Assumption	**OHA Assumption**
3.28%	3.40%

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

In Depth review of Risks Associated with Three CCOs under Moda

Admin load % and profit margin assumption

In the FY2020 projection under the BE MM scenario, the three CCOs assumed the same admin load at 9.1% and profit margin at 0.8%.

The admin load 9.1% is consistent with EOCCO's FY2018 financial result and thus deemed reasonable.

The profit margin 0.8% is significantly lower than EOCCO's FY2018 profit margin 3.7%. Further, per the prior years' financial reporting history, EOCCO's profit margins are: 4.9% for 2017, 3.9% for 2016, 6.0% for 2015, 9.3% for 2014, and 0.8% for 2013. Based on this historical data, the projected profit margin for 2020 seems too conservative.

Risk: the risk noted by DCBS might be alleviated if the profitability is underestimated by the applicants.

Recommendation: Revisit the proforma data to adjust the operating expense

DCBS's review comment regarding strained/limited parental resource for further capitalization

DCBS's review summary memos for NWCCO, WCCCO and EOCCO all state that "Mitigating the above concerns is the fact that the Applicant appears to have parental resources available for further capitalization as needed. The assets available, though, are limited, and with three CCO applicants within the organization, the resources may be more strained and limited than if done under a single application."

Per review of the submitted organization charts, OHA financial analyst noted that EOCCO has multiple equity shareholders and Moda only holds 29% stake of EOCCO. The other significant stakeholder is GOBHI, which also holds 29%.

Moda currently holds 100% stake in both NWCCO and WCCCO as they are newly founded, however, other interested or expected equity partners might contribute upon start-up or in the future. Among those interested parties, only GOBHI for NWCCO would be a common shareholder as for EOCCO, otherwise all the other interested equity partners are different and thus DCBS's concern about strained and limited resources from parent company would be alleviated.

Capital & Surplus for EOCCO

DCBS's analysis shows EOCCO's beginning capital is not enough to meet the RBC requirement. At 2018 year-end, EOCCO has a C&S balance of $24m, however, it only plans to contribute $17m as the starting capital at the beginning of 2020 under the BE MM scenario.

EOCCO plans to distribute $6.5m plus whatever net income it will make in FY2019 as dividends to the shareholders before the CCO 2.0 contract starts.

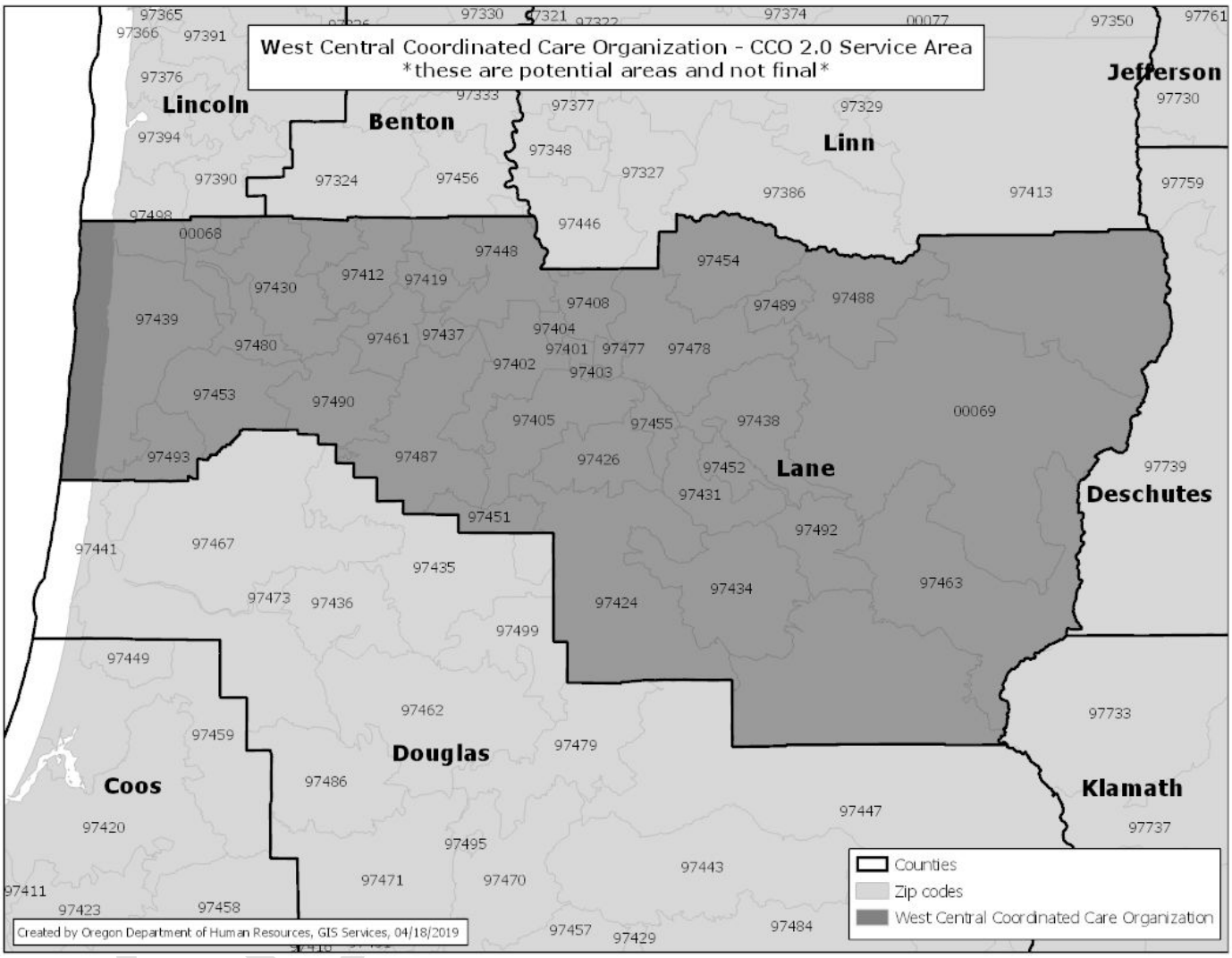
Risk: Aggressive dividend distribution plan will put EOCCO at a less solid financial situation.

Recommendation: Recommend EOCCO to keep more capital funding to meet the RBC requirement before distributing dividend to its shareholders.

Service Area Analysis

Requested Service Area

Applicant is requesting to serve 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 applicants – Trillium and Pacific Source Lane – propose serving Lane County.	100% risk of not meeting their minimum.	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.

Scenario description	Impact on Pacific Source Lane	Impact on West Central	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.

WCCCO minimum enrollment assumption deserves careful review. If PSCSL application is denied, OHA might be able to accommodate WCCCO's minimum enrollment assumptions via its attribution policy.

- If WCCCO is likely to be awarded, recommend OHA determine how to support minimum enrollment assumption.
- Suggest OHA consider requiring more capital from WCCCO, depending on projected enrollment such that estimated RBC is 200% as of 1/1/2020.

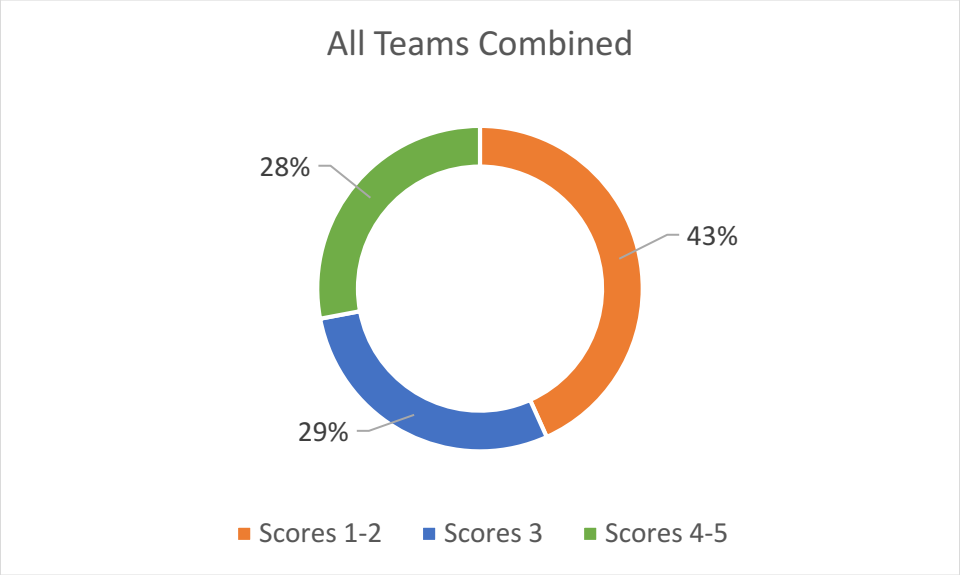
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, WCCCO is likely to receive approximately 22,275 members out of the 35,200 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.

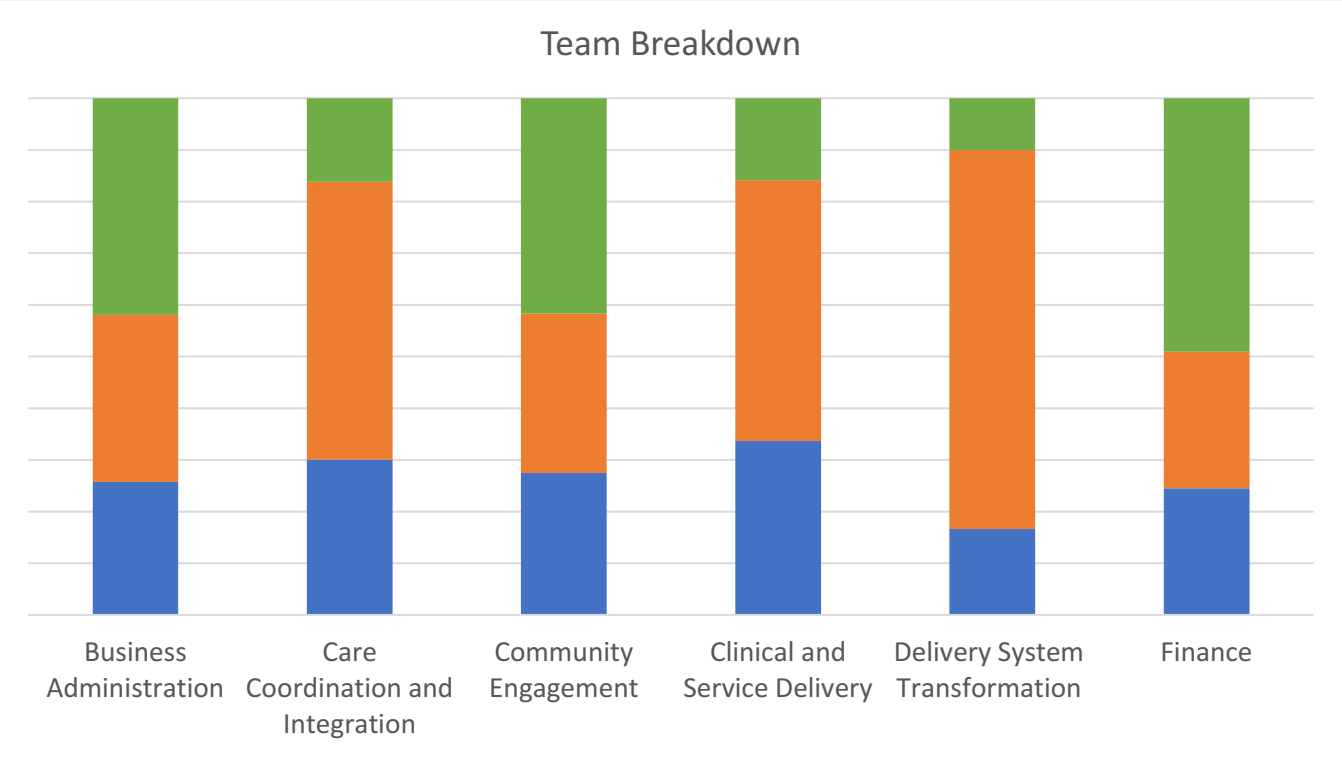
Evaluation Results – Overall Scores

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	FAIL	X		X	
Business Administration	FAIL	X		X	X
Care Coordination and Integration	FAIL	X		X	
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	FAIL	X		X	X
Community Engagement	FAIL	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	8	6	22
Social Determinants of Health	19	30	64
Behavioral Health	69	64	44
Cost	16	11	7
Business Operations	213	105	73

Evaluation Results: Informational Assessment

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

Policy Areas	**1-2**	**3**	**4-5**
Social Determinants of Health	9	9	15
Value-Based Payment	18	14	24
Cost	17	17	23
Business Operations	41	31	25
Behavioral Health	26	15	14

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	1	4	15				
Cost	6	6	6			X	
CCO Performance and Operations	7	3	5	X			

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

Deficiency Analysis

Value-Based Payment
WCCCO had no significant VBP deficiencies.

Cost
WCCCO sufficient responses related to behavioral health. Unfortunately, all other cost aspects of the application were considered incomplete. Responses related to cost containment and care coordination are more significant than merely omissions of detail. Care coordination is not adequately addressed, understanding of how payment and quality are related was not demonstrated, and no link between VPB strategies and cost containment strategies was made.

CCO Performance and Operations
The performance and operations aspect of WCCCO's application was nearly adequate. There is a limited demonstration of an ability to evaluate HRS and/or SDOH activities and investments, and inadequate explanation of HRS investment strategies, and how they might connect to larger HRS goals.

Team Recommendation: **FAIL**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends failing this applicant for the financial section. WCCCO submitted an application that was incomplete, lacking detail and inadequately demonstrated how they will perform cost containment activities. The responses were incomplete answers and lacking explanation for strategic endeavors. WCCCO had strong responses regarding VBP and behavioral health, but these strengths could not overcome several significant deficiencies.

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	4	8	16	X			
Administrative Functions	16	16	31	X		X	
Health Information Technology	16	8	16	X		X	X
Member Transition	18	11	7	X		X	X

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

Deficiency Analysis

Administrative Functions

Information is high level and limited. Specifically, there is very limited information about plans to monitor for fraud, waste and abuse (FWA) – no information on how they will identify and conduct audits on a regular basis; there is no discussion of tools or auditing resources. Limited detail regarding plans for the providing pharmacy information via the required public facing website. The information provided on TPL was largely responsive but was located in the wrong section. Description of the processes to validate encounter claims is very limited and timelines were not provided. Lacking info on the governance structure – how board members are elected or appointed, major operational procedures and processes missing as well as plans for key committees' composition and functions.

Social Determinants of Health & Health Equity

Applicant failed to demonstrate knowledge of how to make available and deliver linguistically and culturally appropriate services or how to deliver services to members who are disabled. Responses indicated the applicant was not familiar with ADA and ACA 1557 requirements. Specifically, there appears to be no language access plan and there was no plan for continuing education for staff on health equity. Equity in employment was not addressed nor was the recruitment and retention of diverse personnel and leadership. No discussion of how REAL-D data would be used in internal SDOH-HE processes. Individually, the deficiencies above **could be remedied relatively quickly**.

Health Information Technology

Very limited and some components were not addressed at all. Overall the Applicant failed to address EHR adoption; the roadmap to adoption did not have any targets or timelines or milestones; all three provider types (physical health, behavioral and oral health) were discussed together which indicates that the Applicant is not aware of provider-specific challenges in EHR adoption; provider HIT training is missing –

they only indicate training for their own staff; HIT plans for years 1-5 were not included and there is not enough detail in the narrative provided to determine if their high-level plans are feasible.

Member Transition

Limited, incomplete and missing responses in this section: no description of the info that they will need to transmit for outgoing members and lacking detail on what types of data would need to be shared, in general; very limited detail on how they will coordinate with other CCOs – what coordination would look like and how will this relationship be maintained; limited detail on the continuity-of-care processes and how it will be maintained during transition; no definition or activities described for warm handoffs indicating a lack of understanding of these concepts.

Team Recommendation: **FAIL**

- In general, responses were limited, incomplete or not responsive. Some questions contained a lot of information but were not responsive to the question being asked.
- The FWA unit appeared largely non-existent and only very limited, high-level plans were presented for how to address FWA responsibilities and no tools and resources were mentioned that would be used to reach this goal. The creation of a FWA unit and all monitoring and auditing processes, would take a **significant effort to correct.**
- The creation of a HIT plan and E.H.R adoption plan and system implementation would take a **significant effort to correct.**
- The responses demonstrate an incomplete understanding of basic healthcare concepts such as warm hand-offs and how to maintain continuity-of-care during a transition. The creation of a transition and receiving plan, with associated coordination processes and transition activities would take a **significant effort to correct.**

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
Health Information Exchange	6	21	1				X
Behavioral Health Benefit	5	3	4	X		X	
Behavioral Health Covered Services	15	10	11	X		X	
Care Coordination	48	17	11	X		X	
Care Integration	19	1	1	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 detailed processes for behavioral health benefits and behavioral health covered services. This included missing detail on processes and timeframes for joint planning, trauma informed care and person-centered planning, member re-engagement, and tribal communication. In general, care coordination was perceived as being poorly defined.

Care coordination activities have been identified as immature. Applicant provided no detail on standards or procedures on targeted populations and relationships to partners who work with these populations (LTSS, 1915i, etc.). Applicant did not discuss processes or standards for sharing care coordination assessments with partners.

Beyond these issues the applicant provided limited responses on:

- How they will form relationships with DHS – this is a heavier lift to resolve
- Descriptions of care coordination model, especially oral health

Applicant's ability to support Health Information Exchanges (HIE) lacked anticipated detail. Applicant failed to provide information on how they would support the use of HIE among their provider network. Future plans regarding HIE usage were generic and did not include descriptions of actionable objectives. No assessment of current provider capabilities was provided in their service area.

Team Recommendation: **FAIL**

Care integration responses provided no detail on encouraging preventive services, oral health monitoring in crisis situations, or how information sharing necessitated by transition of care will be facilitated. Support for members was also identified as lacking; no detail was provided for how performance expectations would be reviewed or monitored for provider types and it was unclear how members would have a role in their treatment planning.

The applicant did not identify tribal facilities in their service area. Missing information and gaps of knowledge about populations and service patterns raised significant concerns about accomplishing coordination goals.

Clinical and Service Delivery

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

Category	**1-2**	**3**	**4-5**	Lacks Detail	People	Process	Tech
Behavioral Health Benefit	6	13	14	X		X	
Behavioral Health Covered Services	39	36	9				
Service Operations	29	11	6	X			
Administrative Functions	31	10	4			X	

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

Deficiency Analysis

Administrative Functions

Responses were missing detail or missing information altogether. Applicant does not appear to use grievance system to monitor or improve system; no discussion of monitoring subcontractor's application of prior authorization criteria or NOABDs. There is no separate discussion of physical, behavioral or oral health providers or how to address barriers; process for data analysis and utilization are unclear. The deficiencies noted indicate a lower level understanding of how to establish network adequacy and utilize grievance and appeal data and would require a **light amount of effort** to establish new methods and processes.

Behavioral Health Benefit

Lack of detail or implied that they would just work with OHA to figure out details; concerns about the credibility of responses. Affiliated commercial entity was referenced but no clear frameworks that would go along with that relationship. The deficiencies noted suggest the Applicant may not fully grasp the barriers that exist in their system. An analysis of the barriers in their system could be accomplished with a **small amount of effort.**

Behavioral Health Covered Services

There was no detail on methods for reaching members. The deficiencies in this area indicate the Applicant has a limited understanding of Medicaid services, especially SPMI services, and how those services should be care coordinated. The deficiencies in this section are estimated to take a **moderate to large amount of effort** to rectify.

Service Operations

Responses were missing detail and sometimes did not address question. There was no differentiation between special populations; no strategies were mentioned, and answers were cut and pasted throughout this section; no detail of how services would be provided to LTC. The responses provided indicate that the

Applicant has challenges understanding its service operations, especially hospital and LTC services. The deficiencies in this section could be addressed with a **significant amount of effort**.

Team Recommendation: **FAIL**

- The Applicant's responses were in general, lacking in detail.
- The deficiencies noted in the Administrative Functions section, indicate a lower level understanding of how to establish network adequacy and utilize grievance and appeal data and would require a **light amount of effort** to establish new methods and processes.
- The deficiencies in the Behavioral Health Covered Benefit section indicate the Applicant has a limited understanding of Medicaid services, especially SPMI services, and how those services should be care coordinated. The deficiencies in this section are estimated to take a **moderate to large amount of effort to rectify.**
- The responses provided indicate that the Applicant has challenges understanding its service operations, especially hospital and LTC services**. The deficiencies in this section could be addressed with a significant amount of effort.**
- The general quality of the responses and the presence of multiple areas requiring **moderate to large amounts of effort** to address 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	8	2	2	X			
Accountability and Monitoring	14	3	1	X		X	X

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

Deficiency Analysis

Accountability and Monitoring

Accountability – Applicant failed to provide details describing the measurement and reporting system such as how metrics are tracked, and how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking sufficient description of external programs, who administers these programs and the purpose/roles of these programs. Lacking sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.

Quality Improvement Program – Applicant failed to provide details describing data systems and process, including description of staffing, policies and procedures. Lacking sufficient information about collecting data, performance benchmarks, and using the data to measure and incentivize quality care. Lacking sufficient information about referrals and prior authorization processes, including how referrals and prior authorizations are requested, the timelines for referral/authorization, and how the procedures will ensure continuity and coordination of care.

CCO Performance – Applicant failed to provide detailed information about measures. Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REALD).

Delivery Service Transformation

Provision of Covered Services – Applicant failed to provide details describing data collection and analysis by sub-categories (by REALD). Lacking detailed plan for improving outcomes and quality of services. Lacking sufficient description of how collected data will be incorporated into quality improvement activities.

Transforming Models of Care – Applicant does not currently have PCPCH in place. Applicant failed to provide details describing a plan for PCPCH, such as the number and types of providers in the area, provider tier levels, member assignment, oversight, and engagement of potential new PCPCH providers.

Team Recommendation: **FAIL**

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

Accountability and Monitoring

- Missing reporting system information
- Missing process to identify and address gaps
- Lack of details on staffing, policies and procedures

Delivery Service Transformation

- Lack of details on process for plan for improvement

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
Social Determinants of Health	2	4	14	X		X	
Community Engagement Plan	13	15	32	X		X	
Governance and Operations	13	13	4			X	
Community Engagement	9	1	0		X	X	

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

Deficiency Analysis

- Lacking detail on member engagement in care planning beyond initial welcome packets.
- Not enough details on how engagement will be culturally and linguistically appropriate.
- Communication with CAC and board not explicitly outlined.
- SPMI and LTC representation not adequate.
- No steps provided to obtain noted agreements with county government.
- Missing some details on how funding is broken out across areas, such as SDOH/HE versus CHP.
- Process for conflict of interest not well detailed or strong enough.

Team Recommendation: **FAIL**

- Not enough details in the plan to demonstrate actual steps for successful engagement, which could include specific contacts within identified organizations. Applicant would need to demonstrate a plan to establish agreements with relevant agencies.
- Plans for engaging with culturally specific organizations need to be articulated to ensure meaningful relationships are built.
- No clear process for meaningful member input to board and to elevate member voice (to governance), beyond CAC member participation in board. Applicant would need to demonstrate understanding of CAC ORS for membership.

Community Engagement – Community Letters of Support

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

Organization Name	Type
Cornerstone Community Housing	Housing, resident services
Direction Service Counseling	Family Support Agency, Social Support Programs
Eugene Therapy	BH
Homes for Good	Housing and resident services
Lane Independent Primary Providers	Provider Association
McKenzie-Willamette Medical Center	Hospital, Medical Clinic
ODS Community Dental	Dental Clinics
OHSU - ORPRN	Rural Practice-Based Research Network
Options Counseling	BH Provider
Oregon Food Bank	Food, Education, Nutrition
Oregon Medical Group	Medical Clinics, Specialty Providers
OSU Center for Health Innovation	Workforce Development
PeaceHealth	Hospital, Medical, BH, Pharmacy
Serenity Lane	BH, SUD
Shelter Care	BH, Homelessness, Housing
The Child Center	BH, ABA

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 response indicates fully delegating responsibility of the behavioral health benefit to their equity partners. Their global budget strategy of a "ground up" approach is not detailed and, therefore, unclear. Applicant bases behavioral health needs on utilization, rather than prevalence. Applicant confuses monitoring to ensure required services are provided versus monitoring and responding to member utilization needs. As a result, applicant does not provide a plan to address what actions is taken if their monitoring reveals an under or over utilization of a services.

Applicant does not have a strategy for integration of the behavioral health benefit or services. Applicant response is heavily tied to a payment model. Applicant's summary of integration does not detail coordinated efforts or workflows, nor how they will engage CMHPs other than financially.

Applicant frequently references commercial affiliate and plans to mirror their expertise but does not detail or offer examples of the models or processes that are successful. Applicant's lack of detail and examples suggests that the affiliation may not be as solidified as needed for a new CCO applicant to begin offering a benefit package.

Recommendations: Applicant to resume full responsibility of behavioral health benefit. Applicant to detail global budget strategy based on their responsibility of the benefit. Applicant to distinguish between ensuring there are services and monitoring for member utilization needs. Applicant to provide strategies, other than financial, to engage providers and promote service integration and innovation. Applicant to provide detailed examples of commercial affiliate's processes and procedures that will be used or adapted for their work.

Appendix

Scoring Validation

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

Intraclass Correlation: Intra-rater Reliability

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

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

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

Interrater Reliability

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

Overall Reliability Results

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

Applicant Results: Interrater Reliability

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

Poor ICC < 0.5	Moderate 0.5 ≤ ICC < 0.75	Good 0.75 ≤ ICC <0.9	Excellent ≥0.90
3	5	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.

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.

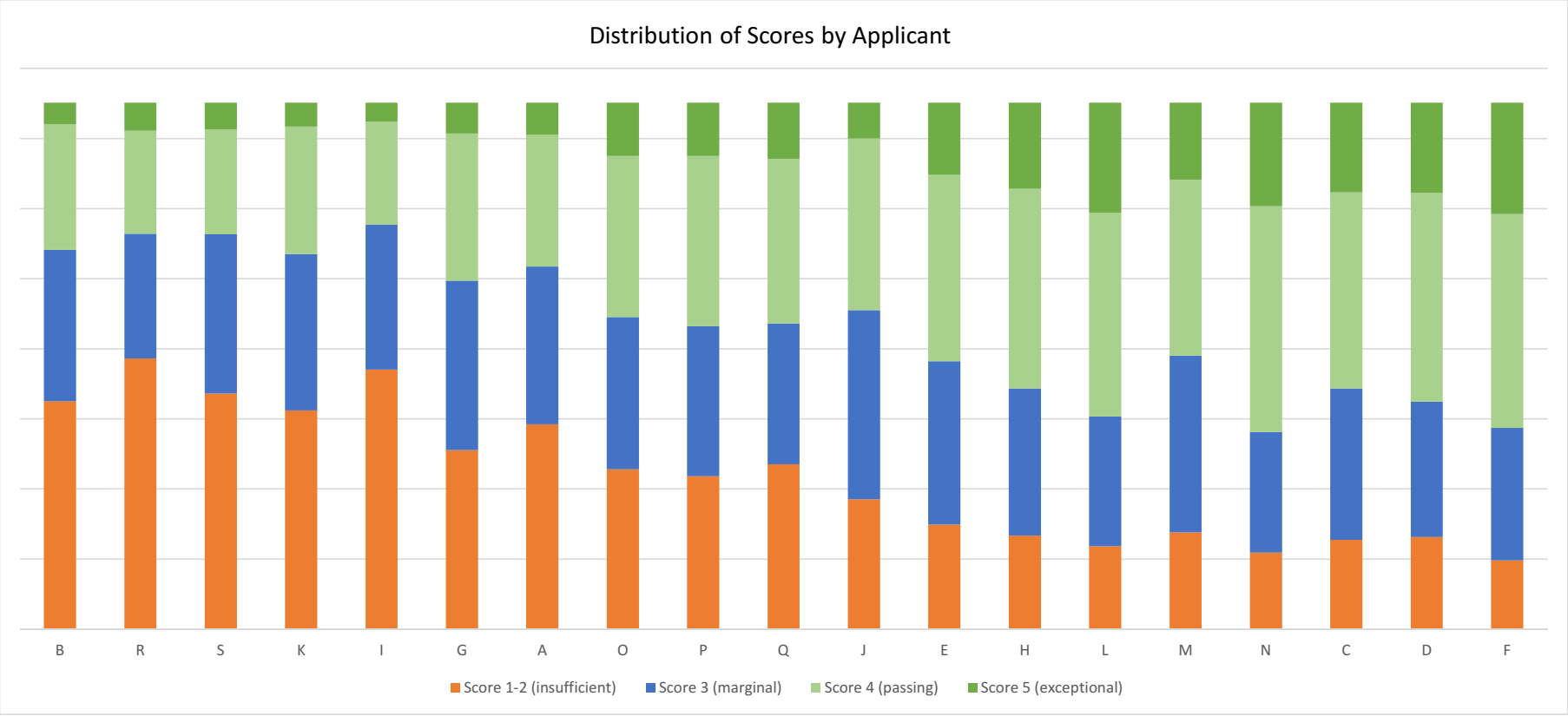
Members with no claims history

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