RFA 4690-19

CCO 2.0
Final Evaluation Report

Applicant K
Yamhill County Care Organization

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

- ASU noted that Yamhill CCO has the risk of potential lawsuit indicated by its high legal accrual $ balance at FY2018 year-end. This has potential financial and operational impact.
- DCBS financial review found that pro forma results appear to be reasonable for projections provided.

Service Area Analysis

- Yamhill CCO is requesting to cover the entirety of Yamhill county, partial Washington county, partial Polk county, partial Marion county, and partial Clackamas county.
- There is a service area exception request to serve the partial counties. Yamhill CCO received passing scores in Business Administration, Care Coordination and Integration, Clinical and Service Delivery, and Delivery System Transformation. They did not pass in the Community Engagement and Finance categories.
- There is low or no risk that Yamhill CCO will be below the enrollment minimum or exceed the enrollment maximum.

Evaluation Results – Team Recommendations

- Finance – Fail; lacked detail across all sections. Understanding of goals, intent, and requirements were not demonstrated. Responses regarding Care Coordination were particularly concerning.
- Business Administration – Fail; limited in detail and indicated gaps in knowledge, technology and process. This includes gaps in FWA processes, technology and general IT knowledge, member transition plans, and policy or processes to access services with languages other than English or Spanish.
- Care Coordination and Integration – Fail; lacked detail in plans for performance monitoring. Did not address, special needs populations, the tribal health system, dual eligible and Medicare Advantage, ODDS, Behavioral health, etc. Applicant described their need for partnership with these populations as "not applicable."
- Clinical and Service Delivery – Fail; responses in these sections were missing detail about subcontractor accountability for BH, communication with members, and long term supports.
- Delivery System Transformation – Fail; missing details about PAs and referrals, quality standards, PCPCH system, and community needs analysis for BH
- Community Engagement – Pass

Community Letters of Support

- 22 letters of support were received from various provider groups and local entities
- Yamhill requested an exception to the Public Presentation with community stakeholders in counties where they are requesting partial coverage

Evaluation Results: Policy Alignment

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

Evaluation Results: Informational Assessment

Yamhill CCO's responses to informational questions scored high in Behavioral Health. The responses scored lower in VBP, Cost, Social Determinants of Health, Business Operations.

Financial Analysis

Division of Financial Regulation

M E M O R A N D U M

May 23, 2019

To: Ryan Keeling

From: [redacted]

Subject: Financial Evaluation of CCO 2.0 Application

Yamhill Community Care Organization

I have performed a financial evaluation for Yamhill Community Care Organization ('CCO') based on the materials provided. CCO filed Certificate of Existence as a nonprofit corporation as of March 22, 2019. CCO is owned, operated and controlled by Yamhill area community and there is no parent company or affiliates. CCO will provide services in all of Yamhill county, and portions of Marion, Polk, Washington, Clackamas, and Tillamook. It was noted that the CCO is applying to service the same areas as previously services based on zip codes.

The CCO entered into Administrative Service Agreements with Performance Health Technology ('PHT'), Ltd. and Providence Plan Partners ('PPP') to provide a multitude of administrative services to CCO. The CCO did not provide how the costs are determined and allocated.

Analyst recommends that the CCO provide how cost is determined and allocated.

The original UCAA workbooks provided by the Applicant were incomplete. On May 16, 2019, Megan Auclair with OHA requested revised UCAA worksheets from the CCO. On May 20, 2019, Mike Brown with CCO provided the updated workbooks. Further review of revised UCAA worksheet, the Analyst notes that the CCO did not provide the capital and surplus prior reporting year (line 39) amount in tab 'UCAA P and L' for BE, MIN, and MAX, thus understating 'Capital and Surplus End of Reporting Year' line 34 and providing the incorrect RBC and other calculations relating to the P & L. Therefore, the Analyst computed beginning capital and surplus to match the 'UCAA Balance Sheet' 'Total Capital and Surplus' line 25 for all assumptions to arrive at the correct ending capital and surplus.

It is worthy to note that under each assumption the CCO included $2.4M in each year for 'Aggregate write-ins for Other-Than-Special Surplus Funds'. Analyst was unable to determine what these amounts are for.

Analyst recommends the CCO to explain the $2.4M Aggregate write-ins for Other-Than Special Surplus Funds.

The 'Company Assumptions' tab provides membership totals for desired service area for years 2020, 2021, and 2022, which is further broken down by Best Estimate ('BE') 100%, Minimum ('MIN') 85%, and Maximum ('MAX') 125% of membership. The CCO states "Minimum membership was set at 85% of the BE of future membership as membership levels below this threshold may warrant financial viability concerns due to serving such a small network." The original request was assumptions to be stressed by BE 100%, MIN 75%, MAX 125% to determine if the CCO financial structure could handle fewer members. Analyst was unable to determine breaking point based on assumptions and stress testing provided by CCO.

Analyst recommends that CCO provide Proforma based on assumptions MIN 75%, or true "breaking point" for membership, unless OHA is sure to grant at least 85% of the "best estimate" enrollment.

Based on the Analyst revised worksheet 'Review_RFA4690-YCCO-Att12 Financial Analysis Workbook Template', the proforma projects BE RBC of 513.5%, 531%, and 549% and capital and surplus of $21.7M, $22.4M, and $23.2M, for year-ending 2020, 2021, and 2022, respectively. The RBC and Capital and Surplus meets the minimum requirement under the BE for each year without being stressed. Review of the Audited Financial Statement for year-ending 2017, the CCO had $11.9M in cash and cash equivalents and $11.6M in investments. The asset portfolio appears to have sufficient liquid assets.

Under all assumptions (BE, MIN, and MAX), the Proforma predicts net income for each year. Non-excessive net losses occurs when stressed with 4% increased claim costs. No single year of net loss after stress testing is deemed excessive. Cumulative net losses are only excessive (14.7% of C & S) when claim costs are increased by 4% under MIN assumption. Under stress testing for 2% and 4%, RBC remains above the 200% RBC threshold.

The CCO appears to have adequate experience and capacity for managing financial risks and establishing financial reserves.

Does the CCO meet the RBC and Capital & Surplus requirements?

Yes. CCO meets the basic RBC, Capital & Surplus, and liquidity requirements under all assumptions and stress testing for 2% and 4% of claims.

Recommendations, Issues, and Additional questions:

- Analyst recommends that the CCO provide how cost is determined and allocated.
- Analyst recommends the CCO to explain the $2.5M Aggregate write-ins for Other-Than Special Surplus Funds.
- Analyst recommends that CCO provide Proforma based on assumptions MIN 75%, if OHA is not prepared to offer at least 85% of the “best enrollment” projection.

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**
299,940	326,602	375,000	255,000	109%	299,940

Capitation Rate				
Applicant Assumption	**Applicant Stated the Rate used**	**Applicant Assumption with 0 Maternity**	**OHA/Optumas Rate Assumption**	**Compare**
$435.23		$454.51	$464.03	-6%

Loss Ratio		
Applicant Assumption	**Recent OHA History**	**Difference**
89%	90%	-1%

Cost Trend	
Applicant Assumption	**OHA Assumption**
2.02%	3.40%

Population Trend	
Applicant Assumption	**OHA Assumption**
1.35%	0.33%

Potential litigation risk

On YCC's FY2018 Exhibit L, it reported $400k's legal accrual at year-end. This is fairly large dollar amount for legal service that's carried out for routine business course. OHA analyst noted this legal service might indicate

potential lawsuit that YCC is engaged in, and if true may potentially impact the organization's business as well as financial situation.

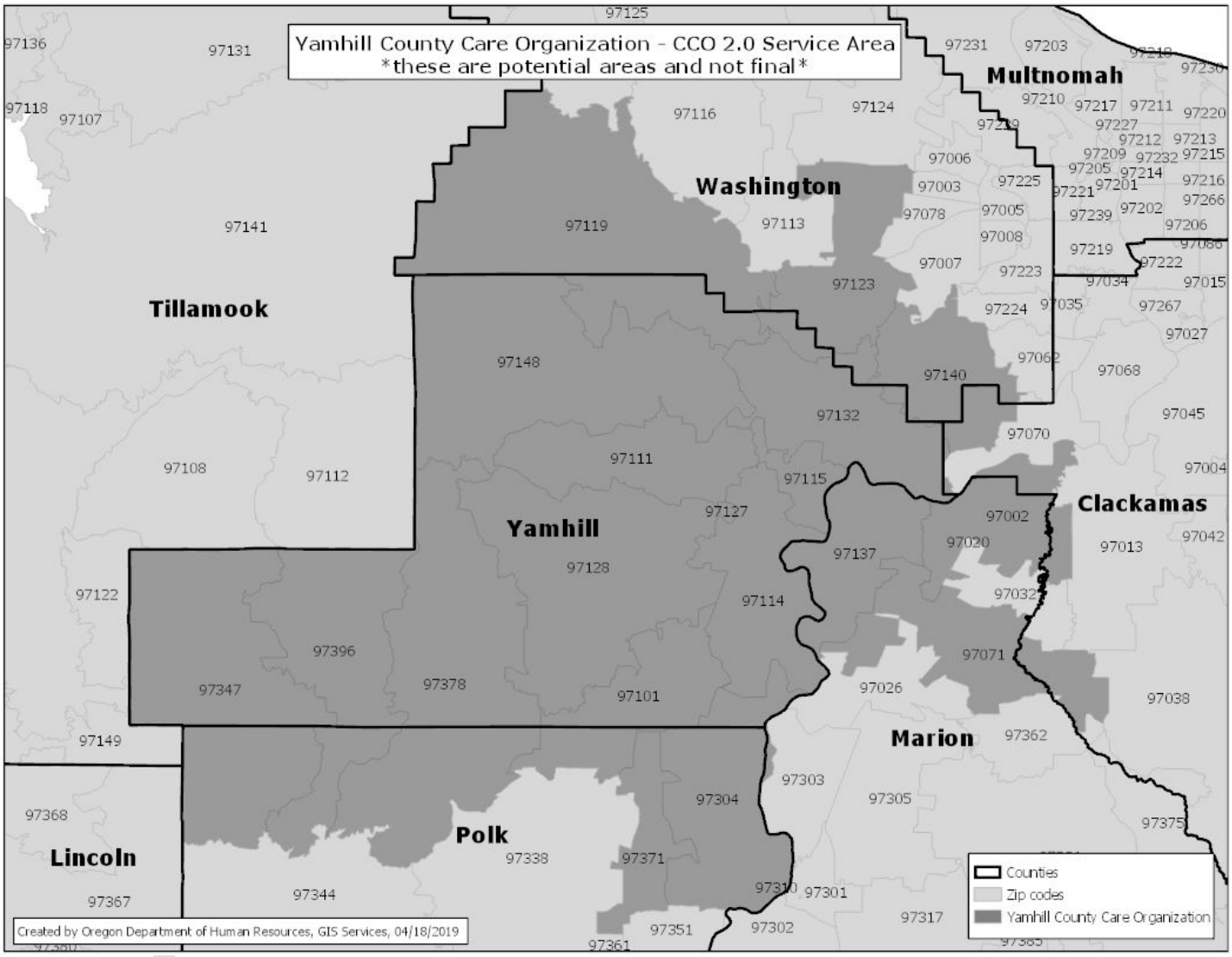
Risk: Potential lawsuit indicated by its high legal accrual $ balance at FY2018 year-end and its potential financial impact or operational impact

Recommendation: Request for audited financial reports for FY2018 to see if the auditors noted any ongoing lawsuit

Service Area Analysis

Requested Service Area

Applicant is requesting to cover the entirety of Yamhill county, partial Washington county, partial Polk county, partial Marion county, and partial Clackamas county.



Full County Coverage Exception Request

Evaluation Team	Scores 1-2	Scores 3
Business Administration	12	18
Care Coordination and Integration	7	23
Community Engagement	10	5
Clinical and Service Delivery	8	25
Delivery System Transformation	4	8
Finance	8	5

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

Enrollment Modeling and Member Allocation Analysis

Minimum enrollment scenario

This model was designed to forecast the likelihood of an Applicant meeting the minimum enrollment threshold as defined in the financial pro formas. The projections rely on overall OHP enrollment by county, the number of Applicants proposing to serve each area, and initial assumptions assume all Applicants are awarded a contract. Alternative scenarios are presented below. The detailed assumptions for this modeling can be found at the end of this report.

Proposed full counties	Proposed partial counties	Service area overlap	Minimum enrollment scenario	Maximum enrollment scenario	Potential risk level
Yamhill	Clackamas, Marion, Polk, Tillamook, and Washington	No other CCO proposing to serve all of Yamhill. Marion Polk Coordinated Care is proposing partial coverage of Yamhill.	No scenarios show enrollment below applicant's minimum.	No scenarios show enrollment exceeding applicant's maximum	Low risk

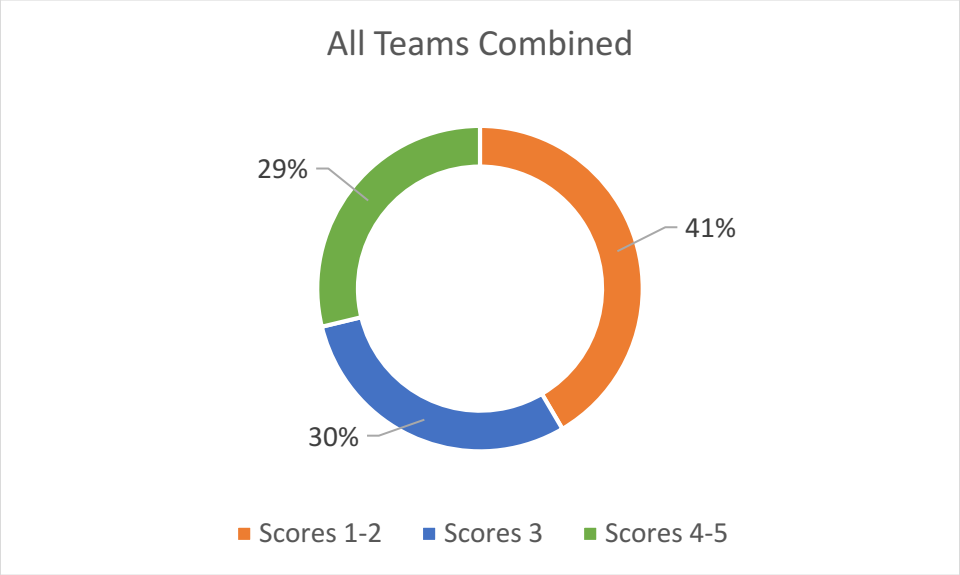
Member Allocation Projection

Based on preliminary matching of the available membership to the Applicant's Delivery System Network submission, Yamhill CCO is likely to receive approximately 26,152 members out of the 21,250 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.

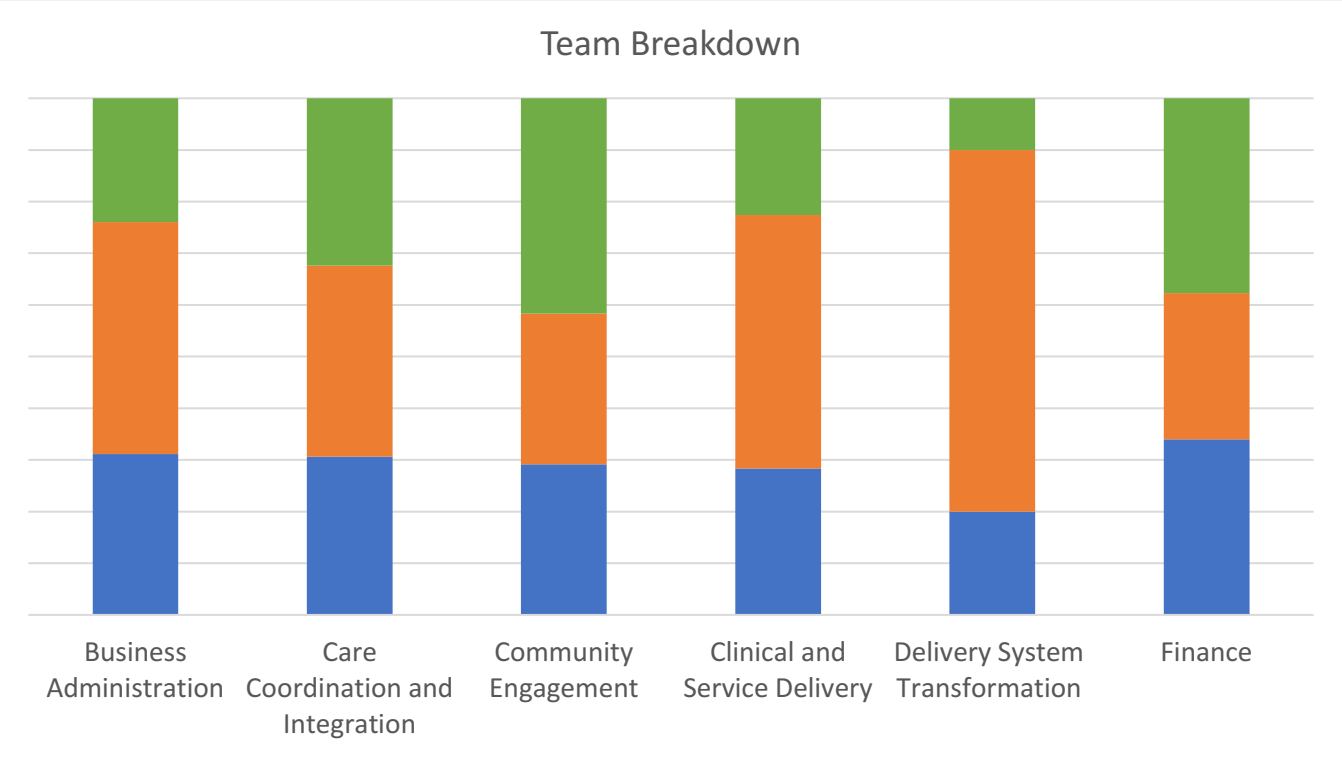
Evaluation Results – Overall Scores

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	X	X
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	FAIL	X		X	
Community Engagement	PASS	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**
Social Determinants of Health	38	29	46
Cost	11	10	13
Behavioral Health	58	59	60
Value-Based Payment	20	9	7
Business Operations	185	116	90

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**
Behavioral Health	13	18	24
Social Determinants of Health	13	14	6
Cost	26	15	16
Business Operations	50	27	20
Value-Based Payment	51	2	3

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
Cost	5	5	8	x		x	
Value-Based Payment	5	8	7	x			
CCO Performance and Operations	5	5	5	x		x	

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

Deficiency Analysis

Cost

Care coordination answers are generally insufficient. Case manager roles were mentioned without connecting these roles to client services. Behavioral health strategy is unclear about whether behavioral and physical health finances will be separated – it is a CCO 2.0 requirement that this not be the case. There is no explanation for how care coordination will drive cost effectiveness.

Value-Based Payment

The PCPCH policy and funding plan may not align with RFA intent. Yamhill stated they would exceed minimum required VBP levels but did not say how. Vague answers leave doubt about what applicant intends to do – frequent mentions of what they "could" or will "potentially" do.

CCO Performance and Operations

Yamhill gave sufficient detail regarding aspects of community benefit. However, HRS strategy, flex services, and program evaluation were all inadequately addressed due to lack of detail. The connection of HRS work to goals of cost, efficiency, and quality improvement were vague.

Team Recommendation: **FAIL**

After considering CCO Performance and Operations, Cost, and Value-Based Payment, the team recommends that Yamhill County Care Organization be given a "fail" for the financial section. Yamhill lacked detail across all sections, to the point that understanding of goals, intent, and requirements were not demonstrated. Responses regarding Care Coordination were particularly concerning for their lack of detail.

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	17	21	25	X		X	
Member Transition	14	20	2	X			
Social Determinants of Health	15	5	8	X			
Health Information Technology	29	6	5	X		X	X

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

Deficiency Analysis

Administrative Functions

For TPL Applicant mentioned OHA contractors but not their own or their own processes. There is no mention of how often Medicare coverage would be checked. There was no description of how Applicant planned to monitor their subcontractors, nor did they describe the business functions of major subcontractors. Large amount of missing detail on the Fraud, Waste and Abuse responses indicating that there might be missing processes or infrastructure. The encounter data responses indicated that the Applicant relies solely on PH tech to validate their claims. There is no mention of how often encounter data is validated, there was no timeline and no processes whereby issues seen could be elevated. There would be a **significant amount of effort** required to remedy all the deficiencies mentioned.

Health Information Technology

There are large amounts of missing information in this section and some questions were not addressed at all. Roadmap to EHR adoption was unclear with very high-level detail only. There was no plan for years 1-5 and no strategy mentioned. Technology gaps are likely, due to very minimal information on how Applicant would implement EHR or any other HIT process. Applicant named “increased risk” as an insight produced by the population health data indicating a lower level understanding of how population data can be used. There were minimal plans for including SDOH data into the VBP model and Applicant indicated they stored their data in “secure folders” indicating some more serious technological concerns. The missing processes, plans, technology and knowledge would take a **significant amount of effort** to remedy.

Member Transition

Several questions were missed and many of the responses are too high level and don’t adequately describe the processes in place for transferring and receiving members. There is a lot of detail missing about data reception specifically. The missing detail indicates that processes surrounding the transfer and receiving of

new members may be under-developed or lacking altogether. The missing processes and procedures would take a **significant amount of time** to remedy.

Social Determinants of Health

There is missing detail on the monitoring of health equity and health equity training. Only one subcontractor was mentioned as providing language services in Spanish however there are many more languages that would need to be accommodated. Applicant plans to hire a public relations firm to communicate with members but no mention of how they will hold this subcontractor responsible. Applicant lists a non-discrimination policy as addressing health equity issues. Work force diversity was not addressed, and it appeared they could benefit from education in this area. Applicant did not submit a plan for traditional health care workers as they stated that their case managers handled this work. This indicates a misunderstanding of the difference between case managers and traditional health care workers.

Team Recommendation: **FAIL**

- Answers provided were largely limited in detail and indicated a high likelihood that there were gaps in knowledge, technology and process.
- Administrative function responses were missing a large amount of detail for FWA processes and indicated that there may be missing underlying processes or infrastructure. Applicant appeared to have no internal processes for validating encounter data, missing detail on frequency of validation and how issues are elevated. These deficiencies would require a **moderate amount of effort to remedy.**
- For the HIT section, there was a large amount of detail missing, and responses indicated that vital databases were stored in secure folders indicating gaps in technology and general IT knowledge. Responses also indicate that the Applicant could benefit from education in how to utilize population health data. These deficiencies would require a **significant amount of effort to remedy.**
- There are large amounts of information missing in the member transition section indicating that underlying processes and procedures may be missing. These deficiencies are thought to require a **significant amount of effort to remedy.**
- The SDOH-HE section contains high level responses that indicate a lack of policy or processes to access services with languages other than English or Spanish. The responses also indicate that Applicant could benefit from education on diversity and traditional health care workers. The missing policies, processes and infrastructure for traditional health care workers would require a **significant amount of effort to remedy.**
- The limited amount of detail and number of missing responses combined with multiple sections needing significant effort to correct led to a team recommendation of FAIL.

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 Covered Services	1	13	22	X			
Care Integration	7	3	11	X		X	
Behavioral Health Benefit	5	3	4		X	X	
Care Coordination	40	21	15	X		X	
Health Information Exchange	11	13	4	X		X	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 included no discussion or plans to mitigate gaps in provision of covered services. Roles and responsibilities of CMHPs lack detail or are undefined and no milestones or dates have been provided.

Behavioral health covered services responses were generally well received. Applicant failed to provide detailed information about housing for SPMI population. Member involvement in transition planning was unclear. Concerns were identified regarding partnership/people overseeing Children's System of Care.

Applicant's ability to support Health Information Exchanges (HIE) was not clearly demonstrated. There appeared to be a significant lack of understanding in the level of technical assistance that OHA provides for this work. HIE tools described by the applicant were focused on CCO-to-provider sharing and not provider-to-provider sharing. Applicant demonstrated a misunderstanding of the role of PreManage as well as key concepts of HIE, and failed to provide well developed future plans for growth in this area. Resolution of these issues is **expected to be a heavy-lift** but is believed to be possible.

Team Recommendation: **FAIL**

Care integration responses lacked detail in plans for performance monitoring. Applicant was not clear on how a successful transition would be ensured, or how a member would be involved in that transition. No detail was provided on how care for special needs populations would be coordinated. Reviewers identified this deficiency as being a **heavy-lift to resolve**. Responses provided in this section lacked detail and understanding of the importance of the tribal health system.

Care coordination responses failed to provide any information on the dual eligible and Medicare Advantage populations. Reviewers were concerned to see the applicant describe their need to describe partnership with these populations as "not applicable." No specific relationships were described with ODDS. No clear approach was provided regarding the Behavioral health pipeline. Applicant provided limited detail on process for tracking, screening, follow ups, use of culturally appropriate materials, and engaging families in transition planning for specific populations. In most responses this applicant failed to include consideration for populations with Developmental Disabilities, health disparities and Intensive Care Coordination.

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 Covered Services	30	30	24	X		X	
Behavioral Health Benefit	14	11	8	X		X	
Service Operations	25	11	10				
Administrative Functions	33	7	5	X		X	

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

Deficiency Analysis

Administrative Functions

In general, the responses in this section were missing a moderate amount of detail. Physical, behavioral and oral health providers were not addressed separately. The Applicant did not use the grievance and appeal system to monitor the correct application of medical necessity criteria and there was no mention of how they monitored subcontractors' notice of adverse benefits (NOABs). There appear to be no accountability mechanisms present and only a manual monitoring process is described – once a year or ad hoc only. The team estimates that the level of detail missing from the responses provided indicate there are **moderate to large deficiencies that need to be remedied**.

Behavioral Health Benefit

There was a moderate amount of detail missing from some questions in this section. The Applicant states that they don't own the BH benefit so they don't address the concerns of delegation at all. There was no information on barriers to warm handoffs. In general, it seems like this section was lacking detail and a good plan. The deficiencies in this section would require a **moderate to large amount of effort to address** as the relationship between the Applicant and subcontractor managing BH services would need modification.

Behavioral Health Covered Services

The responses in this section were lacking detail and there were a lot of typos and acronyms were misspelled. The Applicant still has a risk accepting entity that they are contracting with – Applicant states they monitor subcontractor with complex reporting, but no detail provided. The responses are subcontractor-centric – Applicant defers to the subcontracted County on all BH matters ("the County handles that"). It is clear that that Applicant did not coordinate with the County on most of these responses as they are missing a lot of detail. The responses were also too adult-centric, there was not a lot of

information about children, families or peers. Applicant appears to misunderstand what cultural and linguistic competence is and uses the wrong acronym for LGBTQ. For the hospital questions, Applicant focuses on ER departments only and all other hospital services are not mentioned. For children 1-5, PCIT or any other didactic therapy is not addressed. Complex case management is not addressed. The insurance component of the covered services questions is not addressed. The Applicant doesn't describe how Wraparound is monitored or how survey response rate of 35% in tracked. There is no description of how members know they are being enrolled in CC, or how Applicant is identifying unengaged members. It appears as if there is an assessment for new members, but no timelines are mentioned. Applicant communication strategies need review. The missing information in this section, continual references to subcontractor for BH matters and frequent typos and misspelled acronyms and demonstrated misunderstanding of cultural and linguistic competence, suggest that this Applicant was not familiar with the BH services it manages. The deficiencies in this section are estimated to take a **moderate to large effort to remedy** as they would require a more integrated approach to care and care coordination.

Service Operations

The responses in this section were missing some detail. There was no plan for communicating with members on pharmacy benefit; hospital services- need more detail on all points esp. on processes – they only say that they talk with member; the utilization management responses are missing detail about the prior authorization and other processes. Applicant did not distinguish between utilization for acute or ambulatory care; the responses for DH/LTSS services does not seem that they have much involvement with members in LTSS – answers were confusing. The deficiencies identified in this section would require a **light to moderate amount of effort to remedy** depending on whether there are missing processes or other infrastructure.

Team Recommendation: **FAIL**

- In general, the responses in these sections were missing detail. For the BH sections, the missing detail, references to their subcontracted County for the information, demonstrated misunderstanding of cultural and linguistic competence and misspelled acronyms raised question of credibility.
- There were multiple sections requiring **moderate to high level of effort** to remedy. The relationship between the Applicant and its County, who is subcontracted to provide BH services, with no apparent accountability, seemed most prominent. Team members also indicated that poor communication with members and a superficial understanding of LTSS services, played a role in their recommendation.
- The quality of the responses and multiple areas needed a **moderate to large amount of effort to remedy,** 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
Accountability and Monitoring	12	5	1	X		X	
Delivery Service Transformation	9	1	2	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 standards and expectations are communicated and enforced with providers and sub-contractors. 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, specifically how data is used to improve care and delivery of services. Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination.

CCO Performance - Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services, 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).

Transforming Models of Care – Applicant's response is lacking detail overall. Applicant failed to provide details describing PCPCH, specifically information about members outreach strategies.

Team Recommendation: **FAIL**

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

Accountability and Monitoring

- Lack of details on how referral process and PA process facilitates continuity and coordination of care

- Missing details on process for implementing and communicating quality standards
- Missing details on how applicant supports health system and provider networks on quality programs to improve quality care

Delivery Service Transformation

- Lack of details on PCPCH system including engagement of providers and oversight of PCPCH system
- Missing details on applicant's role for ensuring BH access services, including oversight of sub-contractors
- Missing community needs analysis for behavioral health

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	7	11				
Community Engagement Plan	18	16	26	X		X	
Governance and Operations	10	10	10	X	X		
Community Engagement	5	2	3	X		X	

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

Deficiency Analysis

- Missing minor and major components of Community Engagement Plan – the was not a CAC for each of the counties in the Applicant's service area and the CHA/CHP was missing entirely.
- Little detail on what current levels of engagement are, what the barriers are or what relationships need to be established.
- Housing is not mentioned as an important partner Applicant needs to engage with.
- More detail needed on how communication will work between the CAC and non-CAC members
- More detail needed regarding accountability of board decisions based on CAC recommendations
- Does not explain how they'll use Quality Improvement for the CEP, response simply states they'll do it
- SDOH-HE - Clear process needed for establishing SDOH priorities in the community, that is transparent and equitable and process for sharing project outcomes as well.
- Unclear process for recruiting diverse members, unclear if selection committee of CAC meets ORS
- Unclear if alignment between CHP and HRS/CBI spending or how the CAC is involved besides receiving a report.
- Unclear whether outreach occurs for all members, not just those receiving care
- Missing info on how providers were involved in the application, only public providers inside Yamhill county are mentioned and have agreements with the Applicant, **even though service area extends beyond Yamhill county.**

Team Recommendation: **PASS**

- Recommendation to receive comprehensive OHA technical assistance
- Create clear process for establishing SDOH priorities in the community and for sharing project outcomes and ensure housing spending is included in SDOH spending
- Develop a robust process for CAC recruitment among diverse communities and ensure that it meets ORS requirements
- Develop a robust plan for engaging community in decision making both within and beyond CAC
- Develop outreach strategies for all members—not just those receiving care—including strategies that are culturally and linguistically appropriate
- Establish process for aligning HRS CBI spending with CHP, and for the CAC's involvement

Community Engagement – Community Letters of Support

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

Organization Name	Type
Amity Elementary School	Education
CAC Member 1	CAC Member
CAC Member 2	CAC Member
CAC Member 3	CAC Member
CAC Member 4	CAC Member
CAC Member 5	CAC Member
Capitol Dental	Dental Clinics
Community Connections of Yamhill County LLC	Speech language pathology
Dayton Grade School	Education
Linfield College Education Department	Early Learning Council
McMinnville Public Library	Public Library
Newberg Public Schools	k-12 education
Paul Kushner	YCCO Board Member
Providence Newberg Medical Center	Hospital, Medical Clinics
Sheridan School District	k-12 education
Sunrise Family Clinic	Medical Clinic
Virginia Garcia Memorial Health Center	Medical Clinics
Willamette ESD	k-12 Education, supports
Willamette Valley Medical Center	Medical Clinic
Yamhill Carlton Elementary School	k-12 education
Yamhill County Health and Human Services Department	Community Support Services, Family and Youth Services, Public Health, Veteran and Disability Services

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 states they manage the budget holistically based on utilization. Applicant does not discuss holding responsibility for this and inability to fully delegate. Thus, it is unclear how the behavioral health strategy meets requirements NOT to separate finances for behavioral health and physical health; did not seem to understand the CCO 2.0 goals to ensure that BH services were not limited by financial setup.

Additionally, Applicant delegates to CMHP; their response lacks details on applicant's role for ensuring access to behavioral health services versus delegated entity.

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
4	6	2	0

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

Team Analysis Meetings

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

Monte Carlo Enrollment Modeling – Full Methodology

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

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

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

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

How to read this memo

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

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

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

Considerations

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

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

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

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

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

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

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

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

The simulations also rely on:

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

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

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

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

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

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

Open-card enrollees are included above.

Comparing July 2018 enrollment data to March 2019

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

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

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

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

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

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

Member Allocation Methodology

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

Provider Type

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

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

Lookback Period

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

Excluded Claims

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

Provider Matching Process

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

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

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

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

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

Members with no claims history

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

Full County Coverage Exception Request

YCCO's service level is all of Yamhill County and portions of Marion, Polk, Washington, Clackamas and Tillamook Counties. The portions of these counties are associated with contiguous zip codes that are shared with Yamhill County and are aligned with patient utilization patterns. The original round of CCO contracts established service areas based on zip codes rather than county lines which is one of the reasons YCCO's service area shares zip codes with neighboring counties. Solid utilization pathways for Members in these zip codes have been developed and disruption of continuity of care for Members would happen if YCCO did not apply for the same service area. Retaining these contiguous zip codes in the YCCO service area is critical for continuity of care and coordination of services.

Serving less than the full contiguous counties will allow the Applicant to achieve the transformational goals of CCO 2.0 (as described in this RFA) more effectively than county-wide coverage in the following areas:

- Community engagement, governance, and accountability;
- Behavioral Health integration and access;
- Social Determinants of Health and Health Equity;
- Value-Based Payments and cost containment; Financial viability;

YCCO's proposed service area is the same service area YCCO has served since 2012. In rural communities, Members often travel across county lines to receive services. The Members in these contiguous zip codes who choose YCCO as their coordinated care organization do so because some or all of the services they receive are in Yamhill County. The vast majority of YCCO providers: primary care, dental care, behavioral health care, hospital and specialty practices are in Yamhill County. These providers are well represented on YCCO governance committees. Community members from across the full-service area including in contiguous zip codes participate on the Board of Directors and/or on one of the YCCO committees such as the Community Advisory Council, Early Learning Council, Quality and Clinical Advisory Panel, or Community Prevention and Wellness Committee. YCCO has a history of engaging with community members across its current service area through early learning services, trauma informed care trainings, Member 101 classes, parenting education classes. The 2018-9 CHA and CHIP work has determined needs and priorities for the full-service area when possible, not just Yamhill County.

YCCO's major behavioral health partner, Yamhill County Health and Human Services (YCHHS) has mental health and addiction treatment centers in Newberg and McMinnville and is well integrated across the service area including having mental health providers embedded in schools in all of the school districts in Yamhill County. YCHHS partners with YCCO in making social determinant investments that impact every part of the service area investing in programs like peer support, supportive housing, needle exchange programs, the PAX Good Behavior

Game (a social-emotional behavioral modification intervention for K through sixth grade), employment services, and clinical innovations including integrating BH and MH in primary care clinics as well as integrating PH and DH in the two mental health clinics.

The vast majority of YCCO providers: primary care, dental care, behavioral health care, hospital and specialty practices are in Yamhill County. YCCO has a solid relationship with these providers and has established value-based agreements with 36% of the provider network including primary care quality payments, primary care APM payments, and payments for dental and hospital quality metrics.

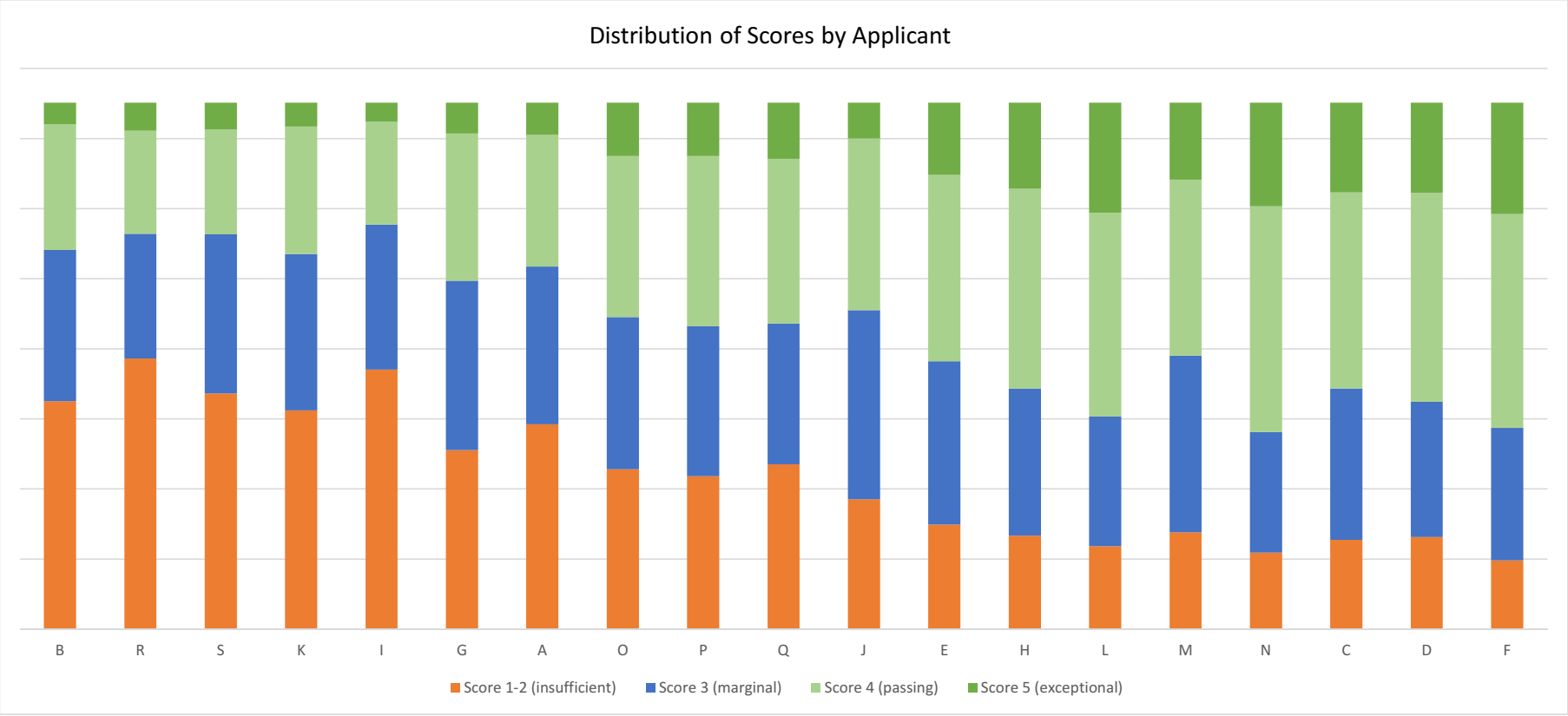
Serving less than the full additional counties provides greater benefit to OHP Members, providers, and the community. YCCO is only applying for portions of neighboring counties due to shared zip codes with those counties; YCCO's service area is well established with an engaged provider network. This service area aligns with Member utilization patterns. The application for this service area is not designed to minimize financial risk, does not create adverse selection and is not an effort to red-line high risk areas. Maintaining YCCO's current service are is critical for continuity of care.

Service Area Table County **(List each desired County separately)**	**Maximum Number of Members- Capacity Level**
Clackamas	100
Marion	100
Polk	2,300
Washington	2,075
Yamhill	24,403

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