OREGON HEALTH AUTHORITY

Actuarial Services

Medicaid Independent Review Report

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ACTUARIAL REPORT

Lewis & Ellis, Inc.

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EXECUTIVE SUMMARY

OHA requested L&E to perform an independent actuarial review of the 2018 Medicaid capitation rate development methodology. L&E will opine as to whether the methodology is actuarially sound (including compliance with all applicable Actuarial Standards of Practice, also called ASOPs) and is executed in a manner that is consistent and unbiased across all Coordinated Care Organizations (CCOs).

The CY2018 rates were developed in a similar methodology as CY2017 rates. Optumas certifies to rates by CCO-type, Category of Aid (COA), and CCO. Rates are developed by region with CCO-specific rating for certain benefits. Utilizing regional rating helps with credibility of the base data, especially since most of the state can be considered rural.

For both CY2017 and CY2018, the target profit and risk/contingency margin was 1.5%. In 2014 and 2015, all regions saw figures in excess of these targets. The 2016 financials appear to be more in line with expectations, with the total profit margin equaling 1.4%.

L&E recognizes that OHA is not fully responsible for the financial success of each CCO; however, L&E believes it is a prudent exercise to evaluate the overall health of each CCO's Medicaid business. If not already a part of the capitation rate development process, L&E recommends that recent loss ratios, non-medical load ratios, and profit margins be considered during the capitation rate development process.

Beginning in 2016, Optumas and OHA recognized that the annual rate of growth had outpaced national averages. For CY2018, if a CCO experienced increases greater than 7%, then the CCO's base data was investigated.

L&E's recommended range is 7.0% to 9.0%. Optumas' description of the 7% derivation uses a more sophisticated calculation of the uncontrollable costs, but does not appear to account for trend data and the changes in rates of growth by CCO. It should be noted that the 7.0% is within L&E's range. Also, looking at the rate of growth by CCO for 2015 to 2016, there are several CCOs that have rates of growth between 7% and 8% with a gap until nearly 10%. Setting the threshold at 8% could have better recognized the decline in rate of growth and better isolated outliers.

With regard to the reduction of the base data during the Reimbursement Review, L&E:

- Reviewed the reductions in the base data due to incentive payments.
- Analyzed the professional per capita reimbursement amounts for outlier CCOs.
- Compared the claim level reimbursements for professional services in the Tri-County region.

The analysis resulted in the following recommendations and observations:

- The first CCO operates in the Southwest region and had a significant increase in the reported incentive payments, accompanied with a drastic increase in the blended professional reimbursements for 2016. Upon further investigation, the increases appear to be due to the Child 6-18 professional reimbursement increases. L&E recommends that further analysis and research be performed on this perceived rate cell outlier.
- The second CCO operates in the Tri-County region and had a decrease in the blended reimbursements for 2016 and a decrease in the reported incentive payments. L&E evaluated the

reimbursements at the claim level for the entire Tri-County region. It was determined that this CCO had higher professional reimbursements.

These 2 CCOS had the highest blended per capita reimbursements in 2016 for professional services when compared to the other 8 CCOs with high rates of growth.

L&E agrees with the use of a threshold to isolate outliers, as it creates an unbiased method for flagging CCOs to investigate. Optumas appeared to be meticulous in its investigation of each CCO's reimbursements and expenses through the analysis of the financial templates and claim level detail.

In L&E's opinion, Optumas follows generally accepted actuarial principles in the development of the rates, meaning that the methodology appears to be actuarially sound. Optumas performed detailed analyses of the data and spent a significant amount of time with each CCO understanding their financial templates and base data.

L&E recommends that further investigation and research be performed on a perceived outlier in one rate cell for a CCO operating in the Southwest region. L&E believes this was an oversight rather than a methodology flaw due to the complex nature of this analysis. L&E is unable to determine the impact, if any, this could have on rates.

Despite this finding, Optumas did not appear to isolate a particular CCO and perform additional analysis with the intent to reduce their rates. Additionally, the 7% threshold was not set to ensure that a particular result occurred. L&E's range recommends a slightly higher threshold; however, setting a higher threshold would not likely have a material impact on rates. Therefore, it is L&E's opinion that the methodology is executed in a manner that is consistent and unbiased across all CCOs.

L&E found the documentation surrounding the Reimbursement Review to be insufficient to properly communicate the changes of the reimbursement review, the analyses performed, and conclusions drawn. L&E recommends that further documentation be provided to adequately document the changes to ensure that intended users (i.e. CCOs) and other qualified actuaries are able to perform an objective appraisal of reasonableness. Optumas should work to improve its documentation across the entire capitation rate development process and communication on key deliverables.

REVIEW OF OREGON'S MEDICAID CAPITATION RATE DEVELOPMENT

Background

On October 18, 2017, the Oregon Health Authority (OHA) issued a Request For Quote (RFQ) to perform an independent actuarial review of the 2018 Medicaid capitation rate development methodology. At the end of October, Lewis & Ellis, Inc. (L&E) was awarded the contract to perform this work for OHA. L&E began work immediately with a final deliverable date of November 30, 2017.

Scope of Work

OHA requested L&E to perform an independent actuarial review of the 2018 Medicaid capitation rate development methodology. L&E will opine as to whether the methodology is actuarially sound (including compliance with all applicable Actuarial Standards of Practice, also called ASOPs) and is executed in a manner that is consistent and unbiased across all Coordinated Care Organizations (CCOs). If material issues are found, then L&E will provide recommended changes to the methodology to address the issues. OHA has provided a definition of materiality as seen in the CMS final rule under 42 CFR 438.2, which defines a material adjustment in terms of the actuarial review as a guideline for L&E's review.

> "Material adjustment means an adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices."[1]

L&E was instructed to review the implementation of various state policy decisions and not the policy decision itself. Under specific sections, if more detail is needed regarding direction, L&E will provide a detailed explanation of the expectations of the review.

OHA's contracted actuary is Optumas. Therefore, the commentary and recommendations throughout the report will be addressed to both OHA and Optumas.

Data Received

OHA provided L&E with all the data files and information. The list of items received from OHA will be outlined in Appendix B. Throughout the engagement, Optumas provided additional information and insight through phone calls and written responses to L&E's questions.

Methodology

The CY2018 rates were developed in a similar methodology as CY2017 rates. Optumas certifies to rates by CCO-type, Category of Aid (COA), and CCO. Rates are developed by region with CCO-specific rating for certain benefits. Utilizing regional rating helps with credibility of the base data, especially since most of the state can be considered rural.

[1] 42 CFR 438.2 - https://www.law.cornell.edu/cfr/text/42/438.2

Region	Member Months[2]
Eastern/Central	1,511,462
Northwest	2,343,774
Southwest	2,654,253
Tri-County	4,042,105
Total	10,551,594

The development of rates by area/region is a common practice. L&E will review the various components of the rating methodology.

Base Data

The base data utilized by Optumas was outlined in the CY2018 Rate Certification and seen below:

- "CY16 detailed dental encounter data (incurred 1/1/2016 – 12/31/2016) provided by OHA. This data is paid through June 30, 2017 and was used in the development of the Dental rates.
- CY16 detailed CCO encounter data (incurred 1/1/2016 – 12/31/2016) provided by OHA. This data is paid through June 30, 2017.
- CY16 eligibility file provided by OHA. This data contains monthly, member-level enrollment information such as enrollment status, CCO enrolled, county of residence, and category of aid.
- CY16 Pharmacy Supplemental Template and emerging CY17 experience submitted by CCOs to assist in informing HEP-C adjustment and pharmacy trends.
- CY16 financial templates (incurred 1/1/2016 – 12/31/2016) as reported by each CCO. These financial templates were provided by each CCO and contain enrollment volume and medical costs, inclusive of encounterable costs, sub-capitated arrangements, and additional incentive payments made to providers outside of the encounter data, including costs related to flexible services. This data is paid through March 31, 2017."[3]

The use of CY2016 encounter and financial data is appropriate for the CY2018 Capitation Rate Development. Additionally, Optumas utilized other data sources to develop a complete picture of the anticipated services and population to be covered in 2018. Optumas made several base data adjustments, including:

- Reimbursement Review
- Other Base Data Adjustments
- Program Changes/Rate Add-Ons

Review of the Financial Templates

The financial templates, reported by the CCOs, were provided for 2014 through 2nd quarter 2017. These financial templates are reconciled to the CCO's audited financial statements. The 2016 financials were used to validate the encounter data, program changes/rate add-ons, and other data throughout the review process.

The loss ratios by region and in total have been increasing over the last several years. Both the Northwest and Tri-County regions have higher loss ratios than the Eastern/Central and Southwest regions.

[2] CY2018 Rate Certification, page 5; Note that these member month figures differ from Exhibit L, Report 12 and the Rate Models
[3] CY2018 Rate Certification, page 8

Additionally, while not federally required, some states have adopted a minimum MLR of 85% for its Medicaid population. There are several regions (and CCOs) that have had loss ratios less than 85%. Optumas appears to be targeting between 89.5% and 90.6% for CY2018. These are slightly increased from CY2017, which targeted between 88.2% and 90.3%. However, loss ratios in certain regions are much lower than these targets.

Loss Ratios			
Region	**2014[4]**	**2015[5]**	**2016[6]**
Eastern/Central	83.7%	84.3%	84.3%
Northwest	88.6%	88.7%	91.9%
Southwest	80.0%	84.7%	88.4%
Tri-County	87.7%	88.3%	91.2%
Total	85.3%	86.8%	89.6%

As expected, the profit margins, before federal income tax, have been reducing over this same time period. Again, certain regions have experienced higher profit margins than what was targeted in the rate certification reports.

Profit Margins (before federal income taxes)[7]			
Region	**2014**	**2015**	**2016**
Eastern/Central	7.8%	6.1%	5.4%
Northwest	4.8%	4.5%	0.7%
Southwest	9.2%	5.7%	3.0%
Tri-County	4.5%	2.0%	-1.1%
Total	6.3%	4.2%	1.4%

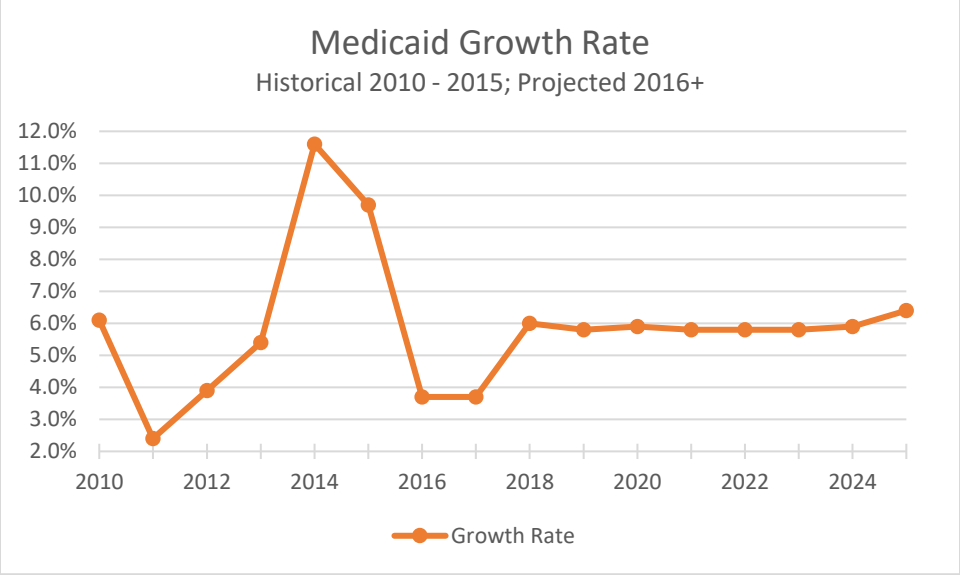
For both CY2017 and CY2018, the target profit and risk/contingency margin was 1.5%. In 2014 and 2015, all regions saw figures in excess of these targets. The 2016 financials appear to be more in line with expectations, with the total profit margin equaling1.4%. To understand the complete picture, the non-medical loadings should be considered. Non-Medical Loadings are discussed in a later section.

L&E recognizes that OHA is not fully responsible for the financial success of each CCO; however, L&E believes it is a prudent exercise to evaluate the overall health of each CCO's Medicaid business. If not already a part of the capitation rate development process, L&E recommends that recent loss ratios, non-medical load ratios, and profit margins be considered during the capitation rate development process.

[4] Loss Ratio = 2014 Exhibit L, Report L8 OHP Total Member Services / 2014 Exhibit L, Report L8 OHP Total Operating Revenues
[5] Loss Ratio = 2015 Exhibit L, Report L8 OHP Total Member Services / 2015 Exhibit L, Report L8 OHP Total Operating Revenues
[6] Loss Ratio = 2016 Exhibit L, Report L6 OHP Total Member Services / 2016 Exhibit L, Report L6 OHP Total Operating Revenues
[7] Profit Margin = (Revenue less Benefits less Non-Medical Loading) / Revenues

Reimbursement Review

Beginning in 2016, Optumas and OHA recognized that the annual rate of growth had outpaced national averages. The national trends in the chart below are based on the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, data for National Health Expenditures in the Medicaid program[8]:



The chart above shows the historical growth rates for nationwide Medicaid spending from 2010 to 2015. Years 2016 and beyond reflect CMS' projection of the Medicaid growth rates. Increased rates of growth are seen for 2014 and 2015, in conjunction with the implementation of the Affordable Care Act (ACA). CMS projected lowered rates of growth in 2016 and 2017 and rates returning to a steady state from 2018 on.

With the rising costs of Medicaid spending seen by the CCOs, OHA implemented a reimbursement review policy during the CY2017 Capitation Rate Development cycle. This review continued during the CY2018 rate cycle. L&E was asked to opine on the following with regard to the CY2018 rate cycle:

- Use of 7% threshold being the defining target for CCO based data investigation.
- If the methodology employed was in line with generally accepted actuarial principles and applied equitably across all CCOs.

[8] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

USE OF THE 7% THRESHOLD FOR CY2018 CAPITATION RATE DEVELOPMENT CYCLE

CY2017 Capitation Rate Development Cycle

During the CY2017 capitation rate development cycle, the rate of growth by CCO from 2014 to 2015 ranged from -2.6% to 27.3%. The average rate is line with the national growth rate for 2015 of 9.7%.

Statistics	2014 – 2015 Rate of Growth[9]
Minimum	-2.6%
Maximum	27.3%
Average	9.1%
Weighted Average[10]	8.6%
Median	9.2%

Based on these results, OHA requested that Optumas investigate the primary drivers of these rates of growth. The drivers of increased costs per member from 2014 to 2015 were driven by:

- Increased reimbursement to providers between 2014 to 2015 for specific CCOs
- Surplus payouts to providers (incentive payments) for specific CCOs
- Increased pharmacy costs (both generic and brand) affecting all CCOs
- Increased A/B hospital costs for specific CCOs[11]

OHA concluded that "for CCOs that were outliers and above a sustainable growth, and also had increased reimbursement from 2014 to 2015 – adjustments were made in claims level reimbursement and/or incentive payments."[12] Therefore, a CCO did not see an adjustment to their underlying base data, used to develop the regional rate, if it had increases beyond their control due to increased pharmacy costs or A/B hospital costs.

CY2018 Capitation Rate Development Cycle

During the CY2018 capitation rate development cycle, the rate of growth by CCO from 2015 to 2016 ranged from -8.7% to 21.3%. The range of trends decreased from the prior cycle but not as significantly as the projected national trends dropped (from 9.7% to 3.7%).

Statistics	2014 – 2015 Rate of Growth[13]	2015 – 2016 Rate of Growth[14]
Minimum	-2.6%	-8.7%
Maximum	27.3%	21.3%
Average	9.1%	7.7%
Weighted Average[15]	8.6%	8.8%
Median	9.2%	7.0%

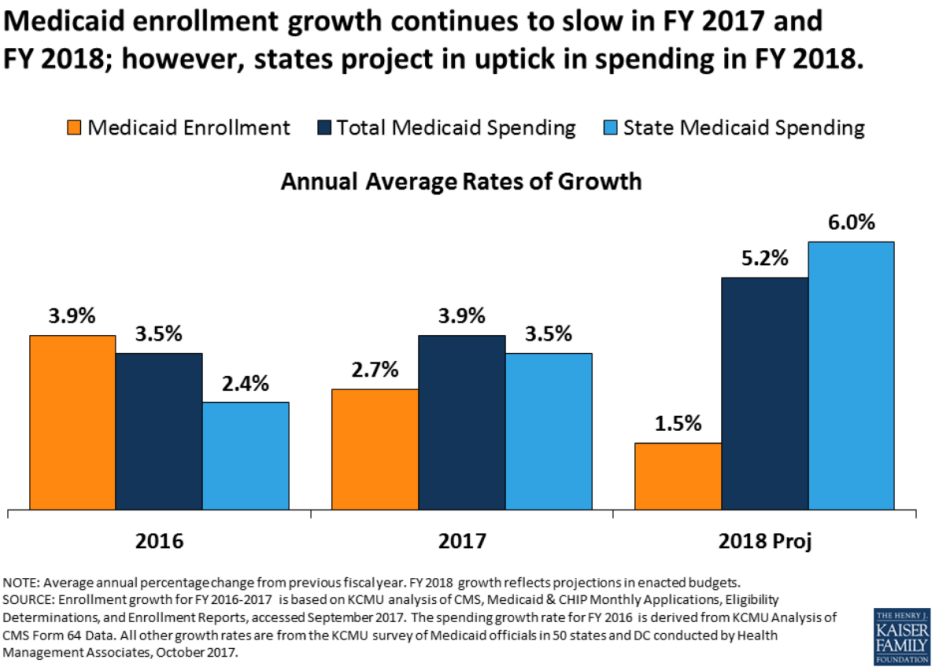
[9] OR CY17 Rates – Appendix VIII Reimbursement Policy
[10] As reported by Optumas on page 2 of OR CY17 Rates – Appendix VIII Reimbursement Policy
[11] OR CY17 Rates – Appendix VIII Reimbursement Policy
[12] Ibid.
[13] OR CY17 Rates – Appendix VIII Reimbursement Policy
[14] OR CY18 Rates – Appendix VIII Reimbursement Policy
[15] As reported by Optumas on page 5 of the "2018 Rate Development Update"

A similar policy was adopted from CY2017 into CY2018 to modify underlying base data by CCO. In CY2018, if a CCO experienced a rate of growth greater than 7%, then the CCO's base data was investigated.

In discussions, Optumas explained how the 7% was developed for the CY2018 Rate Development cycle. There were 3 components plus the sustainable rate of growth that created a range around the 7%:

- Increased Rx spending: 2.5% - 3.0%
- Increased A/B Hospital spending: 0.5% - 1.0%
- Policy change (dental): 0.5% - 1.0%
- Sustainable Rate of Growth: 3.4%
- **Total Range: 6.4% - 8.4%**

In L&E's opinion, the use of the sustainable rate of growth (3.4%) may be too optimistic based on national trends on Medicaid spending. As seen in the chart below, the Total Medicaid spending shows that 2016 into 2017 remained relatively flat and close to the sustainable rate of growth, moving from 3.5% to 3.9%; however, projecting to 2018 shows a larger increase in the Total Medicaid Spending to 5.2%. The Medicaid Growth Rate chart from CMS (above) and this Kaiser Family Foundation[16] chart indicate having a trend assumption, through the sustainable rate of growth, of 3.4% may be too low and not representative of what national trend projections are showing.



Further research showed that Medicaid Expansion states saw lowered rates of growth spending when compared to states that did not expand Medicaid. Therefore, L&E did not focus on the state spending increases in Kaiser's chart because these figures may be slightly inflated based on Oregon's situation as an Expansion state.

[16] https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2017-2018/

L&E did not have sufficient time to confirm Optumas' verbal derivation of the 6.4% to 8.4% range, but the methodology to determine the uncontrollable increases due to increased pharmacy and A/B hospital spending and policy changes appears to be appropriate. The continued use of the sustainable rate of growth, not accounting for actual and projected national trends, may lead to an appropriate number but could be overlooking key information, such as the aging of the population (i.e., higher proportion of membership in the most costly COAs)[17]. It should also be noted that the weighted average of the rates of growth by CCO remained relatively flat, but the extreme values (minimums and maximums) of the rates of growth did decrease from the 2017 rate cycle into 2018.

L&E's recommended range is 7.0% to 9.0%. Optumas' description of the 7% derivation uses a more sophisticated calculation of the uncontrollable costs, but it does not appear to account for national trend data and the changes in rates of growth by CCO. It should be noted that the 7.0% is within L&E's range; however, it is the minimum[18] of the range. Also, looking at the rate of growth by CCO for 2015 to 2016, there are several CCOs that have rates of growth between 7% and 8% with a gap until nearly 10%. Setting the threshold at 8% could have better recognized anticipated national trends and better isolated outliers.

If the Methodology Lines up with Generally Accepted Actuarial Principles and applied equitably across all CCOs

There is a legal review underway that will determine if making a change to reimbursement rates is allowable. L&E will opine on whether the changes were in line with generally accepted actuarial principles and applied equitably across all CCOs.

The use of a capitation rate to reimburse CCOs for Medicaid spending allows a CCO to manage their business so they can provide higher quality medical services in a more cost-effective way. Therefore, a CCO could choose to invest money in certain programs or other ways to prevent more expensive procedures or hospital stays in the future. A threshold on the rate of growth protects all CCOs from having base data modifications when the management of their funds is resulting in lowered rates of growth. For instance, if a CCO increased professional reimbursements with a goal of reduced hospital admissions and experienced a rate of growth lower than 7%, then the CCO would not have base data modifications due to the increased professional payments. Conversely, if a CCO increased professional reimbursements and had a rate of growth higher than 7%, then the increased spending did not have the reducing impacts of the extra investments. Therefore, the extra dollar amounts would likely be removed.

If a CCO has an increase above the threshold, the CCO did not automatically have modifications to its base data. Optumas had multiple meetings with each CCO to identify and evaluate all spending reported on their financials. These meetings led to the identification of excessive spending. L&E was not part of these conversations and was not provided with specific and itemized documentation of conclusions based on these conversations.

Of the 8 CCOs identified[19], six had base data adjustments. L&E was able to reasonably verify the reductions in the base data for 5 of the 6 CCOs with modifications to the base data. The five CCOs had reductions based on the incentive payments, as reported in their financial templates. This methodology

[17] National Health Expenditure Projections 2016-2025 - Forecast Summary (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf)
[18] Based on the 2015 to 2016 rate of growth median statistic
[19] OR CY18 Rates – Appendix VIII Reimbursement Policy

was similar to CY2017. L&E also reviewed the 2 CCOs that did not have modifications and found that the amounts in the financial templates did not identify incentive payments.

L&E was unable to verify the final remaining CCO with the financial template data alone. L&E observed that the change in incentive payments for the remaining CCO from CY2017 to CY2018 was a reduction of nearly 50% in the spending yet the rate of growth for CY2018 remained over 20%. Therefore, L&E performed an analysis of the reimbursement schedules by CCO.

The analysis began with evaluating average professional reimbursements for all CCOs. Initially, L&E explored evaluating the reimbursement schedules between CCOs across each region; however, most counties in Oregon only have 1 CCO offering services in their area. The most predominate exception is found in the Tri-County region, where 2 CCOs offer coverage in all counties. Therefore, L&E determined that it would be inappropriate to evaluate reimbursement schedules between CCOs in the Central/Eastern, Northwest, and Southwest regions. L&E received the 36 months of data (CY2014 – CY2016) for each CCO's professional services on a PMPM basis for the COA categories of ACA 19-44, TANF, Child 6-18, and ABAD & OAA. This data showed all professional costs in the encounter data plus another chart that showed all professional costs including the incentive dollars from the financial templates. L&E analyzed the reimbursement changes year over year and the 2-year annualized changes blended by 2016 COA membership.

For the 8 CCOs with higher rates of growth, it was observed that two CCOs had significant shifts in both the reimbursement schedules across the 2-year timeframe and the incentive payments:

- The first CCO operates in the Southwest region and had a significant increase in the reported incentive payments, accompanied with a drastic increase in the blended professional reimbursements for 2016. Upon further investigation, the increases appear to be due to the Child 6-18 professional reimbursement increases. L&E recommends that further analysis and research be performed on this perceived rate cell outlier.
- The second CCO operates in the Tri-County region and had a decrease in the blended reimbursements for 2016 and in the reported incentive payments. This observation launched the next analysis outlined below.

These 2 CCOS had the highest blended per capita reimbursements in 2016 for professional services when compared to the other 8 CCOs with high rates of growth.

Since the Tri-County region is the only region with multiple CCOs operating in it, L&E evaluated the reimbursement schedules for the two CCOs by obtaining the encounter data. L&E reviewed the total paid claims data for the Tri-County region and compared for overall reasonableness against the 2016 financial templates. To assess the differences by provider and procedure code, it was determined that the raw claim dataset was representative of the financials reported in the Exhibit Ls. L&E did not audit this data but relied on OHA and Optumas to provide accurate base data for these CCOs. L&E reviewed most professional claims[20] with the assistance from OHA regarding the data set. L&E reconciled the encounter data with the financials and felt the encounter data was appropriate for this analysis because L&E's goal was to assess the professional reimbursement levels between the two Tri-County CCOs.

[20] Professional identified by using the column heading [FINAL_OHG_RATECOS] and paid claims were identified by using the column heading [BR_AMT_PAID_DTL]

Claims were then grouped by provider codes, procedure code and modifiers for each CCO. To accurately analyze reimbursement between the Tri-County CCOs, only claims where both CCOs paid a provider for the same procedure and modifier combination were included in the analysis. Claims records where either CCO had 0 frequency amounts or 0 units billed were flagged and removed from the analysis. Claims where both CCOs paid the same provider for an identical procedure code and modifier combination equaled approximately $105M, or 79% of the total paid claim amounts for both CCOs. This analysis showed that one CCO ("CCO X") reimbursed 20% more on average than the other CCO ("CCO Y").

The previous analysis, however, does not accurately account for the differences in utilization between providers for each CCO. L&E performed two additional calculations to isolate differences in utilization across the CCOs. To address this potential concern, CCO X's total utilization was used and then the CCO Y's utilization was used. For each analysis, the unit cost for each claim line was multiplied by one CCO's total utilization (frequency times units billed). These two normalized analyses resulted in CCO X reimbursing from 16% to 26% higher than the CCO Y.

To further the analysis, CCO Y is a coordinated plan with multiple physical health risk accepting entities (RAEs) that contract with doctors, hospitals, and other facilities independently of each other. Claims were separated out for each RAE. This created a set of 4 reimbursement schedules to compare verses the two that were previously compared. Based on L&E's analysis, one of the RAEs had a low amount of claims and a different business model that was inappropriate for this analysis; therefore, this RAE was excluded from the analysis. L&E compared the two reimbursement schedules of the remaining RAEs to CCO X. The reimbursement schedule of CCO X ranges from 25% to 33%[21] higher than the two RAEs of CCO Y.

L&E believes that CCO X in the Tri-County region reimbursed for professional claims at a higher rate than CCO Y and its RAEs. It was clear that this was a change in business practices, which was also confirmed on the "scratch sheet" of the CCO's 2014 financial template[22].

L&E noted that 2 additional CCOs had base data changes that did not have rates of growth in excess of the 7% threshold. Optumas explained that these 2 CCOs had included data within their financials that was outside of the services covered under the Medicaid capitation rate. L&E believes that Optumas performed extensive analyses and evaluation of all the financials of all CCOs to ensure that no data was included that was outside the scope of covered services for the Medicaid capitation rate.

One could argue that to be fair across all CCOs any additional reimbursements to providers should have been removed regardless of rate of growth; however, L&E, as well as Optumas, recognizes that investment in programs or provider incentive reimbursements can lead to lowered costs in other medical service categories. Therefore, L&E agrees with the use of a threshold to isolate outliers, as it creates an unbiased method for flagging CCOs to investigate. Optumas appeared to be meticulous in its investigation of each CCO's reimbursements and expenses through the analysis of the financial templates and claim level detail.

L&E would have researched all other CCOs' claims data (excluding Tri-County CCOs) to see if any Tri-County PCPs appeared within the data set, as an out of network provider. If so, L&E would have compared these reimbursement levels of these additional claims with the 2 CCOs. Credibility would likely be an

[21] Note that this range differs from the prior range. This is due to the excluded reimbursement schedule, while small, had reimbursements that closely aligned to the other Tri-County CCO.
[22] Confidential file name for the CCO's 2014 financial template

issue because use of PCPs in an out of network situation tends to appear infrequently, but this analysis could have provided additional support for the conclusion made by OHA and Optumas.

Reimbursement Review Documentation and Communication

Generally accepted actuarial principles include the Actuarial Standards of Practice (ASOPs). ASOP 41, titled "Actuarial Communications," guides an actuary regarding any "written, electronic, or oral communication issued by an actuary with respect to actuarial services."[23] The CY2018 Rate Certification is an actuarial report. In the ASOP, an actuarial report should "state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report."[24]

In the CY2018 Rate Certification report, the *Reimbursement Review* section states that the aggregate rate of growth was 8.6% from 2015 to 2016.[25] Appendix VIII of the CY2018 Rate Certification states the rate of growth from 2015 to 2016 was 10.9%.[26] Finally, the draft 2018 Rate Development Update, dated July 19, 2017, shows a chart of the percentage change in base data by CCO with a statewide change of 8.8%.[27] Optumas explained that they periodically updated the CCOs of the rate of growth calculations, and this was the difference in all the figures. L&E was directed to use the July 19th document, which did have 8 CCOs above the 7% threshold. The 8.8% aggregate change nor any of the figures seen in the July 19th document are referenced within the final CY2018 Rate Certification or its appendices.

L&E found this documentation to be insufficient to properly communicate the rates of growth, the analyses performed, and conclusions drawn. L&E recommends that further documentation be provided to adequately document the changes to ensure that intended users (i.e. OHA and the CCOs) and other qualified actuaries are able to understand the process and perform an objective appraisal of reasonableness. Specifically, the following information is recommended to be included in the documentation:

- Final rates of growth by CCO used to determine which CCOs are in excess of the identified threshold,
- Modified rates of growth after modifications to show the rates of growth incorporated in the rates,
- Summary of reimbursement adjustments by CCO, and
- Summary of findings of claim-level reimbursements by CCO and conclusions regarding the analysis.

Some these documents may exist, but L&E recommends that they be included in an entire report or package to OHA that clearly lines up with the CY2018 Rate Certification. If some of this data breaches CCO confidentiality for the CY2018 Rate Certification, then regional summaries could be included as an appendix to the Rate Certification in addition to a confidential internal document for OHA and Optumas' records.

Outside of the ASOP 41 recommendations, L&E believes that Optumas' approach follows generally accepted actuarial principles and is actuarially sound as Optumas performed detailed analyses of the data

[23] Actuarial Standard of Practice 41 http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041_120.pdf
[24] Ibid.
[25] CY18 Rate Certification, dated October 25, 2017, page 12
[26] OR CY18 Rates – Appendix VIII Reimbursement Policy
[27] Page 5 of the "2018 Rate Development Update"

and spent a significant amount of time with each CCO understanding their financial templates and base data.

In L&E's opinion, Optumas did not isolate a particular CCO and perform additional analysis with the intent to reduce their rates, despite L&E's recommendation regarding the Southwest region's CCO. Additionally, the threshold was not set to ensure that a particular result occurred. L&E's range recommends a slightly higher threshold; however, setting a higher threshold would not likely have a material impact on rates. L&E has provided recommendations to strengthen the documentation and communication regarding changes made to the base data because inconsistencies appear throughout the documents and the lack of detail calls into question the methodologies employed by Optumas. Additional support would help to better educate OHA and the CCOs so that they have a clear understanding of the changes made under the reimbursement review.

Base Data Adjustments

Optumas made additional base encounter data adjustments for reconciliation and underreporting. The reconciliation adjustment helped to align the encounter data with each CCO's financial template and remove the impact of any sub-capitated encounters in the data. Sub-capitated arrangements were derived from the financial templates. The underreported adjustment included any additional costs that needed to be added to the encounter data but still excluded any sub-capitated amounts.

Optumas also adjusted for changes due to redetermination. Under federal law, every adult and child with Medicaid coverage maintains coverage until an administrative renewal or redetermination finds them ineligible for coverage. This redetermination process usually takes several years to fully implement. OHA was reviewing nearly 1 million enrollees for eligibility during the base data timeframe. Optumas identified and removed any ineligible individuals from the base data, as they would not be covered in 2018. The impact of the redetermination adjustment can be found in Appendix I.E by CCO and COA. Redetermination is a common practice throughout the country, and L&E agrees with Optumas' removal of the ineligible individuals from the base data. This adjustment better projects the anticipated population to be covered in 2018.

Program Changes/Rate Add-ons

Program changes and rate add-ons incorporate costs that are associated with programs that are not included in the base encounter data. It also includes adjustments due to changes in benefits between the base period and the projection period. Below is a listing of the programs that are added to the base encounter data.

Program Add-Ons	
NEMT	Applied Behavior Analysis
ACT/SE	Mammogram Services
Mental Health Children's Wraparound	Dental Rate
CANS	Breakthrough Therapy Adjustment
CAF	Maternity Rate

Some programs' data is included in the base encounter data, such as Breakthrough Therapy and Applied Behavioral Analysis, but most of the programs' data is not. As noted earlier, these amounts are removed in the reconciliation adjustment. Since these programs are covered under the capitation rate, the costs must be estimated outside of the base encounter data to properly incorporate. These add-ons are generally CCO-

specific since the offerings of each program vary by CCO. In general, the methodology for determining the costs of a program includes pulling a CCO's 2016 reported costs from their financial template, using a moderate trend to project 2018, and adding a non-medical cost load.

All adjustment amounts are provided in the CY2018 Rate Certification and its appendices.

L&E analyzed each program change and assessed the materiality of the adjustment. If found to be material, L&E independently calculated adjustments in aggregate and by category of aid (COA). These calculations were compared to Optumas' results to assess overall reasonableness.

Program	Percent of Total Sub-Cap $[28]
ABA	0.1%
ACT/SE	3.9%
A&D Residential	1.9%
MH Children's Wraparound	1.8%
Mammography Services	0.0%
CANS	0.1%
Dental	69.2%
NEMT	23.1%

While L&E performed a high-level review on all programs, L&E primarily focused its analysis on the programs that had higher than 3% of the total sub-capitated dollars.

Applied Behavioral Analysis Adjustment (ABA)

ABA was a program that was added in July 2016, and there are issues in terms of cost and credibility due to the newness and size of the program. Both OHA and Optumas confirmed that there is no credibility to the service. As of 2016, the amount spent associated with ABA on their financial templates was immaterial. The rate adjustments are calculated at a regional and statewide level to capture as much information as possible. Additionally, more emerging data was collected through June 2017 to ensure that the 2018 projection could be estimated using as much data as possible. Optumas noted that national data was used in prior capitation rate development cycles, and it was proven to be an inaccurate representation of the CCOs' experience. Until the size of the program increases, L&E agrees with the aggregated approach and did not dig deeper in the development of this assumption due to immateriality.

ABA has a risk corridor arrangement that will continue through CY2018 due to the uncertainty surrounding this benefit. The risk corridor helps mitigate the risk associated with the volatile nature of the costs and pricing of this benefit. L&E agrees that risk mitigation strategies should continue until the size of the program increases and the data can be relied upon. To increase transparency, L&E recommends that when adjustments are calculated at a regional level that a narrative and/or a demonstration be provided in the rate certification showing or describing the reasonableness of the adjustment.

Assertive Community Treatment and Supported Employment Services Adjustment (ACT/SE)

The ACT/SE adjustment was 4% of all sub-capitated dollars spent among the CCOs; therefore, L&E performed a detailed review of the adjustment. This program has varying outreach by CCO due to costly

[28] Based on each CCO's Exhibit L financial template. From Report L13 – Medical Costs under Expenditures (Sub-Capitated)

care management teams. There is a goal with OHA to increase utilization of these services through CY2018. More about the anticipated increase in utilization can be found in the CY2018 Rate Certification. L&E's independent analysis resulted in an average trend increase of about 25% with trends ranging from 7% to 30%[29]. While these trends are not considered moderate, it is reasonable to expect with OHA's utilization increase goal that the cost of services will increase. L&E finds the development of the ACT/SE rates to be reasonable.

Mammography Services

The adjustment for mammography services is seen in Appendix II.A and is less than $1.00 PMPM for all applicable COAs. This program add-on is immaterial and was not reviewed extensively. To increase transparency and clarity in the CY2018 Rate Certification, L&E recommends that a consistent naming convention be used throughout the entire report. In this example, the narrative describes mammography services, and Appendix II.A shows an adjustment for "BC Screening," which L&E interprets this to mean Breast Cancer Screening and the same as the mammography services.

Dental Rates

Dental rates calculations are more in line with the methodology used to calculate the base rate, using base encounter data. The rates were developed for 2 regions, Tri-County and Non Tri-County and trended using unit cost and utilization trends. Appendix I.H shows the regional rate development. Due to differences in the trends and non-medical loading applied, the PMPMs differ by region. Appendix I.I shows the dental rates by CCO and COA.

L&E reviewed the financial templates and found the buildup of the rates to be reasonable when compared to the numbers seen in Appendix I.H. L&E recommends increased documentation on the development of the dental rates. The appendix shows that there is an IBNR adjustment that is not discussed in the report narrative.

Non-Emergent Medical Transportation (NEMT)

NEMT is an add-on that some CCOs have been offering since July 2015. The adjustment for NEMT is material to the rate development, as it represents roughly 23% of total sub-capitated dollars. This add-on is developed at the CCO level, using information from the financial templates.

L&E compared the data in the financial templates to the rates in Appendix I.G in aggregate. The results were reasonably in line with the methodology described by Optumas.

Other Programs

Other programs include A&D Residential, Breakthrough Therapy, Mental Health Children's Wraparound, Children's and Adolescent's Needs and Strength Assessment (CANS), and Maternity. These programs were not reviewed in detail. It should be noted that A&D Residential is mentioned on page 11 of the CY2018 Rate Certification report and included in Exhibit L, Report 13, but it is not documented in the Program Changes/Rate Add-Ons section of the report. L&E recommends that this be properly explained in the rate certification report.

[29] Excluded CCOs with less than 3% of ACT/SE dollars spent.

Trend

Trend is analyzed by unit cost and utilization/1,000 for each COA and category of service (COS) by region. The trend analysis was based on historical encounter data and financial templates by CCO. A sample of the total trends for 3 COAs by region are shown below.

Annualized PMPM Trends			
Region	**ACA 19-44**	**TANF**	**Child 6-18**
Eastern/Central	4.2%	4.2%	3.5%
Northwest	4.3%	4.2%	3.6%
Southwest	4.2%	4.2%	3.5%
Tri-County	4.6%	4.1%	3.8%

These trends are used to project the 2016 adjusted base data forward to 2018. Based on discussions with Optumas, they develop a range of rates that vary by a trend range. These ranges are presented in draft form to OHA and the CCOs. Optumas works with OHA to determine the rate and certifies to a point estimate trend and rate.

These trends appear to be in line with nationwide averages for Medicaid spending. It is common practice for an actuary to develop trend ranges during a rate certification process that leads to a set of rate ranges. These ranges become the basis of discussion between the actuary and the regulating agency, like OHA.

Program/Rate Add-On Documentation and Communication

Of all the capitation rate development components, the program changes/rate add-ons need more documentation. Most of the methodology for these programs are to reference the 2016 financial templates for cost data and load for trend and administrative costs. However, there are several programs that do not follow this methodology and are developed with encounter data or at the statewide or regional level. Therefore, L&E recommends that the documentation within the program changes/rate add-on section be improved to comply with ASOP 41.

Non-Medical Loading

Optumas defined the Non-Medical Loading to include CCO expenditures that are for items outside of medical services, including General Administrative Expenses, Hospital Reimbursement Adjustments (HRA), Taxes and Fees, and Profit and Risk/Contingencies. The source of data for the development of these assumptions was the financial templates and additional data from OHA.

Base Non-Medical Load

The Base Non-Medical Load includes the general administrative expenses, case management and flex services, profit, and risk/contingencies for each region. This amount is applied to the projected claim costs to develop a rate.

The CY2018 Rate Certification outlines the following:

Base Non-Medical Load			
Region	Administration	Care Mgmt and Flex Services	Total
Eastern/Central	8.6%	0.4%	9.0%
Northwest	7.1%	0.8%	7.9%
Southwest	7.8%	0.7%	8.5%
Tri-County	7.5%	0.3%	7.8%

The financials have the following information on admin expenses:

Administrative Expense Ratio			
Region	2014[30]	2015[31]	2016[32]
Eastern/Central	8.4%	9.7%	10.3%
Northwest	6.6%	6.8%	7.4%
Southwest	10.8%	9.6%	8.5%
Tri-County	7.8%	9.7%	9.8%

Northwest and Southwest's expense ratios appear to be reasonably in line with the historical data. Eastern/Central and Tri-County have both experienced higher expense ratios in 2015 and 2016 than what is projected for 2018. L&E did not have access to accurate year to date 2017 administrative expense data. L&E recommends that additional documentation be provided for the development of the administrative expense loads.

Optumas built in an assumption of 1.0% for profit and 0.5% for risk/contingencies, which were the same assumptions as 2017. As previously noted, the profit margin for all regions exceeded this amount in each year, except 2016. L&E recommends that the profit and risk/contingencies margin be reviewed and documented in the rate development process.

Hospital Reimbursement Adjustment

The HRA is an additional reimbursement made to providers, specifically DRG hospitals, that is included in the capitation rate to account for increases in reimbursements and taxes assessed to these providers. The reimbursement increase, Tier 1, adds 32% additional reimbursement for certain categories of service, including inpatient and outpatient non-A/B hospital services to increase the providers' reimbursements from 68% of Medicare to 100% of Medicare. The second is a new tax that is for an Oregon tax on providers. For CY2018, the rates were increased 3% for the tax for all medical costs, excluding sub-capitated arrangements.

Appendix III for each CCO quantifies the cost impact for both Tier 1 and Tier 2. L&E reviewed the regional base models and found the adjustments and calculations to be appropriate.

[30] 2014 Exhibit L, Report L8 OHP Total Operating Expenses and Total Non-Operating Revenues and Expenses
[31] 2015 Exhibit L, Report L8 OHP Total Operating Expenses and Total Non-Operating Revenues and Expenses
[32] 2016 Exhibit L, Report L6 OHP Total Operating Expenses and Total Non-Operating Revenues and Expenses

TAXES

The taxes have not been finalized as of the CY2018 Rate Certification. Optumas plans to review and update the amounts during the first couple months of 2018.

Risk Factors

Optumas risk-adjusts the rates to reflect a CCO's specific risk relative to the rest of the rating region. Optumas uses the CDPS+Rx to establish member-level risk factors based on demographics, pharmacy data, and diagnoses. Optumas reviews the hospital costs between various facilities through the A/B Hospital adjustment. The CY2018 Rate Certification report outlines the methodology used by Optumas:

- "Development of a regional benchmark for each rating cohort for each rating region.
- Development of a risk factor for each unique CCO for each rating cohort. This risk factor is applied to each payment rate chosen by OHA within the regional benchmark range to develop a CCO specific payment rate.
- The risk factors are applied in a way which is budget neutral to the specific rating region, so no dollars are added or removed to the regional spend due to the application of the risk factors.
- By applying the risk factors to the regional benchmark, the resulting payment rate better matches payment to risk for each specific CCO in that rating region.
- Risk Factors are comprised of two components: CDPS+Rx Risk Score and A/B Hospital Adjustment."[33]

The report continues to document the risk adjustment process through a series of questions that ASOP 45, titled "The Use of Health Status Based Risk Adjustment Methodologies," outlines. Appendix II.B and Appendix II.C outline the risk score by CCO and COA and the A/B Hospital factor adjustments.

Optumas' approach is in line with generally accepted actuarial practices and ASOP 46.

Documentation and Communication

OHA provided a summary of the meetings and general timeline of the annual capitation rate development cycle. In the CY2018 Capitation Rate Development cycle, OHA and Optumas had 62 meetings with CCOs together, as a regional group, and individually. The first meeting began in mid-February 2017 and wrapped up with the final presentation of rates in October 2017. OHA also tracks every email correspondence that is sent out and received regarding the capitation rate development cycle.

The capitation rate development cycle timeline is tight as the bulk of the work begins in May and June with draft rates being delivered in mid-August. OHA and Optumas appear to have a very transparent arrangement with the CCOs. CCOs have multiple meetings with OHA and Optumas throughout the capitation rate development cycle and have the option to request additional meetings as needed.

OHA and Optumas appear to have sufficient communication with the CCOs during the capitation rate development process.

L&E recommends that Optumas improves its documentation of the capitation rate development process to be more in compliance with ASOP 41. As previously discussed, ASOP 41, titled "Actuarial

[33] CY2018 Rate Certification, page 21

Communications," guides an actuary regarding any "written, electronic, or oral communication issued by an actuary with respect to actuarial services."[34] The CY2018 Rate Certification is an actuarial report. In the ASOP, an actuarial report should "state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report."[35] It is apparent throughout the CY2018 Rate Certification report and its supporting documents that there are inconsistencies that should be clarified. The report has already identified a few examples. L&E recommends that the final rate certification reference the figures that were used to make and support decisions and that the report provide additional qualitative support within the narrative to allow the intended users to better understand the process and allow another qualified actuary to objective assess the overall reasonableness.

Based on the Q&A from the CCOs, there appeared to be a significant amount of confusion. Due to the transparent nature of the capitation rate development cycle, multiple versions of each analysis are delivered to the CCOs. L&E believes that this may have led to some of the confusion. L&E has a few recommendations to improve documentation and transparency throughout the rate certification process:

- Ensure deliverables are dated and provide sufficient documentation within the exhibit.
- Address changes from prior versions for clarity.

As previously discussed, L&E struggled to follow the reimbursement review exhibits. L&E recommends that each deliverable be dated in the filename and on the footer of each page to ensure a clear understanding of the timing of the deliverable. Additionally, when calculations are being performed, L&E recommends that a footnote be provided to outline the source of the data, including the timing. If possible, it is also advised to explain why a number may not match a prior version to add more clarity.

Conclusions and Recommendations

L&E completed its review of the Medicaid Capitation Rate Certification Methodology. In L&E's opinion, Optumas follows generally accepted actuarial principles in the development of the rates, meaning that the methodology appears to be actuarially sound. Optumas performed detailed analyses of the data and spent a significant amount of time with each CCO understanding their financial templates and base data.

L&E recommended that further investigation and research be performed on a perceived outlier in one rate cell for a CCO operating in the Southwest region. L&E believes this was an oversight rather than a methodology flaw due to the complex nature of this analysis. L&E is unable to determine the impact, if any, this could have on rates.

Despite the previous finding, Optumas did not appear to isolate a particular CCO and perform additional analysis with the intent to reduce their rates. Additionally, the 7% threshold was not set to ensure that a particular result occurred. L&E's range recommends a slightly higher threshold; however, setting a higher threshold would not likely have a material impact on rates. Therefore, it is L&E's opinion that the methodology is executed in a manner that is consistent and unbiased across all CCOs.

[34] Actuarial Standard of Practice 41 http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop041_120.pdf
[35] Ibid.

L&E has provided recommendations to strengthen the documentation and communication regarding changes made to the base data because inconsistencies appear and lack of detail calls into question the methodologies employed by Optumas. Additional support would help to better educate the CCOs on changes and allow OHA to have a clear understanding of the changes made. While the documentation needs improvement, L&E's work was not hindered by the lack of documentation due to telephone conferences and written responses from Optumas. L&E was still able to perform the review and make recommendations.

All of L&E's findings and recommendations are outlined below. L&E has indicated the section the recommendation falls under:

FINDINGS

- *Reimbursement Review*: L&E recommends that further investigation and research be performed on a perceived rate cell outlier within a Southwest CCO.

RECOMMENDATIONS

- *Base Data*: L&E recommends that recent loss ratios, non-medical load ratios, and profit margins be considered during the capitation rate development process.
- *Reimbursement Review*: L&E recommends that additional analyses or support be provided to prove that the CCO with higher reimbursements was due to a business decision.
- *Reimbursement Review:* L&E recommends that further documentation be provided to adequately document the base data changes to ensure that intended users (i.e. OHA and the CCOs) and other qualified actuaries are able to understand the process and perform an objective appraisal of reasonableness. Specifically, the following information is recommended to be included in the documentation:
    - Final rates of growth by CCO used to determine which CCOs are in excess of the identified threshold,
    - Modified rates of growth after modifications to show the rates of growth incorporated in the rates,
    - Summary of reimbursement adjustments by CCO
    - Summary of findings of claim-level reimbursements by CCO and conclusions regarding the analysis.

  Some of these documents may exist, but L&E recommends that they be included in an entire report and package to OHA that clearly lines up with the CY2018 Rate Certification. If some of this data is too specific for the CY2018 Rate Certification, then regional summaries could be included as an appendix to the Rate Certification.
- *Program Changes/Rate Add-Ons*: L&E recommends that when program changes/rate add-on adjustments are calculated at a regional level that a narrative and/or a demonstration be provided in the rate certification showing or describing the reasonableness of the adjustment.
- *Program Changes/Rate Add-Ons*: In the rate certification, L&E recommends that a consistent naming convention be used throughout the entire report.
- *Program Changes/Rate Add-Ons*: L&E recommends increased documentation on the development of the dental rates. The appendix shows that there is an IBNR adjustment that is not discussed in the report narrative.
- *Program Changes/Rate Add-Ons*: It should be noted that A&D Residential is mentioned on page 11 of the CY2018 Rate Certification report and included in Exhibit L, Report 13, but it is not

documented in the Program Changes/Rate Add-Ons section of the report. L&E recommends that this be properly explained in the rate certification report.

- *Program Changes/Rate Add-Ons*: L&E recommends that the documentation within the entire program changes/rate add-on section be improved.
- *Non-Medical Loading*: L&E recommends that additional documentation be provided for the development of the administrative expense loads. Additionally, L&E recommends that the profit and risk/contingencies margin be reviewed in the rate development process.
- *Documentation and Communication*: L&E has the following recommendations to improve documentation and transparency throughout the rate certification process:
    - Ensure deliverables are dated and provide sufficient documentation within the exhibit
    - Address changes from prior versions for clarity
    - L&E recommends that each deliverable be dated in the filename and on the footer of each page to ensure a clear understanding of the timing of the deliverable.
    - Additionally, when calculations are being performed, L&E recommends that a footnote be provided to outline the source of the data, including the timing. If possible, it is also advised to explain why a number may not match a prior version to add more clarity.

Data Reliance

OHA's engagement of L&E began on 10/30/2017 with the first teleconference being on held on November 1, 2017. During this call, OHA outlined expectations and data requests, including what was included in the proposal. OHA set up one to two meetings each week between November 1, 2017 and November 30, 2017. The purpose of these internal calls was to discuss any questions and additional requests that L&E had.

Appendix B outlines all the of the files and data L&E received from OHA.

Over this month, L&E had two meetings with the actuaries at Optumas to ask additional questions that OHA deferred to Optumas. After each call, Optumas provided L&E with a written response of the questions asked during the call.

L&E has relied on the data, files, and information provided by OHA and Optumas. L&E thanks both OHA and Optumas for their prompt responses and supply of requested data and files.

Limitations

The contents of this report are intended for the Oregon Health Authority as a secondary, independent review of the Capitation Rate Development Methodology. L&E understands that OHA may distribute this report to Optumas and the CCOs, in which case it will be provided in its entirety including all assumptions, caveats, and limitations. In addition, L&E requests that OHA or any recipient notify Lewis & Ellis, Inc. to whom it was distributed.

Any distribution of this report should be made in its entirety. In addition, any third party with access to this report acknowledges, as a condition of receipt, that L&E does not make any representations or warranty as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.

To the best of our knowledge, our determinations were made in accordance with generally accepted actuarial principles and practices. The American Academy of Actuaries (Academy) requires its members to perform professional services only when qualified to do so, and to meet certain qualification standards. The Academy prescribes qualification standards for individuals who issue prescribed statements of actuarial opinion. This report is not a prescribed statement of actuarial opinion. I certify that I am a member of the Academy, that I am qualified to review this work, but this report and any recommendations should not be considered an actuarial opinion.

OHA has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, L&E is financially and organizationally independent from OHA, Optumas, all CCOs, and any entity or individual related to the parties listed above. There is nothing in our relationship with OHA, Optumas, or the CCOs that would impair or seem to impair the objectivity of our work. L&E has provided a letter regarding the perceived conflict of interest with regards to L&E's contract with the Centers for Medicare & Medicaid Services. This letter has been attached as Appendix C.

Acknowledgments

The L&E team would like to personally thank the OHA team and the Optumas Team. Working on a project under an aggressive timeline such as this one could only be possible with the prompt attention of all parties involved. We appreciate OHA providing any documents that we requested in a timely manner. We also appreciate the Optumas team answers our questions in less than 24 hours as well as being available for last minute meetings.

APPENDIX A: ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[36], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States. Each of these organizations requires its members, through its Code of Professional Conduct[37], to observe the ASOPs of the ASB when practicing in the United States.

The ASOPs are not narrowly prescriptive and neither dictates a single approach nor mandates a particular outcome. ASOPs are intended to provide actuaries with a framework for performing professional assignments and to offer guidance on relevant issues, recommended practices, documentation, and disclosure. Each ASOP articulates a process of analysis, documentation, and disclosure that, in the ASB's judgment, constitutes appropriate practice within the scope and purpose of the ASOP.

ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in this Exhibit.

Identification of the Responsible Actuary

The responsible actuary is Jacqueline B. Lee, FSA, MAAA, Vice President and Principal of Lewis & Ellis, Inc. This actuary is available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is November 30, 2017, its subject is a secondary review of the Capitation Rate Development Methodology of the Oregon Health Authority's Medicaid rates for CY2018, and the document version identification is Version #1 (11/30/2017 8:00 PM).

Disclosures in Actuarial Reports

- The contents of this report are intended for the Oregon Health Authority.
- The purpose of this engagement is to provide the Oregon Health Authority a secondary review of the Capitation Rate Development Methodology of its Medicaid rates for CY2018.
- The responsible actuary identified above is qualified as specified in the *Qualification Standards* of the American Academy of Actuaries.
- The assessments and recommendations included in this report involve estimates of the base data, trends, reimbursement review, program changes/rate add-ons, population adjustments, administrative expenses, and profit margins. Actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future. The results are not to be used for any purpose other than to provide the Oregon Health

[36] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[37] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001

Authority with guidance and recommendations regarding its Medicaid Capitation Rate Development for CY2018. This communication should not be relied upon for any other purpose.

- The Oregon Health Authority has agreed to pay Lewis & Ellis, Inc. a fee for preparing this report. Other than with regard to that contract, we are financially and organizationally independent from them. There is nothing in our relationship with the Oregon Health Authority that would impair or seem to impair the objectivity of our work.

- The Oregon Health Authority and Optumas provided data files and other information (seen in Appendix B) used to prepare our report. We have reviewed the data for reasonableness, but have not audited it. To the extent that there are material inaccuracies in the data, our results may be accordingly affected.

- The date through which data or other information has been considered in developing the findings included in this report is November 29, 2017.

- We are not aware of any subsequent events that may have a material effect on the actuarial findings.

- The various documents comprising this actuarial report are contained within the document to which these disclosures are attached.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report, as well as the attached exhibits.

Methods, Procedures, Assumptions, and Data

The methods, procedures, assumptions and data used by the actuary can be found in body of this report, as well as the attached exhibits.

Assumptions or Methods Prescribed by Law

This actuarial memorandum was prepared in accordance with generally accepted actuarial principles.

Responsibility for Assumptions and Methods

The actuary does not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP

The actuary has not deviated materially from the guidance set forth in an applicable ASOP.

APPENDIX B: DATA AND FILES PROVIDED TO L&E

Below are a list of the data and files provided by OHA to L&E:

- Summarized Communication and Timeline ("2018 Rates Development Meeting Recap_v2.xlsx")
- Detailed Email and Communication Tracker ("2018 rate development_CCO communication tracker.xlsx")
- CCO Corporate Structure ("CCO Corporate Structure.pdf")
- CY 2018 Expenditure Report ("CMS CCO CY 2018 Expenditure Report.pdf")
- CY2017 Rate Certification ("Oregon CY17 Capitation Rate Certification 2016-10-10(3).pdf")
    - Appendix VIII ("OR CY17 Rates - Appendix VIII Reimbursement Policy.pdf")
- CY2018 Draft Rate Certification ("Oregon Draft CY18 Rate Certification 2017.09.15.pdf"), including the email sent to all CCOs
    - "OR CY18 - Payment Rate Comparison 2017.09.07.xlsx"
    - "OR CY18 Rates - TPL Summary 2017-09-15 - Other.xlsx"
    - "OR CY18 Rates - TPL Summary 2017-09-15 - Tricounty.xlsx"
- CY2018 Final Rate Certification ("Oregon Final CY18 Rate Certification 2017.10.27.pdf"), including the final emails sent to a sampling of CCOs
    - "2018_Timeline_Rates_Updated_20170901.pdf"
    - Appendix VIII ("OR CY18 Rates - Appendix VIII Reimbursement Policy.pdf")
    - Appendix IX ("Appensix IX ABA & Hep-C Risk Corridor.pdf")
    - Appendix X ("OR CY18 Rates - Appendix X CDPS+Rx Risk Score Methodology.pdf")
    - Appendix XI ("OR CY18 Rates - Appendix XI CCO Q & A.PDF")
- Risk Score data ("ind_score_20170825 run.sas7bdat"
- Payment Comparison ("OR CY18 - Payment Rate Comparison 2017.09.07.xlsx")
- Summary of Base Data Changes ("Summary of Reimbursement Adjustments.xlsx")
- CY2018 Rate Update Presentation ("OR CY18 Capitation Rate Update.pptx")
- Raw Scores ("SumScore_ABAD OAA_ACA_report.xlsx")
- Rate Models
    - "OR CY18 Rates - Regional Rate Model (CentralEastern) 2017.09.06.xlsb"
    - "OR CY18 Rates - Regional Rate Model (Northwest) 2017.09.06.xlsb"
    - "OR CY18 Rates - Regional Rate Model (Southwest) 2017.09.06.xlsb"
    - "OR CY18 Rates - Regional Rate Model (TriCounty) 2017.09.06.xlsb"
- Rate Models – Mental Health only
    - "OR CY18 Rates - MH Only Regional Rate Model (CentralEastern) 2017.09.06.xlsb"
    - "OR CY18 Rates - MH Only Regional Rate Model (Northwest) 2017.09.06.xlsb"
    - "OR CY18 Rates - MH Only Regional Rate Model (Southwest) 2017.09.06.xlsb"
    - "OR CY18 Rates - MH Only Regional Rate Model (TriCounty) 2017.09.06.xlsb"
- Emails to every CCO with 2018 Additional Rate Exhibits, including:
    - Regional Base Change Model, dated 9/19/2017 (Regions: Central/Eastern, Northwest, Southwest, Tri-County)
    - Regional PMPM and Risk Factor Exhibit, dated 9/19/2017, specific to each CCO.

- January 2018 Contract Rate Sheets – pdf for each CCO outlining the capitation rate by Category of Aid (COA) and by CCO Type (e.g. CCO-A, CCO-B, etc.)
- CCO Maternity Models, specific to each CCO, dated 9/7/2017
- CCO Payment Rate Exhibits, by CCO "RDS and Payment Rate Summary"
- TPL Summary
    - "OR CY18 Rates - TPL Summary Other 2017-09-08.xlsx"
    - "OR CY18 Rates - TPL Summary Tricounty 2017-09-08.xlsx"
- Exhibit Ls by CCO for 2014, 2015, 2016, and 2017Q2
- CY2015 Confidential Base Data Exhibits by CCO
- Detailed Claims Data
    - "FC_Claims_Data.txt"
    - "HSO_Claims_Data.txt"
- Reimbursement Review July 2017 ("CCO Rate of Growth Disucssion July 2017.pdf"), including the email distributed to CCOs with this communication
- Answers to L&E's Questions:
    - "Follow Up Questions_LE_20171114_OPT.DOCX"
    - "LE Questions for Optumas 20171107_Final.docx"
- Professional PMPM Unit Costs "Copy of OR Reimbursement Graphs CY14-CY16.xlsx"
- Email outlining the Tri-County CCO risk accepting entities
- CY14 FamilyCare financials "FT_Family_20150501.xlsx"

APPENDIX C: CONFLICT OF INTEREST LETTER

Dallas
Cabe W. Chadick, F.S.A.
S. Scott Gibson, F.S.A.
Glenn A. Tobleman, F.S.A., F.C.A.S.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
Brian D. Rankin, F.S.A.
Bonnie S. Albritton, F.S.A.
Jacqueline B. Lee, F.S.A.
Xiaoxiao (Lisa) Jiang, F.S.A.
Josh A. Hammarquist, F.S.A.
Brian C. Stantz, A.S.A.
Jennifer M. Allen, A.S.A.
Johnathan L. O'Dell, A.S.A.
Larry Choi, A.S.A.
Kevin Ruggeberg, A.S.A.
Traci Hughes, A.S.A.

L&E Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
Leon L. Langlitz, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher J. Merkel, F.S.A.
Christopher H. Davis, F.S.A.
Karen E. Elson, F.S.A.
Jill J. Himes, F.S.A.
Kimberly S. Shores, F.S.A.
Michael A. Brown, F.S.A.
Naomi J. Kloeppersmith, F.S.A.
Stephanie T. Crownhart, F.S.A.
Mark W. Birdsall, F.S.A.
Andrea J. Huckaba, F.S.A., C.E.R.A.

London/Kansas City
Timothy A. DeMars, F.S.A., F.I.A.
Scott E. Morrow, F.S.A., F.I.A.

Denver
Mark P. Stukowski, F.S.A.
William J. Goruk, F.S.A.
Douglas L. Blum, F.S.A.

Indianapolis
Kathryn R. Koch, F.C.A.S.

Baltimore
David A. Palmer, C.F.E.

November 20, 2017

Laura Robison
Chief Financial Officer
Actuarial Services Unit, Oregon Health Authority

Re: L&E's Experience with Oregon's Medicaid Rate Setting

Lewis & Ellis, Inc. (L&E) has been engaged by the Actuarial Services Unit of the Oregon Health Authority (OHA) to perform a secondary, independent review of the Medicaid capitation rate setting methodology. I, Jackie Lee, am the lead actuary on this engagement. I understand that CCOs may question if I feel comfortable producing a report with findings and observations that may be different from the CMS approval L&E was a part of during our 2015 and 2016 reviews of the Oregon Medicaid rate setting.

I have never been a part of the Medicaid reviews here at L&E. I asked the lead actuary, who is contracted with CMS, about the review process for the CMS Medicaid Rate Setting Reviews and L&E's role. He informed me that he is not allowed to disclose L&E's role or L&E's final communication in the CMS approval process. This means that I do not know if L&E provides a recommendation of approval or if L&E simply lets CMS know that there are no further questions.

I know the Medicaid review process is different in scope than the secondary review that I am performing for OHA. In this secondary review, I have access to significantly more data and details of the rating methodology process. Therefore, I view my project as more audit-like than a review. Another way to understand this is that we also perform reviews on behalf of CMS for Medicare Advantage plans. We can be part of a review that results in a plan having approval that could later have an audit with significant findings. I see this no differently.

We have isolated our team to exclude any individuals who have worked on the Oregon CMS review team but have Medicaid experience. I am completely comfortable saying that I feel 100% independent

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from the CMS Medicaid review, and I will not hesitate to report any differing findings I have from the CMS approval.

Thank you,

Jacqueline B. Lee, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

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