2018 CCO Rate Development Briefing

Independent Reviews & Next Steps

January 5, 2018

Oregon Health Authority

Agenda

- 2018 CCO rate development process recap
- Regional rate comparisons
- Independent review results
- Next steps

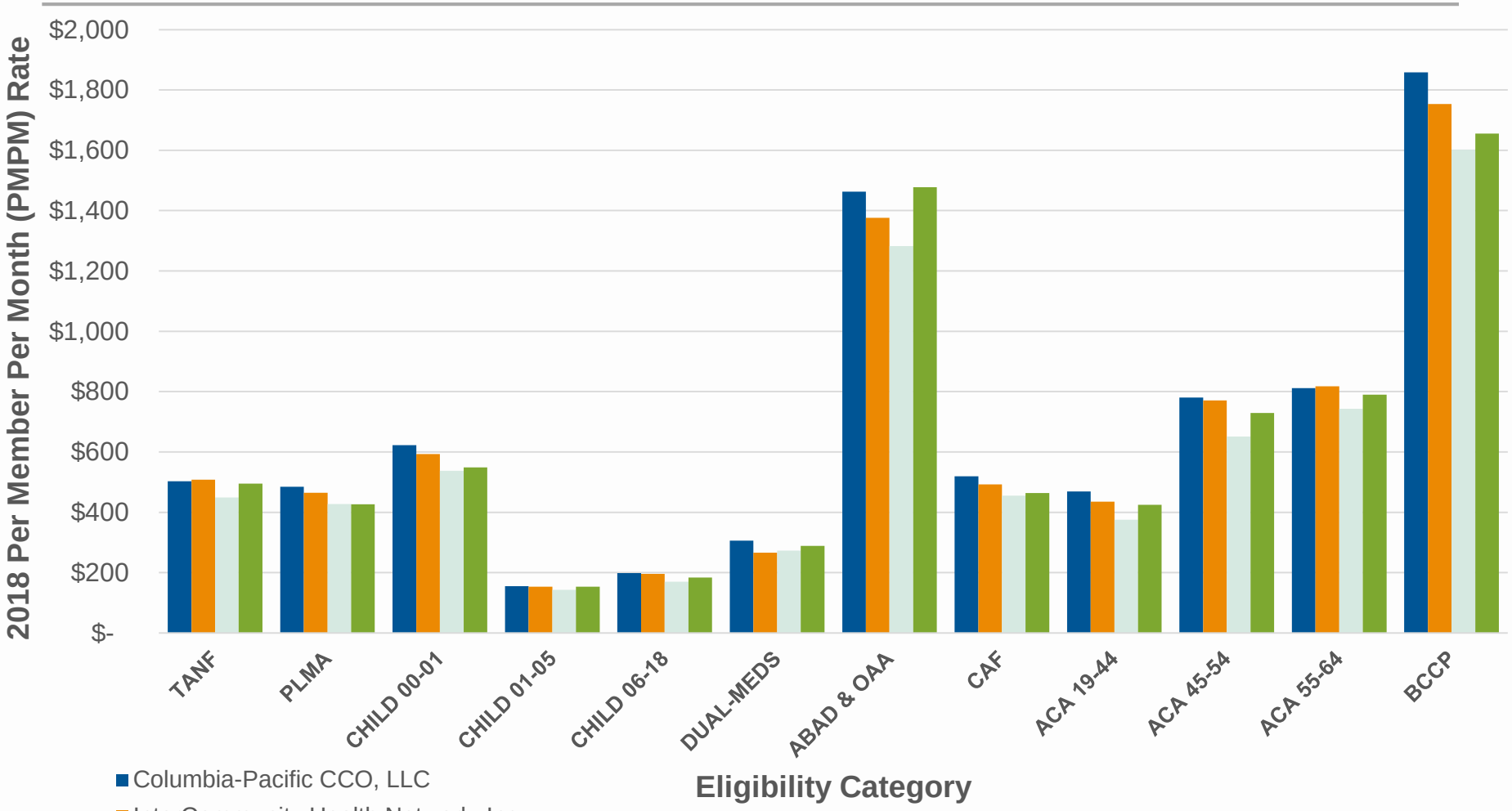
2018 CCO Rate Development Process

- Rates developed on a regional basis
  - Based on encounter data and financial information submitted by CCOs, validated by OHA and Optumas
  - Includes review of costs to develop rates that are actuarially sound (reasonable, appropriate, and attainable)
- Rates for CCOs within a region mainly vary based on the risk of the population served by the CCO and A/B hospital cost factors (where relevant)
  - CCO-specific rate "add-ons" derived from each CCO's financial data also leads to minor differences between CCOs

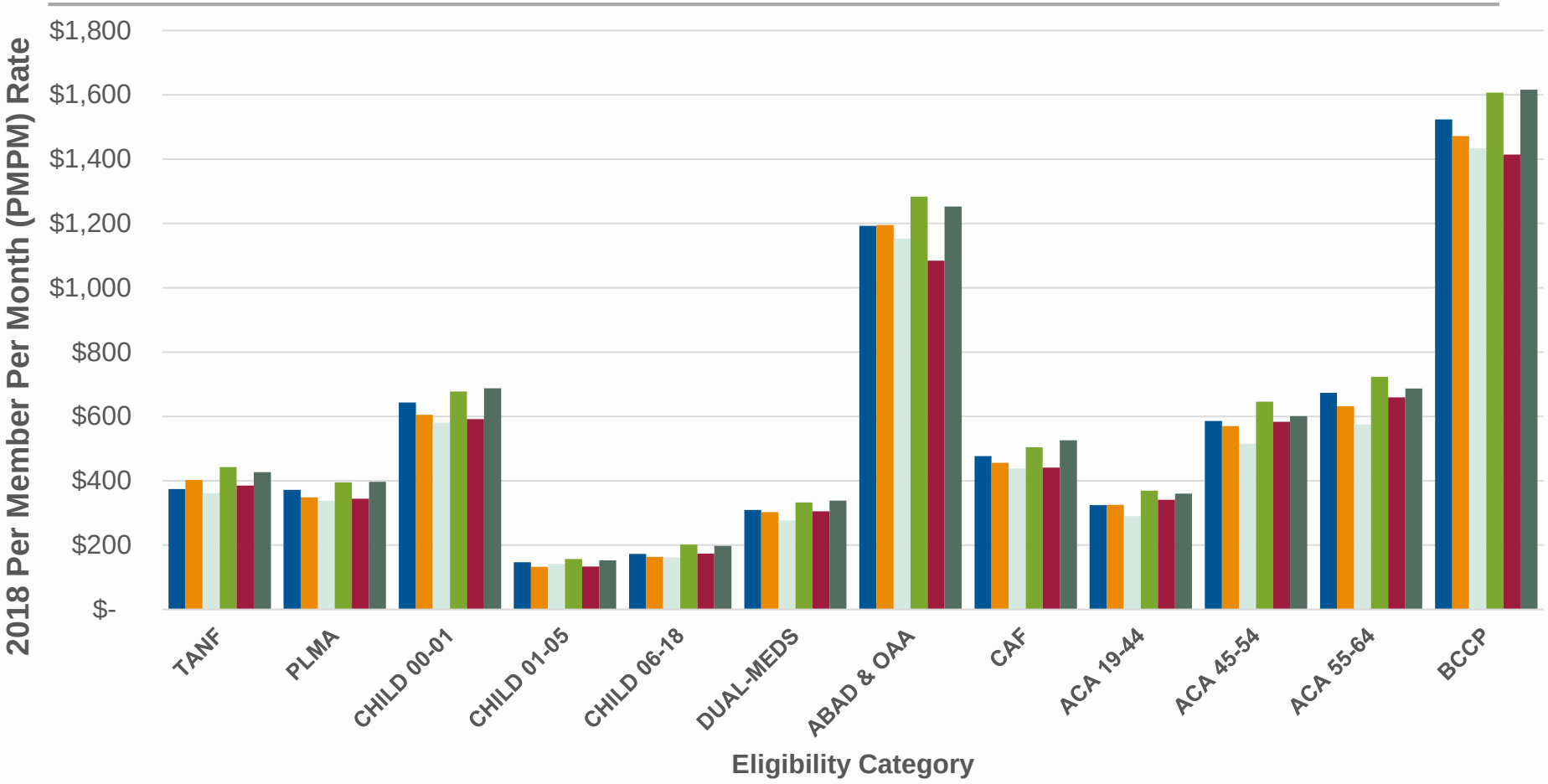
Regional Rate Comparisons

- Rate comparisons across CCOs have focused on the "average" rate paid to each CCO
  - Reflects the rate paid to a CCO for each eligibility category
  - Vary dependent upon the mix of members each CCO serves
- Comparison of rates for the same eligibility category show how rates compare for similar populations
- Rate comparisons not normalized for risk or A/B hospital cost factors and may represent non-overlapping areas within a region

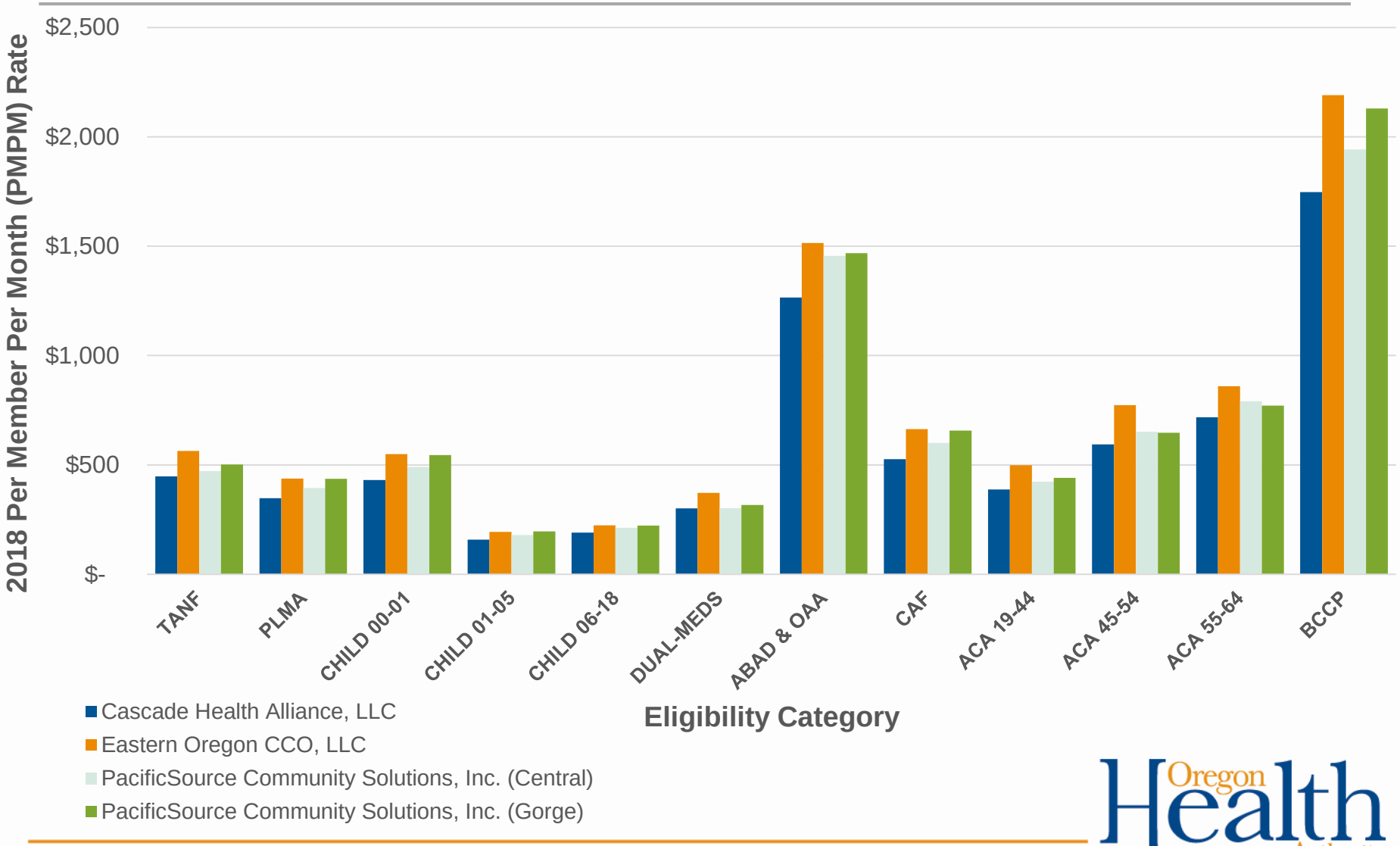
Regional Rate Comparisons – Northwest



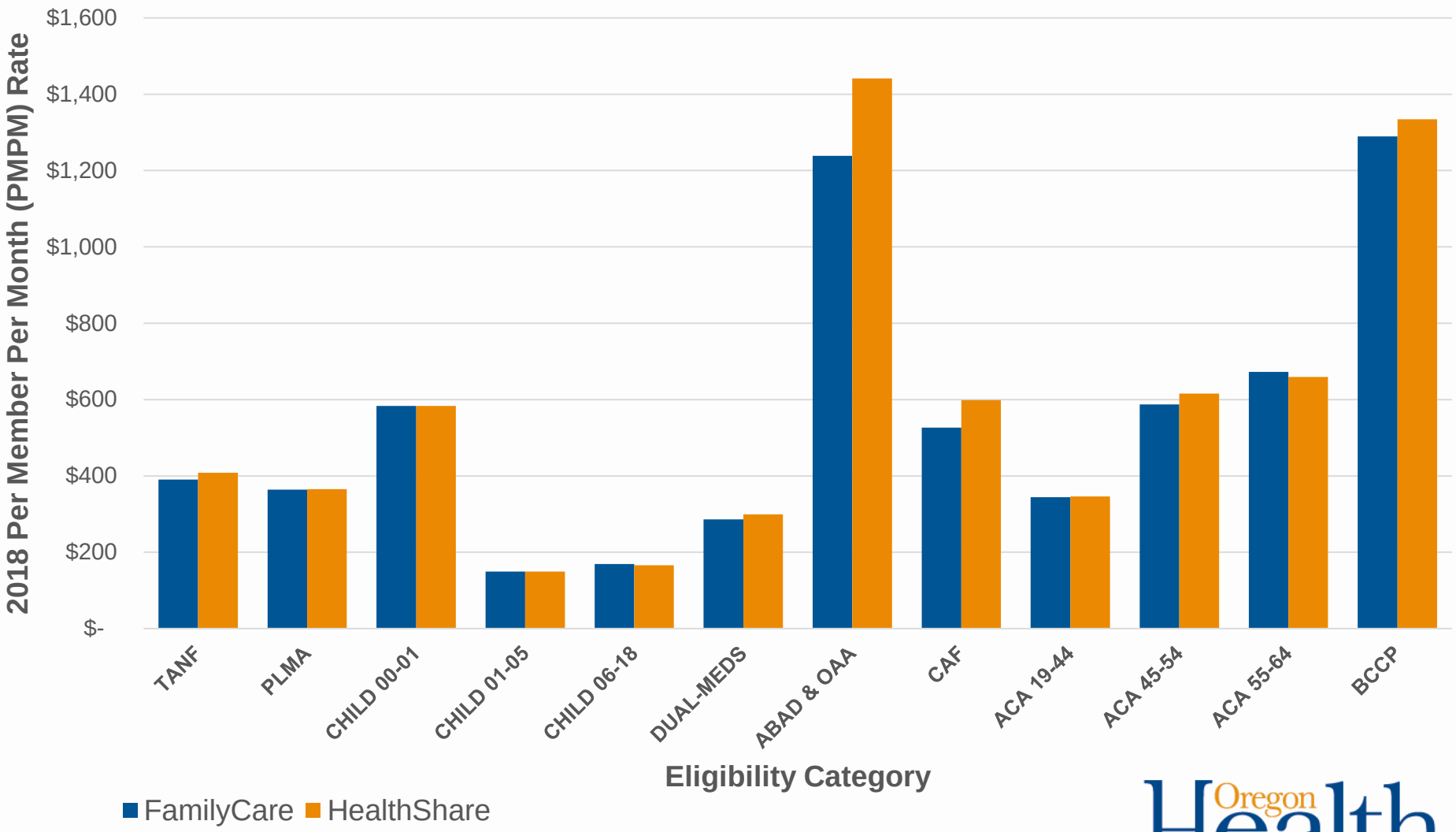
Regional Rate Comparisons - Southwest



Regional Rate Comparisons – Central/Eastern



Regional Rate Comparisons – Tri-County



Regional Rate Comparisons – Tri-County

Eligibility Category	FamilyCare 2018 Rate	Health Share 2018 Rate	% Difference (Health Share – FamilyCare)
TANF	$391	$408	4.4%
PLMA	364	365	0.4%
Child 0-1	583	583	0.1%
Child 1-5	149	149	-0.1%
Child 6-18	169	166	-2.1%
Dual-Meds	286	299	4.8%
ABAD/OAA	1,238	1,441	16.4%
CAF	526	599	13.7%
ACA 19-44	344	346	0.6%
ACA 45-54	587	616	4.8%
ACA 55-64	673	659	-2.0%
BCCP	1,289	1,334	3.5%
Maternity	10,373	10,052	-3.1%
Weighted Average (Each CCO's Member Mix)	**$378**	**$410**	**8.5%**
Weighted Average (FamilyCare Member Mix)	**$378**	**$386**	**2.3%**

Regional Rate Comparisons – Tri-County

Eligibility Category	FamilyCare 2018 Rate	FamilyCare 2016 % Member Months	Health Share 2018 Rate	Health Share 2016 % Member Months
TANF	$391	6.9%	$408	6.2%
PLMA	364	1.7%	365	1.2%
Child 0-1	583	3.7%	583	2.7%
Child 1-5	149	11.7%	149	10.4%
Child 6-18	169	23.5%	166	26.0%
Dual-Meds	286	2.1%	299	7.6%
ABAD/OAA	1,238	2.6%	1,441	6.2%
CAF	526	1.5%	599	1.2%
ACA 19-44	344	31.1%	346	24.6%
ACA 45-54	587	8.3%	616	7.4%
ACA 55-64	673	6.8%	659	6.3%
BCCP	1,289	0.0%	1,334	0.0%
Maternity*	10,372	0.2%	10,052	0.1%

*Maternity cases are included in other eligibility categories.

Independent Review Results

- OHA engaged two vendors to conduct independent reviews of the 2018 CCO rate methodology and process
- Lewis & Ellis conducted an actuarial review and opined on whether methodology is actuarially sound and executed in a consistent, unbiased manner
- Manatt conducted a regulatory review and opined on whether methodology complies with federal and state requirements

Regulatory Review of 2018 Rate-Setting Process

Manatt, Phelps & Phillips, LLP
December 6, 2017

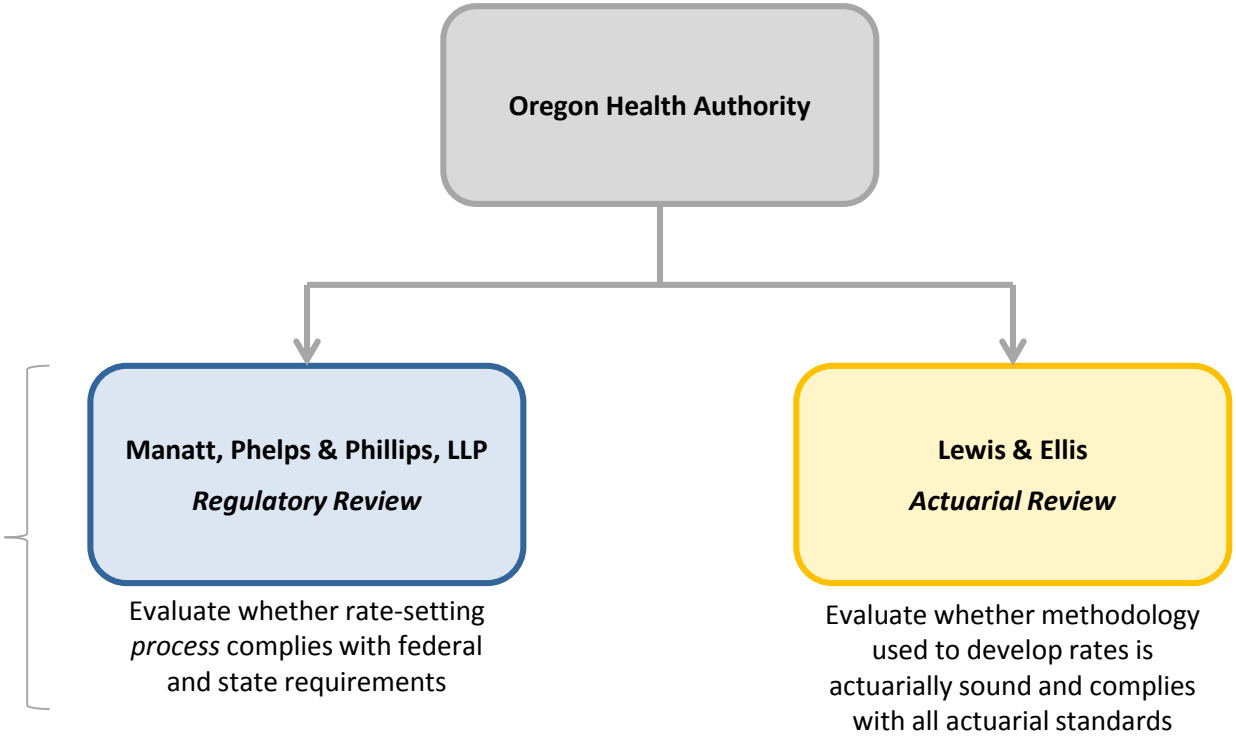
manatt

Agenda

- Overview of Review Scope and Process
- Findings

Independent Review of 2018 Rate-Setting Process

The Oregon Health Authority commissioned an independent two-part review to evaluate the 2018 rates for Coordinated Care Organizations (CCOs)



Scope of Regulatory Review

Federal Requirements

- Federal rules at 42 C.F.R. Part 438
- 2017 – 2018 Medicaid Managed Care Rate Development Guide
- Guidance issued by the Centers for Medicare and Medicaid Services (CMS)
- Special Terms and Conditions governing Oregon's 1115 waiver

State Requirements

- Oregon Revised Statutes related to CCOs
- Oregon Administrative Rules provisions related to CCOs

Note: *There were no provisions in Oregon statutes or rules that related to CCO rate-setting*

Overview of Regulatory Review Process

- Discuss with OHA background on rate-setting process
- Review key documents:
  - 2018 actuarial memorandum and certification, including appendices and inventory of CCO questions
  - Federal rules and guidance
  - State statute and rules
- Interview Optumas for additional details on rate-setting process
- Share draft memorandum for review and comment
- Revise memorandum to clarify facts and provide additional explanation

Review occurred November 1 -30

Findings

Summary of Findings

The State generally complied with the process for setting rates with a few exceptions

Complies with Federal Requirements

- Services covered under capitation rate
- Rates were developed at the rate cell level for each CCO
- Complies with rate development standards *(unless otherwise noted)*
- Rate certification describes process used to set rates *(additional details may be needed in some areas)*
- CCOs required to certify accuracy of data submitted *(some risk related to CCO data caveats)*

Minor Modifications or Additional Documentation Needed

- Did not consider medical loss ratio in developing rates, instead using it as a monitoring tool
- Limited detail included in certification with respect to some areas
- Included flexible services as an element of the non-benefit component
- Used standard risk margin for all plans (Note: STCs are ambiguous as to when the requirement to use a differential risk margin takes effect)

Emphasis of presentation; additional details in memorandum

Assessment of "Actuarial Soundness"

To be actuarially sound, rates must be projected to provide for "all reasonable, appropriate, and attainable costs that are required . . . for the operation of the MCO"

Federal Requirements

- Rates must be actuarially sound at the rate cell level *for each MCO*
- Rates only need to account for "reasonable, appropriate, and attainable costs," meaning that the rate need not cover costs that the State concludes are unreasonable or inappropriate, so long as the level of costs that the rate covers is attainable
  - Adjustments to base data may be used to ensure rates reflect only reasonable and appropriate costs
- States have multiple tools for ensuring that rates are appropriate for each MCO; States are **not** required to build up rates for each MCO
  - Risk adjustment
  - Rate regions

Assessment of "Actuarial Soundness" (cont'd)

State Process

- Optumas used regional data to account for variation in costs across regions
- Adjustments to data were made to ensure the reasonableness and appropriateness of costs
  - Upward adjustments to account for new services (e.g., applied behavioral analysis)
  - Downward adjustments to account for provider reimbursement rates higher than what the State considered appropriate
- Regional rates were tailored to each CCO to account health of population or mix of higher- or lower-cost hospitals
- Rates were identified for each rate cell for each CCO in the appendices to the actuarial certification

Conclusion: Complies with the process requirements to develop rates at the rate cell level that are tailored to each CCO and that are intended to account for reasonable, appropriate, and attainable costs.

We defer to the independent actuarial review to determine whether the rates were sufficient to account for all reasonable and appropriate costs

Rate Development Standards

Federal Requirements	State Process	Conclusion
Use appropriate **base data** from the most recent three-years	Used data from only one year	Generally complies with requirements; may need to provide rationale for using one year of data
Develop and apply **trend factors**	Developed region-specific trends for price and utilization	Complies with requirements
Develop the **non-benefit component**	Developed non-benefit component taking into account all of the types of expenses specified in the rules	Complies with requirements
Make appropriate **adjustments** to data	Made several adjustments to account for reasonable and appropriate costs	Complies with requirements; defer to independent actuarial review for appropriateness of adjustments
Take into account **medical loss ratio** (MLR)	Did not consider MLR when setting rates; does consider MLR when evaluating rates set previously	Recommend revising process to consider MLR when developing rates
If using, apply a **risk adjustment model** in a budget neutral fashion	Applied national risk adjustment methodology plus state-specific model to account for mix of higher- and lower-cost hospitals	Generally complies with requirements; defer to independent actuarial review for the appropriateness of the adjustment to account for the mix of hospitals

42 C.F.R. § 438.5

Special Contract Provisions Related to Payment

Federal Requirements

- **Risk sharing mechanisms** must be described in the contract and developed in accordance with standard actuarial practice
- **Incentive arrangements** may not provide for payments in excess of 105% of the approved capitation payment
- **"Pass-through" payments** are not permitted, unless CMS has approved the specific pass-through payments

State Process

- **Risk sharing arrangements** (i.e., risk corridors) are set out in contract, but the process for establishing the corridors is not described
- The rate development memorandum and certification do not address the **incentive payments** or confirm that total payments will not exceed 105% of the approved capitation rate
- The cap on **"pass-through payments"** is not calculated in the rate development memorandum or actuarial certification

Conclusion: Additional information may be required on risk corridors, incentive payments, and pass-through payments. CMS may require supplementary documentation as part of the rate review process

Rate Certification

State must submit a rate certification documenting each aspect of rate development in sufficient detail for CMS or its actuaries to understand and evaluate it

Federal Requirements	State Process	Conclusion
Base data	Certification did not document what base data was requested and why any base data requested was not provided. Certification did not explain use of only one year of data	CMS may request additional details
Trend factors	Certification describes trend development at high level but does not articulate how data was evaluated and weighted	CMS may request additional details
Non-benefit component	Certification indicates that financial data was used to develop non-benefit component but does not describe how that data was used	CMS may request additional details
Adjustments	Certification includes considerable detail on most adjustments, but does not describe the cost-impact of non-material adjustments	CMS may request additional detail on the aggregate cost impact of non-material adjustments
Risk adjustment	Certification provides significant detail on risk adjustment methodology	Complies with requirements
Special contract provisions related to payment	Certification provides limited details on risk corridors, incentive payments, and pass-through payments	CMS may request additional details

42 C.F.R. § 438.7

Certification of Data

Federal Requirements

- States must require that managed care plans (including CCOs) certify the accuracy and completeness of data submitted
- Certification must be signed by the plan's CEO, CFO, or an individual who reports directly to the CEO or CFO
- The certification must be made concurrently with the submission of the data

State Process

- The State requires that the CEO, CFO, or their delegate certify that the data submitted is accurate, complete, and truthful
- The CCOs must submit the Encounter Data Certification and Validation Report Form concurrend with each submission.
- One CCO includes caveats on each data certification

Conclusion: Complies with the requirements, but there is some risk that CMS could conclude that, since the State does not reject the CCO's certification as invalid due to the caveats, it is not truly requiring the certification.

Rate-Setting Requirements in Special Terms and Conditions

Oregon must also comply with requirements in the Special Terms and Conditions governing the State's 1115 waiver

Federal Requirements

- **Flexible services** must be paid from CCOs' savings and not considered in setting capitation rates
- The State must develop a variable **profit margin** to reward "high performing" CCOs, but the STCs are ambiguous as to when this requirement takes effect

State Process

- **Flexible services** were explicitly include in the non-benefit component of the rate
- The State used a **fixed profit margin**, though the State is developing a definition of "high performing" CCOs to establish variable profit margins in the future

Conclusion: Rates may need to be readjusted to eliminate costs associated with flexible services. Depending on how CMS interprets the effective date of the STC related to profit margin, CMS may require the State to redevelop rates to vary the profit margin or it may conclude that the uniform profit margin is appropriate

Discussion

Thank you!

Anne Karl
Partner

212.790.4578

akarl@manatt.com

Appendix

Additional Questions

Several questions on rate-setting were submitted to the legislative counsel. Our responses are below

Question 1: Do federal regulations (Medicaid Managed Care Rule - 42 CFR 438) require that capitation rates developed for managed care organizations (Oregon's coordinated care organizations) be actuarially sound for each rate cell for each CCO contract?

Answer 1: Yes. Rates must be actuarially sound for each rate cell for each CCO, but Oregon is not required to account for all costs of each CCO when developing rates. Instead, Oregon must ensure that rates provide for all "reasonable, appropriate, and attainable" costs. If the State determines that particular costs are unreasonable or inappropriate, the rate need not be sufficient to cover such excess costs, so long as the level of costs that the rate covers is attainable. Oregon, like other states, has multiple tools for ensuring that rates are appropriate for each CCO and are not required to build rates specific for each CCO. A full discussion of this issue is found in Section II.A.3 of the memorandum.

Question 2: Does anything in Oregon law allow the state to deviate from following the Medicaid Managed Care regulations?

Answer 2: No. Oregon statute and rules related to CCOs do not impose any requirements on rate-setting. Additionally, state law does not supersede federal Medicaid requirements, and all federal Medicaid requirements apply unless CMS grants a waiver of such requirements.

Question 3: Does Oregon's 1115 waiver with the federal government allow the state to deviate from following the Medicaid Managed Care regulations?

Answer 3: Yes, but only to allow the State to shorten the time period for disenrollment without cause and to contract with only one plan for dental services and one plan for mental health services. The State must comply with all federal rules related to rate setting. See Section I.A.3 for a more detailed discussion.

Additional Questions (cont'd)

Several questions on rate-setting were submitted to the legislative counsel. Our responses are below

Question 4: Broadly speaking, if the Oregon Health Authority submitted capitation rates to CMS that were not actuarially sound for each CCO contract, would the agency be in violation of federal or Oregon laws or regulations?

Answer 4: Yes. If the rates were not actuarially sound for each CCO contract, the State would be out of compliance with federal rules. In such a case, CMS would likely require that the State re-develop and re-submit rates. See Section II.A.3 for a broader discussion of what it means for rates to be actuarially sound for each CCO.

Question 5: Does OHA's policy decision to truncate primary care reimbursements for some CCOs in developing the capitation rates violate the global budget provisions in state law or any federal regulations, include 42 CFR 438.6(c)?

Answer 5: No. The State may make adjustments to costs in base data to reflect "reasonable, appropriate, and attainable costs" of participating in the managed care program. The State is not required to develop cost-based rates for each CCO. See Sections II.A.3 and II.A.4 for further discussions.

Question 6: By withholding base data used to develop CCO capitation rates from public view based on a trade secret designation, is the state violating the transparency standards in federal regulations or Oregon statutes?

Answer 6: No. The federal rules and STCs require transparency with respect to the modification or phase out of the waiver itself—not the development of the rates. There are no provisions in federal rules or STCs that require the State to publish its base data. Similarly, there are no state statutes or rules requiring that the State make publicly available the data used in developing rates.

Independent Review

Medicaid Capitation Rate Development
Oregon Health Authority

Jackie Lee, FSA, MAAA
Eliseo Rodriguez
12/6/2017

Lewis & Ellis, Inc. • Actuaries & Consultants

Scope of Work

- Perform an independent actuarial review of the 2018 Medicaid capitation rate development methodology
- Opine as to whether the methodology is actuarially sound
- Opine as to whether the methodology is executed in a manner that is consistent and unbiased across all CCOs

*Definition of materiality as seen in the CMS final rule under 42 CFR 438.2

Conclusions

- Optumas follows generally accepted actuarial principles in the development of the rates, meaning that the methodology appears to be actuarially sound.

- It is L&E's opinion that the methodology is executed in a manner that is consistent and unbiased across all CCOs.

Data Received

- Key deliverables provided by OHA
  - Actuarial certification reports
  - Financial Templates
  - Reimbursement Review documents
  - Email correspondence
- L&E met with OHA multiple times per week
- Had 3 Discussions with Optumas and OHA
- Optumas provided written responses to L&E's questions

Financial Templates

- Reviewed key financial data for 2014, 2015, and 2016

Region	2016 Loss Ratio	2016 Profit/Loss
Eastern/Central	84.3%	5.4%
Northwest	91.9%	0.7%
Southwest	88.4%	3.0%
Tri-County*	91.2%	1.5%
Total*	89.6%	2.3%

- L&E recommends that recent loss ratios, non-medical load ratios, and profit margins be considered during the capitation rate development process.

*Note: there is a change to correct the Tri-County and Total Profit figures from the report due to an error in including a CCO's premium deficiency reserve in the original calculation.

Reimbursement Review

- L&E's scope of review:
  - Opine on the following with regard to the CY2018 rate cycle:
    - Use of 7% threshold being the defining target for CCO base data investigation.
    - If the methodology employed was in line with generally accepted actuarial principles and applied equitably across all CCOs.

Reimbursement Review

- Use of 7% threshold being the defining target for CCO base data:
  - Increased Rx spending
  - Increased A/B Hospital spending
  - Policy change (dental)
  - Sustainable Rate of Growth
- In L&E's opinion, the use of the sustainable rate of growth may be too optimistic.

Reimbursement Review

- If the methodology employed was in line with generally accepted actuarial principles and applied equitably across all CCOs:
  - Methodology
    1. Determine the outliers
    2. Investigate financial template data
    3. If not resolved by #2, investigate reimbursements

Reimbursement Review

Determine outliers

- 8 CCOs with Rates of Growth > 7%

  - 2 CCOs had immaterial/ irrelevant provider incentive payments
  - 6 CCOs needed more investigation

Reimbursement Review

Investigate financial template data

- Review provider incentive payments
- L&E was able to reasonably verify the reductions in the base data for 5 of the 6 CCOs with modifications from financial templates.

Reimbursement Review

Investigate reimbursements

- Reviewed year over year changes for professional services
  - Southwest CCO - large increase in Child 6-18
- Reviewed encounter data for Tri-County
  - One CCO in the Tri-County region reimbursed for professional claims at a higher rate

Program Changes/Rate Add-Ons

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

- Determined materiality
- Reviewed financial template data

Program Changes/Rate Add-Ons

Determined Materiality

- Dental, NEMT, ACT/SE

Reviewed financial template data

- Reasonably verify rates

- L&E recommends increased documentation for increased transparency

Non-Medical Load

- Reviewed key financial data for 2014, 2015, and 2016

Region	2016 Expense Ratio	2018 Assumption
Eastern/Central	10.3%	9.0%
Northwest	7.4%	7.9%
Southwest	8.5%	8.5%
Tri-County*	7.3%	7.8%

- L&E recommends that additional documentation be provided for the development of the administrative expense loads.

*Note there is a change in the Tri-County admin figures from the report due to an error.

Recommendations

- Improve documentation to be more in line with ASOP 41 “Actuarial Communications”
- L&E recommends that further investigation and research be performed on a perceived rate cell outlier within a Southwest CCO.

Conclusions

- Optumas follows generally accepted actuarial principles in the development of the rates, meaning that the methodology appears to be actuarially sound.

- It is L&E's opinion that the methodology is executed in a manner that is consistent and unbiased across all CCOs.

Questions

Next Steps

- No change to 2018 rates; rate certification addendum with enhanced documentation
  - Will address provider reimbursement analysis, analysis of the rate cell outlier, medical loss ratios, and non-medical loads
- If warranted, rate amendment in early 2018 to address redetermination impact and/or any other emerging issues
  - OHA already planned to work with Optumas and CCOs to analyze the impact of redetermination clean-up on 2018 CCO rates
  - OHA/Optumas will also work with CCOs to analyze other emerging issues that may materially affect rates to determine if a prospective amendment to the rates is necessary

DISCUSSION & QUESTIONS?

Oregon Health Authority

FamilyCare Member Transition

Patrick Allen, Director

January 5, 2018

Oregon Health Authority

FamilyCare Membership

- Approximately 112,000 members in the tri-county area
- To ease the transition of members, FamilyCare extended its contract through January 31, 2018
- 5,200 members will transition to Willamette Valley Community Health
- 120 members will transition to Yamhill Community Care
- 105,000 members will transition to Health Share of Oregon
- About 1,700 Tribal members will be moved to fee-for-service

Transition Steps Underway

- FamilyCare is providing member-level data
  - to identify members with high needs
  - to identify primary care physicians and help maintain continuity of coverage
- Health Share agreed to provide 6-month continuity of care for behavioral health providers
- DHS has increased call center hours and staff
- OHA stood up a website with frequent updates:

  http://bit.ly/2EWzcu8

Transition Steps Ongoing

- Continue partnership with FamilyCare to transfer data
- Focus on member support
  - Continuity of care
  - Pharmaceutical prescriptions and needs
  - High-needs individuals
- Engaged with multiple agencies to provide support to FamilyCare employees
- Analysis of Health Share rates
- Monitoring the ongoing transition
  - Denials
  - Care coordination
  - Primary care physician assignments
  - Access to Care