**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-25-26**
**Baltimore, Maryland 21244-1850**

**State Demonstrations Group**

May 23, 2023

Dana Hittle
Interim Medicaid Director
Oregon Health Authority
500 Summer Street NE E-35
Salem, OR 97301

Dear Ms. Hittle:

The Centers for Medicare & Medicaid Services (CMS) has approved the Evaluation Design for Oregon's Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Oregon Health Plan Substance Use Disorder" (Project Number 11-W-00362/10). We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design stated in the demonstration's Special Terms and Conditions (STCs) for this amendment, especially under these extraordinary circumstances.

The approved Evaluation Design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). CMS will also post the approved Evaluation Design on Medicaid.gov.

Please note that, consistent with the approved Evaluation Design, the draft Final Report will be due to CMS 18 months after either the expiration of the demonstration approval period or the end of the latest rating period covered under the state's approved expenditure authority, whichever comes later.

We look forward to our continued partnership with you and your staff on the "Oregon Health Plan Substance Use Disorder" demonstration. If you have any questions, please contact your CMS project officer, Felicia Pailen, who may be reached by email at Felicia.Pailen@cms.hhs.gov.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2023.05.23 11:14:57 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Nicole Lemmon, State Monitoring Lead, Medicaid and CHIP Operations Group

**Oregon Health Plan - COVID-19 PHE Risk Mitigation Amendment under the Oregon Health Plan Substance Use Disorder 1115 Waiver**

Section 1115 (a) Demonstration

Project Number 11-W-00362/10

# EVALUATION DESIGN AND PROPOSED FINAL REPORT

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**Oregon Health Plan Substance Use Disorder Section 1115 (a) Demonstration**
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This document is intended to fulfill the evaluation design condition of approval required under CMS's letter dated February 4, 2022 regarding the COVID-19 Public Health Emergency (PHE) section 1115 demonstration application submitted by the Oregon Health Authority (OHA) on January 14, 2022. CMS approved the request as an amendment to the "Oregon Health Plan Substance Use Disorder" section 1115(a) demonstration (Project Number 11-W-00362/10) per Attachment II (CMS Risk Mitigation Approval Letter dated 2/4/2022).

CMS advised OHA on the primary evaluation requirements for this demonstration: a simplified evaluation design will be due 180 calendar days after the demonstration's approval, and a final report will be due 18 months after the demonstration expires or the end of the latest rating period covered under the state's approved expenditure authority. This report is intended to cover the evaluation design, and as 2020 MMLR filings have been finalized, the appendix to this report may also be sufficient for the final reporting requirements on this waiver amendment if CMS so agrees.

This evaluation design contains descriptions of the history and purpose of the demonstration, a general overview of the research questions to be examined in the final report, an outline of data sources that would be useful to both contextualize and respond to these questions, a brief narration of the analyses to be conducted, and any anticipated limitations to the evaluation approaches.

## Historical Background of the Demonstration

The demonstration application pertains to the 2020 calendar year rating period. OHA applied to change the minimum medical loss ratio (MMLR) risk mitigation arrangement applying to Coordinated Care Organizations (CCOs) from a three-year period to a one-year period. Following are technical specifications from CMS.

| STATE | RATING PERIOD BEGIN | RATING PERIOD END | PROGRAM | RISK MITIGATION ARRANGEMENT | RATE ACTION IDENTIFIER |
|---|---|---|---|---|---|
| OR | 01/01/2020 | 12/31/2020 | CCO | Min MLR with remittance | Oregon_CCO_20200101-20201231_Amendment_20220110 |
| OR | 01/01/2020 | 12/31/2020 | CCO | Min MLR with remittance | Oregon_CCO_20200101-20201231_Amendment_20201012 |

In March 2020, with the onset of the (novel coronavirus) COVID-19 pandemic, the Oregon Health Plan (OHP), like other Medicaid programs, saw a sharp reduction in members' utilization of medical services. This downturn in services was a direct result of the quarantine of individuals who did not seek medical care and the temporary discontinuance of certain services, such as elective surgeries, by providers.

OHA responded to this emerging PHE in concert with its managed care organizations (MCO), also known as coordinated care organizations (CCO), through weekly meetings with its CCOs to monitor the access to care, discuss collaborative ways to ensure care was being provided and increase opportunities for care through the use of telehealth. Additionally, OHA allowed temporary telehealth flexibilities through the Oregon state of emergency.

The rating period in which the COVID-19 pandemic originated was calendar year 2020 (CY 2020). Since the capitation rates paid to the CCOs were determined prior to the beginning of the rating period, the inclusion of medical costs and expenditures from the CCOs for medical services were expected to be at a level in line with historical rates. While a managed care delivery system is set up to allow the CCOs to

earn some profit by making people healthier through sound utilization management, the state was facing a situation where CCOs were set to reap an unjustified windfall at a time when provider payments were cratering. The state also wanted to support Medicaid providers in their time of need with sufficient revenue to keep their doors open and ensure ongoing access for OHP members.

In response to this situation, OHA proposed and implemented a change to the MMLR provisions in effect in 2020. Previously, the MMLR provisions were based on a three-year period of 2020-2022. The revised MMLR provisions stipulated that CCOs which spent less than 85% of their revenue on documented medical expenditures would be required to remit the unspent portion below 85% back to OHA. In connection with this MMLR change, OHA expanded the definition of medical expenditures that were allowable in the MMLR calculation to include Provider Stabilization Payments, which were defined as any payment, including Value-Based Payments, from Contractor to a Provider that were:

(i) Made during a COVID-19 Emergency;
(ii) When combined with any other payments to the Provider made for Covered Services rendered during the period, no greater than a reasonable estimate (based on historic claims data) of the claims the Provider would have submitted to Contractor for Covered Services provided to Members under this Contract but for the COVID-19 pandemic; and
(iii) Made to ensure the availability of the Provider, both during and after any COVID-19 Emergency, to deliver Covered Services to Members under this Contract.

In total, these measures were taken to ensure that OHP revenue would either be spent in 2020 on providing necessary care and maintaining patient access, or else remitted to OHA and CMS.

OHA provided contract amendments to CCOs for signature on July 20, 2020, and submitted signed contract amendments to CMS on August 28, 2020 along with a rate certification amendment submitted on 10/12/2020. CMS advised in December 2021 that the documentation in the rate certification amendment was insufficient, and that an additional rate certification amendment was required to document the MMLR change. Because the additional rate certification would complete the required documentation after the effective date of the regulatory prohibition in 42 CFR § 438.6(b)(1), CMS advised that a demonstration application would be required to approve the MMLR change. OHA submitted that additional rate certification amendment on 1/14/2022, along with the demonstration application.

**Purpose of the Demonstration**

The purpose of this demonstration is to allow an exemption from the regulatory prohibition in 42 CFR § 438.6(b)(1) to promote the objectives of Oregon's Medicaid program. The expenditure authority is expected to support making appropriate, equitable payments during the PHE to help maintain beneficiary access to care.

The demonstration application pertains to the 2020 calendar year rating period. OHA applied to change the minimum medical loss ratio (MMLR) risk mitigation arrangement from a three-year period (which was in place going into the 2020 calendar year rating period) to a one-year period. In absence of this risk mitigation provision, there would have been a significant risk that one or more CCOs would be overpaid for care not delivered during the PHE.

The demonstration application would permit Oregon to add or modify risk sharing mechanisms after the start of a rating period provided that the contract and rating period(s) begin or end during the COVID-19 PHE. This expenditure authority exempts the state from compliance with the requirements under 42 C.F.R. § 438.6(b)(1) and allows Oregon to add or modify the risk sharing mechanism(s) after the start of the rating period as specified in the state's contracts with its Medicaid managed care plans. The authority would exempt, as necessary, states from compliance with the current requirements in section 438.6(b)(1), until the end of the PHE. The authority would allow one or more retroactive risk mitigation arrangements to remain in place even if the state and the managed care plan had agreed to these arrangements after the requirements in section 438.6(b)(1) became effective.

## Research and Evaluation Questions

The following evaluation questions were adopted from CMS guidance to provide background on and report on specific scope of the demonstration under this authority. The first two questions provide background for the demonstration application, and are addressed above.

1. What was the purpose of the demonstration?
2. What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?

The remaining questions examine OHA's hypothesis that the demonstration facilitated attaining the objectives of Medicaid, and the authority supported states in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care during this period that otherwise would have been challenging due to the prohibitions in section 438.6(b)(1).

3. To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?
4. What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?
5. What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans?
6. What were the principal lessons learned in implementing the demonstration flexibilities?

## Methodology

*Data Sources*

OHA used qualitative data including feedback from CCOs during regular meetings and negotiations on rates and contracts during 2020, along with descriptive statistics on total expenditures and MMLR filings to contextualize and respond to the proposed research questions.

OHA communicated the proposed MMLR change to CCOs during a regularly scheduled meeting with their CEOs on June 2, 2020, and a regularly scheduled capitation rates workgroup meeting on June 30, 2020, with follow-up CCO comments requested by July 6. OHA then received signed contract amendments by August 2020.

CCOs filed MMLR templates for the 2020 calendar year rating period by September 2021, and these templates provide the quantitative basis of OHA's evaluation.

CCOs' 2021 MMLR templates were submitted in September 2022, and CCOs' 2022 MMLR templates are expected to be submitted in August 2023 and reviewed by December 2023. Because the 2022 MMLR filings (which would complete the three-year MMLR period that would otherwise have been in effect) will be due after the 18 month period for demonstration reporting, OHA limited its quantitative analysis to 2020 MMLRs. OHA also notes that the counterfactual situation that would have been in place with a three year MMLR and no Provider Stabilization Payments would almost certainly have resulted in lower 2020 spending by CCOs, which would render a three-year MMLR calculation based on actual 2020-2022 filings a moot exercise.

*Analytic Methods*

The analysis was conducted by OHA's Office of Actuarial and Financial Analytics (OAFA), using the data sources above to address the listed questions. OAFA reviewed the qualitative CCO feedback as part of evaluating the research questions listed above.

OAFA also assembled summary statistics from the 2020 MMLR filings to quantify the impact of the MMLR provision as well as the related Provider Stabilization feature.

The application of these analytic methods to the research questions listed above will be applied as follows:

| Research Question | Outcome Measures | Data Sources | Analytic Methods |
|---|---|---|---|
| 1 | Narrative explanation | CCO contact points and feedback, including contract signing | Qualitative summary |
| 2 | Narrative explanation | Contract documentation | N/A |
| 3 | Quantitative summary of 2020 MMLR findings | 2020 MMLR filings, incl Provider Stabilization Payment data | Summary statistics |
| 4 | Quantitative summary of 2020 MMLR findings | 2020 MMLR filings, incl Provider Stabilization Payment data | Summary statistics |
| 5 | Narrative explanation | CCO contact points and feedback, including contract signing | Qualitative summary |
| 6 | Narrative explanation | N/A | N/A |

Due to the timing of the waiver filing and the availability of the data sources noted above, the evaluation was conducted subsequent to the February 4, 2022 CMS approval, and completed prior to the submission of this evaluation design and proposed final report. Because the final report is included in this document, further details on the analytic methods are reported on in the responses to the proposed research questions.

*Limitations to the Evaluation Approach*

The evaluation approach is limited by the data sources; however, this approach is intended to follow CMS's guidance to use qualitative methods and descriptive statistics to understand the successes, challenges, and lessons learned in implementing the demonstration. As noted above, the state cannot demonstrate any counterfactual outcomes that would have occurred in absence of the demonstration approval, but the state can infer the effectiveness of the MMLR change through the existence of a refund combined with the volume and prevalence of Provider Stabilization Payments.

**Attachment I: Proposed Final Report**

The following responses to the evaluation questions are intended to examine how the demonstration facilitated attaining the objectives of Medicaid, and how the authority supported OHA in making appropriate, equitable payments during the COVID-19 PHE to help with maintenance of beneficiary access to care during this period that otherwise would have been challenging due to the prohibitions in section 438.6(b)(1).

1. What was the purpose of the demonstration? In 2020, OHA responded to the risk that the PHE would significantly reduce the medical expenditures of CCOs, as evidenced by emerging claims data and general provider feedback. OHA drafted a contract amendment which changed the minimum medical loss ratio (MMLR) rebate provisions in the CCO contract from a three-year calculation period to a one-year calculation period. Contracts amendments were presented in July 2020 and signed by CCOs in August 2020. CMS later advised that the rate amendment filed for this contract action did not contain sufficient analysis of the impact of the MMLR change on 2020 capitation rates. A rate certification amendment was filed in January 2022 at CMS's direction, and provided further analysis, including a statement that there would not be an impact on the previously published capitation rates. However, because the rate amendment was filed after the December 2020 effective date of section 438.6(b)(1) changes regarding retroactive risk mitigation provisions, Oregon was required to seek this waiver in order to maintain the 2020 MMLR change.

   Please refer to the Historical Background and Purpose of the Demonstration sections of this evaluation design submission for further discussion.

2. What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority? OHA negotiated a change from a three-year MMLR calculation and rebate, to a one-year MMLR calculation and rebate for 2020 only. Included in this one-year MMLR calculation were expanded flexibilities for telehealth as well as Provider Stabilization Payments.

   Please refer to the Historical Background and Purpose of the Demonstration sections of this evaluation design submission for further discussion.

3. To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans? As shown in Table 1 below, the total aggregate expenditures associated with this section 1115 demonstration was a savings of $7.6 million federal funds, or $11.2 million total funds. Complete data on CCOs MMLR measurements can be found in Attachment III, which is the annual report required by CMS to document managed care MLR data.

   Furthermore, in 2020, 11 CCO contracts applied $64.9 million in total Provider Stabilization Payments to their provider network. In absence of these payments, a further 3 CCOs would have had MLRs below 85% - highlighting the benefit of providing CCOs with the flexibility to spend on provider networks to ensure access, while preventing against their retaining windfall profits.

   In absence of the waiver, the one CCO with an actual remittance would have been significantly less likely to have a MMLR rebate under the three-year MMLR period. Moreover, in absence of the waiver, a portion of the $64.9 million in Provider Stabilization Payments would likely have been retained by CCOs (due to a lack of immediate remittance), rather than being used to support the Medicaid system. Therefore, the waiver allowed OHA to ensure that 2020 payments to plans did not allow for an excessive level of profit.

**Table 1. CCO MLR and Provider Stabilization Data**

| CCO | Reported MLR | Remittance | Provider Stabilization Payment | MLR without PSP |
|---|---|---|---|---|
| Advanced Health, LLC | 88.90% | $0 | $0 | 88.90% |
| Allcare CCO | 86.00% | $0 | $826,810 | 85.69% |
| Cascade Health Alliance, LLC | 89.05% | $0 | $2,765,532 | 86.47% |
| Columbia-Pacific CCO, LLC | 85.77% | $0 | $700,377 | 85.39% |
| Eastern Oregon Coordinated Care Org., LLC | 85.14% | $0 | $0 | 85.14% |
| Health Share of Oregon | 86.53% | $0 | $16,998,380 | 85.60% |
| InterCommunity Health Network, Inc. | 91.98% | $0 | $0 | 91.98% |
| Jackson County CCO, LLC | 85.55% | $0 | $2,359,179 | 84.65% |
| PacificSource Community Solutions (Central) | 87.75% | $0 | $5,861,399 | 86.02% |
| PacificSource Community Solutions (Gorge) | 85.54% | $0 | $2,437,135 | 82.38% |
| PacificSource Community Solutions (Lane) | 86.84% | $0 | $8,945,277 | 84.34% |
| PacificSource Community Solutions (Marion Polk) | 88.55% | $0 | $15,762,321 | 85.75% |
| Trillium Community Health Plan, Inc. | 79.87% | $11,215,984 | $0 | 79.87% |
| Umpqua Health Alliance | 89.32% | $0 | $5,771,946 | 85.87% |
| Yamhill Community Care | 87.93% | $0 | $2,465,095 | 86.39% |
| **Total** | | **$11,215,984** | **$64,893,450** | |

4. What problems does the state anticipate would have been caused by the application of section 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems? As shown in Table 1, in absence of the flexibility granted under this waiver, Oregon and CMS would have paid an extra $11.2 million in profits to a CCO whose favorable financial experience in 2020 was heavily driven by lower utilization experienced during the PHE. Instead, profits for all CCOs for 2020 were limited to levels commensurate with a single-year 85% minimum MMLR. Furthermore, CCOs were incentivized by the one-year MMLR to spend money on care and maintain access in 2020, rather than rebate money back to OHA/CMS, as demonstrated in part by the $64.9 million in Provider Stabilization Payments.

   Therefore, the one-year MMLR advanced the objectives of Medicaid by providing more accurate payment, and encouraging CCOs to provide stabilization payments that helped keep providers afloat during the 2020 and maintain access for Medicaid Members.

5. What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the state Medicaid agency and Medicaid managed care plans? The principal challenge faced by the state resulted from the regulatory restriction under 42 CFR 438.6(b)(1) that applied even after the state had thought it had filed timely contract and rates actions. However, the CMS waiver process has provided an expeditious means to address the regulatory restriction.

   Managed care entities were advised of the change during a regularly scheduled meeting with their CEOs on June 2, 2020, and signed all contract amendments by August 2020. OHA did not receive concerning feedback from CCOs regarding challenges of moving to a one-year MLR, which at the time of the notification and contract signing was in accordance with the timing requirements under CMS regulations.

6. What were the principal lessons learned in implementing the demonstration flexibilities? CMS

had advised in this process that rate actions must accompany contract actions that could reasonably impact capitation rates, and those rate actions/amendments should provide sufficient analysis of the contract changes to demonstrate the changes, or lack thereof, to capitation rates on account of the contract actions. Oregon and its vendor actuaries will be better prepared to observe this requirement in future years.