Fiscal and Operations Division

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From: Rochelle Layton, CFO

To: Senate Health Care Committee

Subject: Risk Adjusted Rates of Growth for 2025

Senate Bill 1041 (2019) requires OHA to publish annually a **risk-adjusted rate of growth** measurement (RAROG) for each Coordinated Care Organization (CCO). The purpose of publishing RAROG is to hold CCOs accountable and to understand statewide spending. Following is a summary of the results for 2025, along with an outline of how results are calculated. In addition, OHA also posts all the detailed CCO financial reports on this website: https://www.oregon.gov/oha/FOD/Pages/CCO-Financial.aspx.

What is risk-adjusted rate of growth?
Rate of growth measurements look at changes in *CCO spending*[1]. CCO spending is considered in setting capitation rates in future years, so a restrained rate of growth helps meet statewide goals on medical spending.

Risk adjustment means changing the rate of growth measurement to account for changes in the health risk of CCOs' membership. Health risk is measured by diagnosis and prescription drug data that indicate the presence of medical conditions. Risk adjustment can be helpful because CCO membership changes each year and adjusting for the changes in membership allows RAROG to focus on underlying cost growth.

While Oregon's Cost Growth Target program also measures CCO spending, the methodology and included expenditures are different from the risk-adjusted rate of growth methodology. The Cost Growth Target program measures total health care expenditures at the CCO level.[2]

RAROG results for 2025
The following table shows each CCO's rate of growth, comparing calendar year 2025 to 2024. The Unadjusted column shows the rate of growth without accounting for the health risk associated with that CCO's membership. The Risk-Adjusted column, however, shows the rate of growth considering the changes in health risk of that CCO's population.

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[1] CCO capitation rates also change from year to year, but those capitation rates represent *OHA spending on CCOs*, or equivalently, *CCO revenue*.
[2] The Cost Growth Target methodology and included expenditures are described in detail in the specification manual.

CCO	**Unadjusted** Rate of Growth 2024-2025	**Risk-Adjusted** Rate of Growth 2024-2025	**Annualized** RAROG 2022-2025
Advanced Health, LLC	5.1%	1.7%	-0.4%
AllCare CCO	6.9%	5.1%	5.7%
Cascade Health Alliance, LLC	3.1%	-0.8%	7.7%
Columbia Pacific CCO, LLC	7.4%	4.2%	7.8%
Eastern Oregon Coordinated Care Org., LLC	7.9%	4.9%	4.0%
Health Share of Oregon	4.6%	0.4%	5.2%
InterCommunity Health Network, Inc.	9.2%	8.2%	5.1%
Jackson County CCO, LLC	4.3%	1.8%	6.5%
PacificSource Community Solutions (Central)	7.6%	4.8%	4.0%
PacificSource Community Solutions (Gorge)	11.5%	10.0%	2.4%
PacificSource Community Solutions (Lane)	5.0%	2.6%	4.5%
PacificSource Community Solutions (Marion Polk)	1.7%	-1.0%	4.4%
Trillium Community Health Plan, Inc. (Southwest)	2.7%	-1.0%	4.7%
Trillium Community Health Plan, Inc. (Tri-County)	14.1%	10.9%	6.2%
Umpqua Health Alliance	3.2%	2.3%	8.0%
Yamhill Community Care	5.0%	1.7%	3.7%
Statewide Weighted Average	**5.5%**	**2.3%**	**5.0%**

The statewide weighted averages above show an unadjusted growth rate of 5.5%. After risk-adjusting, the growth decreases to 2.3%, which is lower than the state's target rate of growth. The application of risk-adjustment resulted in the statewide rate of growth decreasing as would be expected when adjusting for health status of a gradually aging population. The 2024-2025 risk adjustment also reflects the completion of redeterminations in 2024 following the end of the COVID-19 Public Health Emergency.

As with the preceding year, this year's adjustment uses *Oregon-specific* risk weights for non-disabled adults and *"national"* risk weights under the CDPS+MRx version 7.3 model for all other aid categories. The Oregon-specific weights were calibrated to provide a more accurate assessment of the cost of care incurred by Oregon's Medicaid population, primarily for the purpose of capitation rate setting.

Individual CCO rates of growth can be influenced by many factors. Even after risk adjustment, individual CCO RAROGs can be unusually high or low in a single year and may reflect factors such as changes to local hospital pricing or large individual claims. The final column in the table above shows an average RAROG over the past three years.

Program notes

The preceding rates of growth reflect CCOs' Medicaid spending funded by capitation rates. They do not include separately-funded programs such as Healthier Oregon (HOP) and Basic Health Program (BHP). Among other considerations, YSHCN experience could not be compared to the prior year, as the 2024 experience was non-existent. Certain expenditures funded by non-capitation sources such as quality pool and Health Related Social Needs (HRSN) benefits were also excluded from this measurement.

The resulting statewide averages are also impacted by Medicaid program changes. In 2025, increases to inpatient psychiatric rates were expected to add 0.3% to CCO costs. Outside of these program changes, there was elevated growth in overall behavioral health expenditures. These increases were somewhat offset by decreases in incentive payments and flexible services spending.

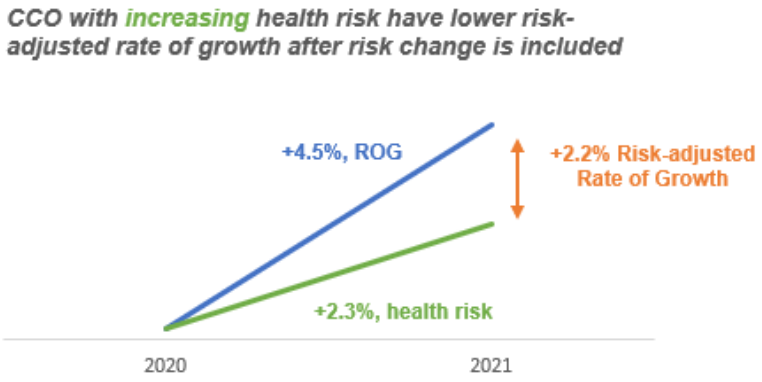
Methodology

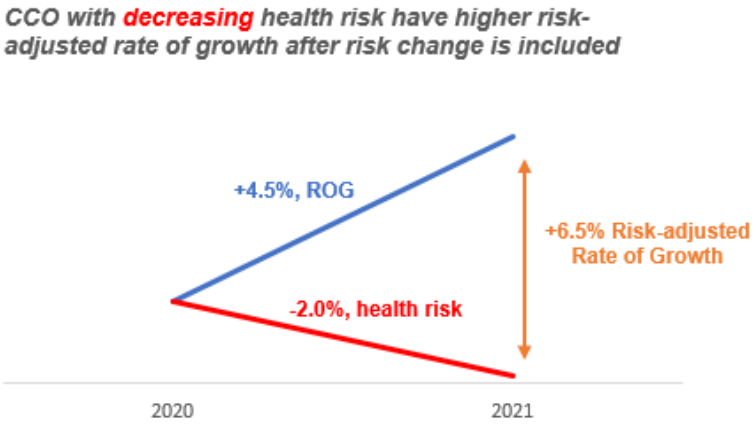
To calculate risk-adjusted rates of growth, OHA analyzes CCOs' spending reports[3], and applies a risk adjustment methodology to physical and behavioral health spending for members in specific eligibility categories[4]. Secondly, OHA adds non-risk adjusted spending categories and other components. The result of these calculations is the total risk adjusted per member per month cost in a base year. After calculating PMPMs for consecutive calendar years, the results are compared to determine the RAROG.

Risk Adjusted Spending: Physical and behavioral health spending for most Medicaid	+	*Other Spending, not adjusted:* Non-risk adj'd members Dental and maternity Incentive payments	=	Total Risk Adjusted Per Member Per Month spending (PMPM)

Relation between rates of growth and risk scores

A CCO's rate of growth may be impacted and explained by growth in acuity, or health risk, in their population, such as more members with chronic disease in one year than the other. Following are two examples of the same growth (unadjusted) and the resulting impact to the risk-adjusted rate of growth if the health risk increased or decreased.





[3] CCOs submit financial data to OHA on a quarterly basis. These reports contain CCO spending patterns.

[4] Some eligibility categories are not risk adjusted: pregnant women, infants, foster children, breast and cervical cancer patients, and Medicare-eligible members.