

Where we are and where we're going:

Rate Setting for Coordinated Care Organizations

Introduction

In 2012, Oregon's 1115 Medicaid demonstration (Waiver) with the Centers for Medicare and Medicaid Services (CMS) established coordinated care organizations (CCOs) as Oregon's Medicaid delivery system. This was the beginning of the coordinated care model. Across Oregon, 16 CCOs are working to transform the health care delivery system on a local level to bring better health, better care and lower costs to Oregonians. CCOs are responsible for integrating care and delivering physical health, behavioral health and oral health services to their members.

An important part of the Waiver gives Oregon flexibility to tie payments more closely to outcomes, rather than just paying for services delivered. Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Incorporating innovative payment methods and offering incentives for quality outcomes will support better care and lower costs.

This brief will explain:

- The background of rate setting and global budgeting
- CMS' direction regarding Oregon's prior and current rate-setting methods
- The 2015 proposed rate redevelopment timeline
- Potential implications of rate setting and rate redevelopment on CCOs

The Global Budget

As part of the coordinated care model outlined in the Waiver, OHA employs "global budgets" to compensate CCOs. By integrating funding streams, the global budget represents the total cost of care for all services for which the CCOs are responsible and held accountable for managing, either through performance incentives and/or being at financial risk for paying for health care services.

CCO global budgets are comprised of two major components: capitated and non-capitated. The capitated portion includes funding for all services that can be disbursed to CCOs in a prospective per member, per month payment. The capitated portion includes all services currently provided by physical health, behavioral health, and most recently oral health services. The non-capitated portion of the global budget calculation includes the quality pool incentive payments and will include future programs and services that are provided outside of managed care capitated rates.

In addition to this idea of a global budget, the Waiver includes a commitment that the coordinated care model will reduce medical inflation by two percentage points on a per member per month basis, from a trend calculated in the President's budget of 5.4% to 3.4% at the statewide level. OHA is accountable for the reduction in trend at the statewide level. This is commonly referred to as the "2% test."

The Waiver addresses the new population afforded Medicaid coverage by the Affordable Care Act, or "Expansion population," by delaying the state's accountability for the cost of these members' services into the annual growth rate calculation until state fiscal year 2015 when more utilization data is available. Additionally, the Waiver acknowledges that the rates for the Expansion population may need to be modified in 2015 or 2016 based on actual experience of the CCOs due to demonstrable differences in health status or an identifiable shift in the pattern of utilization (Attachment H: Part III, Section B Expenditure Tracking for Trend Reduction Test). The expectation reflected in the language of the Waiver was that initial estimates of health status and utilization may need to be adjusted once utilization data became available.

2014 Rate Setting Methodology

To allow flexibility in meeting the global budget at the CCO level when setting rates, OHA continued using the capitation rate methodology known as the "cost template," which was used to set rates from 2011 to 2014. The cost template was a rate setting model created by OHA actuaries. The cost template was provided to CCOs to report their financial costs and anticipated trends. Each year, CCOs were restricted to an aggregate target increase/decrease in costs to meet the sustainable rate of growth. Beginning in 2012, the cap on an aggregate target increase was 3.4%.

CMS Guidance for 2015

In 2014, OHA received guidance from CMS to adjust the cost template rate methodology previously used and to align future rate setting with the Actuarial Standards of Practice (ASOP) requirements. This guidance was issued in the form of both an Oregon specific letter from CMS requiring an action plan and reinforced by a [2015 Rate Setting Managed Care Consultation Guide](#). The CMS guidance issued in September 2014 provided specific guidance on how rates needed to be developed in accordance with ASOP, with emphasis on the ACA Expansion population (Section II of the guide) due to 100% federal funding of this population.

The Oregon-specific guidance from CMS required a plan for redeveloping the rate setting methodology. CMS asked OHA to address the lack of encounter data used in setting the rates and to move away from the cost template rate setting methodology used from 2011 to 2014. OHA made intentional steps during the 2015 rate setting process to align to CMS guidance while continuing to support Oregon's health system transformation goals.

Expansion Population Rate Methodology

The Expansion population consists of adults without dependent children and parents with incomes up to 138% of the federal poverty level. The medical needs of this population were not well known at the time the 2014 capitation rates were developed. The cost of this new population had to be estimated with little data. OHA had some experience for the Oregon Health Plan Standard population; however, this population is a fraction of the existing Expansion population.

In 2014, CMS and the Federal Office of the Actuary (OACT) started the process of thoroughly reviewing Medicaid rate methodologies submitted by all states, including Oregon. To assist states in understanding what was expected by CMS and the OACT, CMS released the 2015 Managed Care Rate Setting Consultation Guide in September of 2014 (referenced above).

Since the Expansion population rates were developed with little to no actual utilization data, CMS expects states to incorporate all emerging experience into the rate development and monitor the actual experience versus projected experience, to ensure that projections are reasonable with respect to the actual risk of these new populations. This is discussed in Section II of the 2015 Managed Care Rate Setting Consultation Guide and was re-iterated by CMS and the Office of the Actuary in several technical assistance calls in both 2014 and 2015.

Given the guidance from CMS and lack of data available in the initial 2015 rate setting, OHA engaged Optumas, an actuarial firm, to reexamine the 2015 rate methodology and to incorporate emerging experience from the ACA population in updated 2015 rates. Additionally, Optumas will be developing 2016 rates in tandem with the 2015 rate redevelopment process.

OHA and Optumas are committed to working toward the global budget as envisioned in the Waiver and meeting the requirements as specified by CMS and the Actuarial Standards Board. Concurrently, OHA is investigating alternate methods to be used in future rate setting to meet objectives of the Waiver that includes a global budget with a sustainable, predictable rate of growth.

The Timeline for 2015 and 2016 Rate Setting

An overview timeline (attached) shows the steps toward developing both 2015 and 2016 rates. OHA expects to have 2015 rates completed by July 3, 2015 and 2016 rates developed by September 30, 2015, assuming no delays in obtaining needed information from CCOs. The effective date of the revised 2015 rates has not yet been determined.

Potential Impact of 2015 Rate Setting on CCOs

The redevelopment of 2015 CCO capitation rates may result in an increase or a decrease in per capita payment to CCOs from the current 2015 rates. These changes are necessary to decrease the current variability in rates between CCOs within the same geographic region and fluctuations from year to year. The changes will also establish new ACA Expansion population

rates to better reflect actual experience. The redeveloped 2015 rates will establish a more consistent baseline on which to base future predictable growth.

OHA is working with CCOs to minimize impacts of these potential changes. Future discussions and decisions around the effective date of redeveloped rates are expected to occur over the next two months. The risk mitigation strategy related to the ACA Expansion population that is required by CMS is also being examined.

For More Information

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Calendar Year 2015 and 2016 Rate Development

