

Oregon Health Authority

CCO 2.0 Procurement Rate Methodology

January 1, 2020 – December 31, 2020 Capitation Rates



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1. Background

Over the past five years, Oregon's unique coordinated care model has made progress on the triple aim goals of better health, better care and lower costs. To guide the next five years of the Oregon Health Plan, the Oregon Health Authority (OHA) and **Optumas** worked in partnership with the Oregon Health Policy Board (OHPB), policymakers, stakeholders and OHP members to create the next iteration of the CCO program, referred to as CCO 2.0. These ideas are intended to address the gaps and challenges that persist within the CCO health care system under the first iteration of the program (CCO 1.0).

To support CCO 2.0 policy development and fulfill their commitment to transparency, OHA sought significant public input. Thousands of Oregonians took part through:

- OHPB meetings
- Stakeholder meetings and presentations
- Public forums
- Online surveys, and
- A phone survey of OHP members.

OHA's CCO 2.0 policy recommendations build upon Oregon's strong foundation of health care innovation and seeks to make improvements based on best practices and evidence, as well as stakeholder and community input. As part of CCO 2.0, OHPB focused on four key areas:

1. Improve the behavioral health system and address barriers to access to and integration of care
2. Increase value and pay for performance
3. Focus on social determinants of health and health equity
4. Maintain sustainable cost growth

Overall, OHA's CCO 2.0 policies aim to remove barriers between behavioral, physical and oral health. These policies will help all members receive the right care, at the right time and in the right place.

Policies will:

1. Require CCOs be fully accountable for the behavioral health benefit
2. Assess capacity of comprehensive services
3. Address prior authorization and network adequacy issues that limit member choice and timely access to providers
4. Use metrics to incentivize behavioral health and oral health integration
5. Expand programs that integrate primary care into behavioral health settings
6. Require CCOs to support electronic health record adoption and access to electronic health information exchange
7. Develop a diverse and culturally responsive workforce
8. Ensure children have behavioral health needs met with access to appropriate services

By moving toward a focus on increased value and pay for performance over the next five years, OHA expects the CCOs to make a significant move away from fee-for-service payments and move toward paying providers based on value. The proposed CCO 2.0 policies will reward providers and health systems for delivering patient-centered and high-quality care. OHA will ask CCOs to develop value-based payments (VBPs) to improve health outcomes in the areas of: hospital care, maternity care, behavioral health, oral health and children's health care. Recommended policies will:

1. Increase CCOs' use of VBPs with providers by requiring annual, CCO-specific VBP growth targets » Achieve a 70 percent VBP goal by 2024
2. Increase CCOs' support of Patient-Centered Primary Care Homes (PCPCHs): » Require VBPs for PCPCH infrastructure and operations
3. Provide technical support and align payment reforms with other state and federal VBP efforts and focus on social determinants of health and health equity from the beginning, Oregon's coordinated care model recognized that many things affect our health outside of the doctor's office

Over the next five years, CCOs will increase their investments in strategies to address social determinants of health and health equity. CCOs will build stronger relationships with members, nonprofit organizations, hospitals, schools and local public health departments. CCOs will align goals at the state and local level to improve health outcomes and advance health equity. OHA will develop measurement and evaluation strategies to increase understanding of spending in this area and track outcomes. Recommended policies will:

1. Increase strategic spending by CCOs on social determinants of health, health equity and disparities in communities, including encouraging effective community partnerships
2. Increase CCO financial support of non-clinical and public health providers
3. Align community health assessments and community health improvement plans to increase impact
4. Strengthen meaningful engagement of tribes, diverse OHP members, and community advisory councils (CACs)
5. Build CCOs' organizational capacity to advance health equity
6. Increase the integration and use of traditional health workers (THWs)

To support sustainability, CCO 2.0 policies address the major cost drivers currently in the system. OHA will also identify areas where CCOs can increase efficiency, improve value and decrease administrative costs. Recommended policies will:

1. Strengthen current financial incentives
2. Set up new tools to evaluate and reward CCOs for improving health outcomes and containing costs
3. Ensure program-wide financial stability and program integrity through improved reporting and strategies to manage a CCO in financial distress
4. Use program purchasing power to align benefits and reduce costs with a focus on pharmacy costs

The remainder of this report describes the components of the CCO 2.0 rate methodology used for the next CCO contract. The components shown within this report are subject to change pending further OHA policy, legislative changes and the review of emerging CY2018 data. Statewide capitation rates shown within this report should be considered informational as part of the CCO 2.0 procurement and may be refined as part of the final actuarial certification submitted in Fall of CY2019.

2. Rate Development Process

2.01 Overview

The following key concepts were considered when developing the rate methodology for the CCO 2.0 program:

- 1) **Statewide Base Data** – To support the concept of OHA monitoring changes to the CCO 2.0 program globally, the starting point for the rate development will be a statewide base data, split by category of aid (COA) and category of service (COS). The base data will be comprised of CY2016 and CY2017 base data. For 2020 forward, at least two years of base data will be used as part of the CCO 2.0 rate development. OHA plans on evaluating the CCO program for potentially avoidable costs in future rate settings, which may result in managed care adjustments if needed and/or potential reimbursement adjustments.
- 2) **Service Areas/Area Factors** – OHA has proposed nine Service Areas as part of the CCO 2.0 program. Oregon could be considered a predominantly rural state with a handful of metropolitan areas. Due to its rurality, there are differences in practice patterns (e.g., access to care) depending on where a CCO's member base is concentrated and these differences need to be considered when developing the capitation rates for each of the nine proposed Service Areas. In addition, differences will be accounted for as part of the area factor development.
- 3) **Member Risk Differential** – In order to assess differences in member acuity, the rate methodology will incorporate a risk score tool, CDPS+RX, to assist in better quantifying the membership risk across the individual CCOs once membership has stabilized. Due to current statute (ORS 414.652), OHA plans to institute a six-month risk corridor at the beginning of CY20 to mitigate the risk of over- and under-paying due to differences in risk between CCOs. However, this is subject to change as OHA is also planning to propose a legislative concept for this statute in the upcoming 2019 session.
- 4) **Social Determinants of Health (SDOH) Risk Differential** – OHA plans on enhancing the member risk differential for CY2022 by incorporating Social Determinants of Health (SDOH) factors to support the key priorities of CCO 2.0.
- 5) **Data Quality** – Using the historical base data from CY2016 and CY2017 allows the actuary to apply the appropriate adjustments to the base data required to ensure all data is appropriately accounted for within the base data.
- 6) **Withhold** – Under CCO 1.0, OHA paid a Quality Pool Incentive based upon quality metrics outside the capitation rate. Under CCO 2.0, this funding will now be operationalized as a withhold and therefore be contained within the rate development methodology.
- 7) **Variable Margin (CCO Specific Margin)** – CCO 2.0 will vary the margin loaded into the capitation rates by CCO to reward CCOs that are high performing and show success in achieving the sustainable rate of growth, improving efficiency in care delivery, and investing in effective Health Related Services (HRS)/Social Determinants of Health (SDOH). For more details about how OHA will evaluate performance, please see the Appendix II. Prometheus Analytics.
- 8) **Hospital Reimbursement** – Under CCO 1.0, OHA included a separate add-on in the rates called hospital reimbursement adjustment (HRA) that was a pass-through to DRG hospitals. Under CCO 2.0 and based on new managed care pass-through regulations, OHA will transition away from HRA starting CY2020. Please see Hospital Reimbursement Adjustment (HRA) Transition in Section 2.06 for more details about the transition and impact to CCO rates.

- 9) **Biennial rebasing** – Under CCO 1.0, OHA reviewed data and rebased the capitation rates each year. In an effort to create more stability in the program, OHA will move to a biennial cycle of rebasing.

The rate methodology described in this certification is centered around the idea of creating Service Area specific rates from a statewide base data by COA. This Service Area approach is then supplemented with the development of health-based risk factors, CDPS+RX, that reflect the unique risk of each Service Area and CCO. These risk factors and area factors are applied to the statewide base data resulting in Service Area specific payment rates that are commensurate with the Service Area's unique risk. OHA has proposed the nine Service Areas. Area factors and risk factors (CDPS+RX) will be applied in a budget neutral manner with respect to the statewide base data.

The goal of the rate development process is to develop a payment rate for each rating cohort within each Service Area that is consistent with all applicable guidelines and Actuarial Standards of Practice (ASOPs):

- ASOP 5 – Incurred Health and Disability Claims
- ASOP 23 – Data Quality
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies
- ASOP 49 – Medicaid Managed Care Capitation Rate Development and Certification

The final payment rate is the certifying actuary's best estimate which is developed to reflect the inherent risk of the covered population for each Service Area, intended to match payment to risk across all Service Areas and CCOs.

2.02 Base Data

Data Reporting

As part of the CCO 2.0 Procurement Rate Development process, **Optumas** relied on the following data sources to compile the statewide base data:

1. CY16/CY17 detailed CCO encounter data (incurred 1/1/2016 – 12/31/2017) provided by OHA. This is the same base detailed encounter data used within the CY18 and CY19 rate development, respectively.
2. CY16/CY17 eligibility file provided by OHA. This data contains monthly, member-level enrollment information such as enrollment status, county of residence, and category of aid.
3. CY16/CY17 financial templates (incurred 1/1/2016 – 12/31/2017) as reported by each participating CCO. These financial templates were provided by each CCO and contain enrollment volume and medical costs, inclusive of encounterable costs, subcapitated arrangements, and additional incentive payments made to providers outside of the encounter data, including costs related to flexible services.
4. CY17 subcapitated financial templates (incurred 1/1/2017 – 12/31/2017) as reported by each CCO. These financial templates were provided by each CCO and contain detailed financial information for any subcapitated entity subcontracted with a CCO during CY17.

As part of the data validation process within each of the CY18 and CY19 rate cycles, **Optumas** worked in conjunction with OHA and each CCO to ensure that a reconciliation between reported costs (financial template) and base data (encounter data, subcapitated expenditures, and supplemental payments) used in rate development was completed.

Covered Services

The services covered under the CCO 2.0 program vary by CCO type. The rating categories of service used in the development of the CCO 2.0 Procurement rates are listed below, by CCO type. As part of CCO 2.0 development, OHA reviewed the CCO types and made the policy decision to add substance abuse services to CCO-E and CCO-G types. In CCO 1.0, CCO-E and CCO-G did not include substance abuse services. Medicaid members who have the option to choose CCO-E/G will now have access to a coordinated full behavioral health benefit – inclusive of both mental health and substance abuse services.

A value of “X” indicates that these services are covered by the particular CCO type; grey shading indicates that a service is excluded from a particular CCO type’s benefit package:

COS	CCO-A	CCO-B	CCO-E	CCO-G
Inpatient - A & B Hospital	X	X		
Inpatient - DRG Hospital	X	X		
Inpatient - Other	X	X		
Outpatient - A & B Hospital	X	X		
Outpatient - DRG Hospital	X	X		
Outpatient - Other	X	X		
Physician Services	X	X		
Prescription Drugs	X	X		
DME and Miscellaneous	X	X		
Substance Abuse	X	X	X	X
A&D Residential	X	X	X	X
Mental Health Services Inpatient	X	X	X	X
Mental Health Other Non-Inpatient	X	X	X	X
Applied Behavior Analysis (ABA)	X	X	X	X
NEMT	X	X	X	X
Dental	X			X

Covered Populations

The populations covered under the CCO 2.0 program have been grouped into various rating categories of aid (COA). As part of CCO 2.0 development, OHA and **Optumas** reviewed the rating COAs used in the past and did not find compelling evidence to adjust or break up the groups for CCO 2.0 at this time. However, OHA may decide to adjust these rating COAs when finalizing the 2020 CCO rates in mid-2019. The rating COAs for CCO 2.0 are included in the table below:

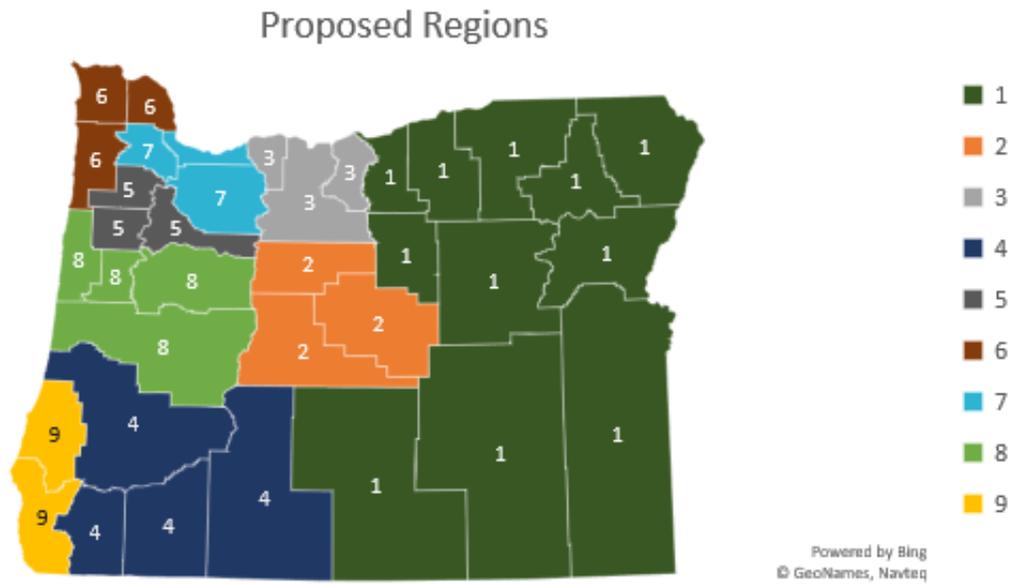
COA	Description
TANF	Temporary Assistance to Needy Families (TANF) - Ages 19 to 64
PLMA	Poverty Level Medical (PLM) Female Adults
CHILD 00-01	PLM, TANF, and CHIP - Age Under 1
CHILD 01-05	PLM, TANF, and CHIP - Ages 1 to 5
CHILD 06-18	PLM, TANF, and CHIP - Ages 6 to 18
DUAL-MEDS	Blind, Disabled, and General Assistance Client (AB/AD) and Old Age Assistance (OAA) - Duals
ABAD & OAA	Blind, Disabled, and General Assistance Client (AB/AD) and Old Age Assistance (OAA) - Non-Duals
CAF	Children in Adoptive, Substitute, or Foster Care
ACA 19-44	Affordable Care Act (ACA) - Expansion Male and Female Adults Ages 19-44
ACA 45-54	Affordable Care Act (ACA) - Expansion Male and Female Adults Ages 45-54
ACA 55-64	Affordable Care Act (ACA) - Expansion Male and Female Adults Ages 55-64
BCCP	Breast and Cervical Cancer Program
CAK 00-01	Covered All Kids 00-01
CAK 01-05	Covered All Kids 01-05
CAK 06-18	Covered All Kids 06-18

In addition to the rating cohorts noted above, a separate maternity supplemental case rate has been developed for members who fall within one of these COAs and incur a delivery event. Details surrounding the rate development for the COAs noted above, as well as the maternity supplemental case rate, can be found in subsequent sections throughout this report.

Proposed Service Areas

As part of the CCO 2.0 Procurement rate development, OHA has proposed nine Service Areas within Oregon, capitation rates will vary by Service Area and COA. The development of the CCO 2.0 Procurement rates relies upon statewide aggregated base data and area factors developed for each Service Area. The Service Areas are intended to capture differences in delivery cost, such as unit cost and provider practice pattern differences, across the state. OHA reserves the option to adjust Service Areas based upon the results of the CCO procurement.

The proposed Service Areas are shown below:



2.03 Area Factors

The Service Area Factors are intended to capture differences in delivery cost, such as unit cost, facility mix, and provider practice pattern differences across the state. Each Service Area will have a set of unique factors that will be applied to the statewide base data PMPMs for each COA, resulting in Service Area specific PMPMs for each COA. Area factors will be developed for each Service Area using the following grouping:

COA	Area Factor - Broad COA
TANF	TANF/PLMA
PLMA	TANF/PLMA
CHILD 00-01	CHILD
CHILD 01-05	CHILD
CHILD 06-18	CHILD
ABAD & OAA	ABAD & OAA/BCCP
CAF	CAF
ACA 19-44	ACA
ACA 45-54	ACA
ACA 55-64	ACA
BCCP	ABAD & OAA/BCCP

Some key assumptions within the area factor development are:

1. CY16 and CY17 data were used for the initial area factor development. CY18 data will be used to inform the final area factor development when it becomes available in the Spring of CY2019. The data consists of all CCO expenditures including FFS expenditures, subcapitated expenditures, and incentive expenditures reported by the CCOs during the CY16 and CY17 time periods.
2. DRG outpatient and DRG inpatient expenditures are adjusted to reflect the OHA policy of reimbursing DRG facilities at 80% of Medicare. The 80% of Medicare is inclusive of the rate

restoration amount that moved funding from HRA to the base data. Please see Hospital Reimbursement Adjustment (HRA) Transition in Section 2.06 for more details about the transition and impact to CCO rates.

3. Both CY16 and CY17 data were arrayed by COA and converted to a PMPM by proposed Service Area, such that the PMPM for a given COA represents total cost of care for members residing in a specific Service Area.
4. The PMPMs for each Service Area are normalized (relative to the statewide) for population risk using concurrent risk scores from the CDPS+RX model. This normalization process is done for each COA (excluding CAF, Dual-Med, Child 00-01, and PLMA populations) within each Service Area and separately for both CY16 and CY17. This results in a Service Area specific PMPM for each COA that can then be aggregated across Service Area Groupings (shown in chart above) and then compared to the statewide aggregate PMPM to derive the Service Area Factor for each area factor group shown in table below.
5. The maternity case rate has its own Service Area Factors, one for Vaginal deliveries and one for C-Section deliveries. Only the reimbursement normalization (80% of Medicare) is applied within the maternity area factor development, as health-based risk scores are not applied to the case rate. Maternity area factors are shown on page 14.
6. The area factor for the Dual-Meds COA is based upon the area factor developed for the ABAD & OAA COA. The normalized factor displayed above may be different due to the budget neutral application.

COA	Service Area 1	Service Area 2	Service Area 3	Service Area 4	Service Area 5	Service Area 6	Service Area 7	Service Area 8	Service Area 9
TANF	1.28	1.04	1.07	0.93	1.05	1.06	0.94	1.01	1.03
PLMA	1.28	1.05	1.07	0.93	1.05	1.06	0.94	1.01	1.03
CHILD 00-01	1.10	1.11	1.10	1.01	0.95	1.12	0.95	1.04	1.03
CHILD 01-05	1.10	1.12	1.10	1.01	0.95	1.12	0.95	1.04	1.03
CHILD 06-18	1.10	1.12	1.10	1.01	0.95	1.12	0.95	1.04	1.03
DUAL-MEDS	1.28	0.98	1.15	0.89	1.07	1.12	1.00	0.95	1.11
ABAD & OAA	1.27	0.97	1.14	0.89	1.07	1.12	0.99	0.95	1.10
CAF	1.53	1.11	1.16	0.91	1.02	0.86	1.01	0.87	1.16
ACA 19-44	1.26	1.07	1.18	0.91	1.04	1.23	0.96	0.98	1.03
ACA 45-54	1.25	1.07	1.18	0.91	1.03	1.23	0.96	0.98	1.03
ACA 55-64	1.25	1.07	1.18	0.91	1.03	1.23	0.96	0.98	1.03
BCCP	1.27	0.98	1.15	0.89	1.07	1.12	0.99	0.95	1.10

CY18 data will become available in the Spring of CY2019 and be used to inform the CY20 Procurement rates. Therefore, all area factors shown within this document and applied to the initial procurement rates are subject to change.

2.04 Base Data Adjustments

As part of the statewide base data development, multiple adjustments were required to ensure that the base data from CY16 and CY17 was an appropriate starting point from which to project the CCO 2.0 capitation rates. The following section describes adjustments made to the base data in the development of the CCO 2.0 capitation rates.

Underreporting/Reconciliation Adjustments

Optumas received CY16/CY17 encounter data for each CCO through OHA, which was used as the basis for the base data development. Once the encounter data was compiled, adjustment factors were developed to align the reported encounter data with costs reported within submitted financial templates. The first adjustment has been referred to as the ‘Reconciliation Adjustment’; the purpose of this adjustment is to adjust the raw encounter data for specific costs known to be missing from the original data submission as well as to remove the impact of known subcapitated encounters. The removal of known subcapitated encounters is necessary since reported subcapitated costs from the financial template are included in the base data and would be duplicative if not removed from the encounter data. An Underreporting Adjustment was then developed to account for any additional costs that were underreported in the detailed encounter data but indicative of non-subcapitated costs. The combination of these two adjustments is used to ensure consistency with all reasonable costs reported by each CCO.

The aggregate impact of the Underreporting and Reconciliation adjustments to the base data can be found below:

	PMPM Impact	
	2016	2017
Statewide Underreporting Adjustment	2.64%	2.72%

Once the underreporting/reconciliation adjustments are applied to the encounters, **Optumas** added reported costs related to subcapitated arrangements plus costs related to provider incentive programs, including incentive expenditures previously excluded that were paid out of Quality Pool incentive revenue. Including these expenditures is key to moving to a withhold for the Quality Pool in CCO 2.0. The Withhold is discussed further in Section 2.09 of this report.

After developing the base data using the process noted above, **Optumas** conducted the “triangulation” process within each rate cycle. This process was used as a validation process between the encounter data, reported financials for rate purposes, and the financial income statements and solvency report called the “Exhibit L” to ensure consistency between the various sources. The Exhibit L report is a report of revenue and expenditures prepared by each participating CCO and is reconciled to the CCOs’ audited financial statement to ensure accuracy of the reported figures.

To the extent that discrepancies between the data sources existed, reconciliation efforts were completed between **Optumas** and OHA to develop a consistent base data starting point for the CCO 2.0 Procurement rates.

Reimbursement Adjustments

As part of CCO 2.0, OHA has implemented reimbursement policy surrounding DRG facility reimbursement to support the transition of Hospital Reimbursement Adjustment (HRA), this is discussed more in Section 2.06. Under this policy, all DRG Facility reimbursements will be commensurate with 80% (moving from 68%) of base Medicare. Therefore, the base data for DRG OP and DRG IP has been adjusted to reflect a level of reimbursement consistent with this policy. There are not reimbursement adjustments made to any other COS within the rate development. The aggregate impact of the DRG facility reimbursement adjustment can be found below:

COS	DRG Adjustment Dollars	
	2016	2017
Inpatient - DRG Hospital	\$ (33,050,548)	\$ (16,048,580)
Outpatient - DRG Hospital	\$ 14,795,114	\$ 23,647,027
Maternity - Inpatient	\$ (6,243,965)	\$ (3,428,947)
Maternity - Outpatient	\$ (43,398)	\$ (94,020)
Total	\$ (24,542,797)	\$ 4,075,480

The overall impact is a reduction in some of the COSs due to the base data containing reimbursement that is greater than 80% of Medicare.

Redetermination Adjustment

The federal government granted Oregon approval in Sept. 2015 to defer Medicaid eligibility renewals to prevent Oregonians from losing health benefits due to flawed technology and the Cover Oregon’s system failure. Under federal law (42 CFR 435.603(a)(3), 42 CFR 457.315(b), 42 CFR 435.912, and 42 CFR 435.916), every child and adult on Medicaid remains eligible for coverage until an administrative renewal or redetermination finds they are ineligible.

Oregon’s plan was updated with revised timelines and the state received subsequent federal approvals. The goals of the federally-approved deferred renewal plan was to:

- Maintain health coverage for vulnerable children and adults who qualified for Oregon Health Plan coverage (and coverage under other Medicaid programs) but risked losing coverage if the state resumed renewals without adequate systems to replace Cover Oregon.
- Replace Cover Oregon with a new eligibility platform (the ONE system) as rapidly as possible, establish ONE’s reliable functionality for Medicaid application and eligibility renewal processing and complete the labor-intensive process of manually converting all case records from the failed Cover Oregon system to ONE.
- Manage ONE deployment and complete Medicaid renewals within OHA agency budget and staffing constraints by refocusing agency priorities and resources, engaging private partners to bolster staff capacity and improving systems.

OHA restarted Medicaid renewal processing for an eventual total of 951,186 members, placed on temporary hold as a consequence of Cover Oregon’s system failure, in March 2016. Prior to September 2016, OHA identified a subset of members who posed significant processing complexity. OHA informed

the federal government (and a federally-mandated oversight committee) these members would be processed at the conclusion of the restarted Medicaid renewal process. A small percentage of Cover Oregon renewals also had eligibility records in legacy systems. To avoid eligibility systems overriding each other in MMIS, OHA processed converted cases as planned and then performed a clean-up sweep to determine who was left that had: 1) not been renewed as part of another case or application, and 2) required further research to resolve records across eligibility systems.

The members that have been removed from the eligibility roster due to redetermination are healthier and less costly members. Because these members are part of the CY16/CY17 base data, their removal from the CCO program requires that the base data be adjusted to a level that it would have been absent these members that have been removed due to redetermination. The adjustment is an upward adjustment developed by **Optumas** via identifying the specific members impacted by redetermination and removing their cost and eligibility from the CY16/CY17 base data, then comparing the PMPM post removing these members to the original PMPM informing the necessary base data adjustment. The aggregate impact of the redetermination adjustment can be found below:

	PMPM Impact	
	2016	2017
Statewide Redetermination Adjustment	4.07%	1.68%

These adjustments are the same adjustments made within the CY18 and CY19 rate cycles.

The adjusted base data is shown in Appendix I.A.

2.04 Supplemental Rates

CCO 2.0 includes capitation rates developed for several program types, depending on the services provided by the CCO:

1. CCO-A: Physical Health, Mental Health, Substance Abuse, NEMT, and Dental services
2. CCO-B: Physical Health, Mental Health, Substance Abuse, and NEMT services
3. CCO-E: Mental Health, Substance Abuse, and NEMT services
4. CCO-G: Mental Health, Substance Abuse, Dental, and NEMT services

The following subsections summarize the development of the Dental capitation rates, Behavioral Health capitation rates (CCO-E/G), and Maternity Case Rate.

Dental Rate

Dental rates will not be subject to the statewide methodology, instead, dental rates will be developed consistent with CCO 1.0 such that there are two sets of dental rates. One set of dental rates for Service Area 7 (Urban) and another for the rest of the state (Rural). Developing two separate rates for the state accounts for differences in utilization patterns between the Urban and Rural areas.

Base Data

CCO 2.0 Dental Procurement rates are based upon CY17 encounter and enrollment data, provided by OHA, as the primary data source. This data reflects payment dates through April 2018 and is the same base data used for the CY19 dental rate development.

The encounter data provided to **Optumas** did not contain reliable paid amounts; therefore, **Optumas** was required to develop a unit cost component for the dental base data. **Optumas** shadow priced the CY17 encounter data using procedure code level unit costs from Oregon Specific Dental Provider Fee Schedules provided by some of the participating Dental Care Organizations (DCOs). Once the shadow pricing process described above was completed, the base data was summarized by COA and COS.

Base Data Adjustments

The only base data adjustment made to the CY16 and CY17 data was for IBNR (Incurred but Not Reported). The base data used in the development of DCO rates include 4 months of runout. Please see Appendix I.D. which shows all the adjustments for each base data by COA, COS, and Service Area.

Dental Program Changes

There are no policy changes to the dental program for the CCO 2.0 procurement contract period, CY20.

Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied from the midpoint of the base period (CY17) to the midpoint of the contract period (CY20), for a total of 36 months.

Optumas developed trend separately for utilization and unit cost, which vary by COA and COS. Please see Appendix I.E. which shows the detailed annualized trend percentages by COA and COS, and separately for both utilization and unit cost components.

Non-Medical Load

The final rating adjustment made in the development of the dental rates is an allowance for non-medical costs related to providing dental services. The non-medical load applied to dental rates under the CCO 2.0 program is the same as the non-medical load applied across the CCO capitation rates.

Payment Rate

The table below includes a summary of the CCO 2.0 Procurement Dental capitation rates developed for each Urban (Service Area 7) and Rural (All other Service Areas) by COA:

Dental Region	COA	Dental Rate
Urban	TANF	\$ 30.26
Urban	PLMA	\$ 26.82
Urban	CHILD 00-01	\$ 0.91
Urban	CHILD 01-05	\$ 29.42
Urban	CHILD 06-18	\$ 30.94
Urban	ABAD & OAA	\$ 27.94
Urban	DUAL-MEDS	\$ 29.16
Urban	CAF	\$ 29.09
Urban	ACA 19-44	\$ 25.15
Urban	ACA 45-54	\$ 30.98
Urban	ACA 55-64	\$ 33.52
Urban	BCCP	\$ 20.32
Rural	TANF	\$ 25.69
Rural	PLMA	\$ 22.59
Rural	CHILD 00-01	\$ 1.54
Rural	CHILD 01-05	\$ 25.45
Rural	CHILD 06-18	\$ 29.09
Rural	ABAD & OAA	\$ 28.32
Rural	DUAL-MEDS	\$ 27.34
Rural	CAF	\$ 30.98
Rural	ACA 19-44	\$ 23.48
Rural	ACA 45-54	\$ 32.10
Rural	ACA 55-64	\$ 32.83
Rural	BCCP	\$ 25.41

Hepatitis C DAA Adjustment & Risk Corridor

Due to the uncertainty surrounding future utilization of Hepatitis-C Direct-acting Antivirals (DAA)therapies, a risk corridor will be in place during CY20 contract period for Hepatitis-C DAA pharmaceuticals. In addition, Optumas only relied on CY17 data to inform the adjustment due to the uncertainty. Information surrounding the risk corridor policy for Hep-C can be found in the Risk Corridor section of the sample 2020 contract found in the RFA. OHA expect to expand coverage for Hepatitis C in early 2019 and will evaluate the rates in the spring of 2019 to reflect the current coverage level for CY20.

The table below shows the Hepatitis-C per capita spend by Service Area:

Service Area	CY17 MMs	Hep-C PMPM
Service Area 1	548,800	\$3.84
Service Area 2	559,525	\$4.21
Service Area 3	147,042	\$3.17
Service Area 4	1,510,513	\$5.26
Service Area 5	1,410,807	\$4.05
Service Area 6	275,547	\$6.88
Service Area 7	3,709,552	\$6.85
Service Area 8	1,606,286	\$4.62
Service Area 9	262,629	\$2.36
Statewide	10,030,702	\$5.38

Maternity Rates

Service Area specific maternity case rates were developed using CY16/CY17 encounter data, trended to the midpoint of CY20. Cost per delivery was developed using statewide costs per event by vaginal and caesarean deliveries. Service Area factors are then developed for each type of delivery, vaginal and caesarean. These area factors are applied to the statewide cost per event to get the cost per event for each Service Area. Each Service Area’s cost per event for vaginal and caesarean delivery types is blended together using the appropriate mix from each Service Area’s base data to get the aggregate maternity case rate. The next step was to apply non-medical load, inclusive of the managed care tax of 1.5%. The non-medical load applied is consistent with the non-medical load applied to other services for each Service Area. The resulting fully loaded CCO 2.0 maternity case rates, gross and net of 5.0% withhold, are shown Appendix I.G.

2.05 Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major service category from the midpoint of the base period to the midpoint of the contract period. Annual trend rates, by COA and COS, are shown in Appendix I.C.

Trend factors were developed for both utilization and unit cost using historical data from the CCO program, reported financial data, and supplemental information reflecting emerging. There was not a pre-determined algorithm related to how the projected trends are developed; instead **Optumas** evaluated emerging CY18 data along with historical data by COA and COS from a statewide perspective and developed the trends shown in Appendix I.C.

The overall impact of the trend on an annual PMPM basis is 4.5%.

2.06 Non-Medical Loading

For the CCO 2.0 procurement rates, a statewide non-medical load was applied to the projected medical costs to account for expected CCO expenditures associated with the following items: general administration, underwriting gains, risk/contingency margin, case management, and potentially Health Insurance Providers Fee (HIPF). All Service Areas will receive the same non-medical load for the first two years of the CCO 2.0 program. However, starting in year 3, CY22, OHA will implement the variable margin policy that will give the CCOs an opportunity to earn additional percentage points associated with their margin, resulting in CCO specific non-medical loads across the program. The variable margin is discussed more within Appendix II. Prometheus Analytics.

The magnitude of each of the aforementioned non-medical loading components were reviewed separately, using a combination of historical financial data reported on CCO financial reports and State-directed policies. OHA reserves the right to update the non-medical load based upon the result of the CCO 2.0 procurement.

Base Non-Medical Load

Optumas has developed a statewide non-medical load with the components shown below:

Region	Administration	Care Management & Health-related Services	Profit & Risk Contingency	Total
Statewide	7.5%	1.5%	1.0%	10.0%

Hospital and Managed Care Tax

OHA created two quality and access pools that will be distributed through qualified directed payments, as approved under a Section 438.6(c) Preprint. One pool for Rural Type A/B hospitals and the other pool is for qualifying public academic health centers. Oregon Health & Science University (OHSU) is the only hospital that meets quality and access pool criteria as a public academic health center. These pools ensure qualifying hospitals are able to maintain and/or improve quality and access for Medicaid members. OHA anticipates adding a new DRG hospital quality and access pool in CY20. Please see Hospital Reimbursement Adjustment (HRA) Transition in Section 2.06, for more details about the HRA transition and impact to CCO rates.

In January 2018, the Insurer Tax was approved. The Insurer Tax has been included in the CY19 capitation rates as 1.5% of the total capitation rate. **Optumas** has incorporated this adjustment within the CCO RDS exhibits shown in the appendices, the Insurer Tax is labeled as “MCO Tax” within the RDS exhibits in Appendix I.

Hospital Reimbursement Adjustment (HRA) Transition

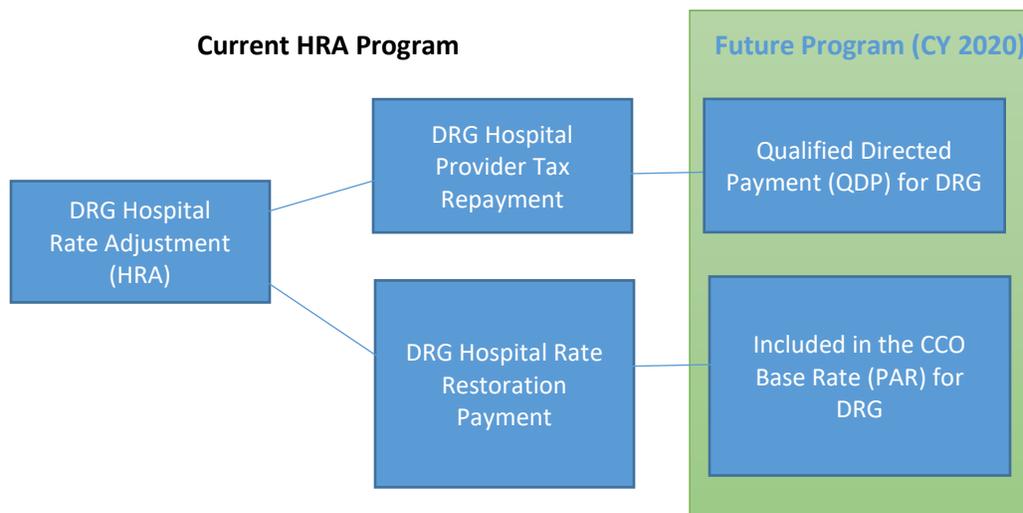
Since 2009, the Oregon Hospital Tax program has used HRA payments to ensure Medicaid funding levels maintain access to care. In 2011, HRA payments were expanded to include the DRG hospital rate restoration component, which is considered reimbursement to hospitals for Medicaid services and not

related to tax repayment.¹ Today, HRA includes both tax repayment and rate restoration. HRA payments are included in the CCO rates as a separate line item and are distributed by CCOs to eligible DRG hospitals in monthly payments based on past utilization.

In 2016, the Centers for Medicare and Medicaid Services (CMS) issued new managed care pass-through payment regulations that require the HRA program to be phased out or transitioned to a qualified directed payment (QDP) that is tied to quality and access. Starting in 2018, the Oregon Health Authority (OHA) has elected to transition the HRA program as required by CMS.

As part of the 2019-2021 Medicaid Budget proposal submitted by Governor Kate Brown, the OHA will take the following steps to complete the transition of HRA for DRG hospitals:

- 1) Beginning in CY 2020, the tax repayment portion of HRA payments will be transitioned to QDPs that support access and quality care for Medicaid clients, as required by new federal regulations. This transition will replace the current HRA program and is like the mechanism used in the current Type A&B hospital provider tax program.
- 2) Also beginning in CY 2020, the rate restoration portion of HRA will be moved into the base DRG hospital par rate used in the CCO rate development process. This means that starting January 1, 2020, the percentage of Medicare cost used by the OHA in calculating the base hospital capitation payment to the CCOs (known as “par” rate) will increase from 68% to 80% of base Medicare, and the “non-par” rate for non-contracting hospitals to be four percentage points less, or 76% of base Medicare (see ORS 414.743).



The transition of the DRG HRA program will support transparency and simplicity and meet CMS requirements. The transition is designed to be budget neutral for DRG hospitals and may include rule changes or other administrative processes to ensure the continuation of program policy goals.

¹ OHA uses the HRA as a form of reimbursement for hospitals participating in Oregon’s Hospital Tax program. In compliance with federal Medicaid regulations, the program does not hold any individual hospital harmless from the tax.

OHA and the Oregon Association of Hospitals and Health Systems have developed an initial work plan to begin work as soon as possible on the QDP program for DRG hospitals. OHA intends to submit necessary documentation to CMS for approval, so implementation can begin January 1, 2020.

2.07 Health Based Risk Score

The risk score is designed to quantify a CCO’s specific risk relative to the statewide risk. When developing the risk factor, **Optumas** considered member risk (Member Health Status) by using the risk tool CDPS+RX, which assigns each member a risk score based on their demographics, pharmacy utilization, and diagnosis information. For procurement rates, the normalized risk factor for the service area is included to proxy the approximate risk.

Risk Score

Consistent with ASOP 45, The Use of Health Status Based Risk Adjustment Methodologies, a few key questions were considered when making the decision to use the CDPS+RX risk tool:

- 1) *How did CDPS+RX compare to Medicaid RX tool within the OR program?*

In order to determine which risk tool to use, **Optumas** completed a correlation analysis in 2015 for both the Medicaid Rx and CDPS+RX risk tools. The correlation analysis is designed to ensure that members with high risk scores have high annual expenditures and members with low risk scores have low annual expenditures. The correlation analysis was conducted by rating cohort on a statewide and regional basis. The results of this analysis indicated that CDPS+RX had a slightly higher correlation than Medicaid RX, so the decision was made to continue using the CDPS+RX risk tool in CCO 1.0, and continue in CCO 2.0.

- 2) *Was there significant correlation across each rating cohort between risk scores and annual medical expenditures at the member level, such that the data provided evidence that the risk tool was producing reasonable results?*

Once the risk tool was chosen, **Optumas** had to decide which rating cohorts the CDPS+RX risk tool would not be a good predictor of risk. The table below summarizes which rating cohorts are subject to CDPS+RX risk tool analysis – cohorts with an ‘x’ indicate risk-adjusted cohorts.

COA	Risk-Adjusted?
TANF	X
PLMA	
CHILD 00-01	
CHILD 01-05	X
CHILD 06-18	X
DUAL-MEDS	
ABAD & OAA	X
CAF	
ACA 19-44	X
ACA 45-54	X

COA	Risk-Adjusted?
ACA 55-64	X
BCCP	

The following reasons have been considered as to why certain cohorts are not risk-adjusted:

1. **PLMA** – Since the PLMA cohort consists of pregnant women, challenges exist when using a tool such as CDPS+RX to measure risk of the population. This population typically has shorter enrollment duration than other cohorts, and the largest cost driver is typically the delivery event incurred by these members, which is accounted for through the maternity case rate payment.
2. **Child 00-01** – This cohort consists of children under the age of 1. The driver of cost differences within this cohort are typically indicative of costs associated with the birth of a newborn rather than a chronic condition. Additionally, durational concerns play a role in this decision, since the majority of these members will reside in a different cohort the following year, which conflicts with the prospective nature of the risk score tool.
3. **Dual-Meds** – Since not all claims for Medicare eligible are available in Medicaid data, the full spectrum of diagnosis codes that relate to this population cannot be used in the calculation of each members’ risk score. Furthermore, the majority of costs are the responsibility of Medicare and not necessarily reflective of costs that CCOs are responsible for. Therefore, the CDPS+RX tool has not been used for this cohort.
4. **CAF** – Due to the transient nature of foster care children, as well as the unique utilization profile that these members have, the CDPS+RX tool may not necessarily capture the true risk of this population.

3) *Did the data have all the necessary data elements to support the risk tool? If so, were they consistently reported for all CCOs?*

Optumas worked with OHA to ensure that the data being used in the risk score analysis had all the relevant data elements; in particular, nine diagnosis codes from encounter claims were used in producing the risk score for specific members. This was consistent across all CCOs. Therefore, no bias results due to some CCOs reporting more/less robust diagnosis information in encounter data.

4) *Which weights should be used, State specific or National?*

After discussions with OHA regarding the state specific weights, the decision was made to continue the use of national weights until state specific weights can be developed using more recent data. OHA may explore development of state-specific weights during the course of CCO 2.0.

5) *Should concurrent or prospective models be used?*

Optumas uses both models, prospective risk scores will be used to develop the final CCO 2.0 procurement rates by applying normalized risk score to the statewide base data. Concurrent risk scores are used to normalize the base data as part of the area factor analysis to ensure that any differences due to member acuity are not captured within the area factor.

6) *How to handle members with limited data due to duration within experience period?*

Optumas reviewed the impact of duration for members across the state. Based on this approach, it was decided to use a 3-month duration requirement in which a member had to have 3 or more months of duration before their risk score counts. Any member with fewer than 3 months of duration received the average for that CCO and rate cohort. In addition to the duration requirement, which is based on duration within the CY17 experience period, a snapshot month of December 2017 has been used for member assignment in the risk score analysis. This month has been selected since it reflects a more recent membership snapshot for CCOs, which is after the redetermination efforts that had occurred through the first part of CY17.

Please see Appendix I.F. for a summary of risk scores.

2.09 Withhold and Payment Rate Percentile Choice

As part of the CCO 2.0 procurement rates, OHA has made a policy decision to move the existing Quality Pool incentive that has historically been paid outside the capitation rates, to a withhold that will be part of the capitation rates.

Consistent with the Final Rule, **Optumas** has developed the CCO 2.0 Procurement rates in a manner that ensures that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound by including all reported expenditures associated with quality pool incentives as part of the CY16 and CY17 base data. This results in the base data being higher than historical base data and allows OHA to implement the withhold providing participating CCOs with the total funding commensurate with historical funding inclusive of the Quality Pool.

The procurement rates shown within this exhibit reflect the 50th percentile of rate range developed by **Optumas**. OHA has chosen this percentile to ensure that the implementation of the 5.0% withhold along with an assumed 60%-80% earn back percentage results in a level of funding that is still considered actuarial sound and reasonable.

The implied rate of growth between the CY20 Procurement Rates and the CY19 Capitation Rates is below the rate of growth included within the Governor's proposed budget. The table below contains a rate comparison between CY19 and CY20, please note the following:

1. The Total (CY19 Net Quality Pool) is being driven by CY20 containing expenditures related to Quality Pool. This causes a high rate of growth since Quality Pool was not included in CY19 rate development. Quality Pool expenditures are now being included in CY20 to accommodate the change from incentive to withhold.
2. The Total (CY19 Gross Quality Pool) has CY19 being adjusted to include the Quality Pool Incentives, which lowers the rate of growth to 4.9%.
3. The removal of HRA and adding the funding into the premium development for CY20 Procurement Rates inflates both comparisons. When this is normalized, the rate of growth is below the proposed Governor's Budget.

Area	COA	CY17 MMs	CY19 Rates, Net HRA and Tax	CY20 Procurement, Net Tax	Change
Statewide	TANF	759,514	\$ 466.89	\$ 519.19	11.2%
Statewide	PLMA	109,505	\$ 412.19	\$ 469.59	13.9%
Statewide	CHILD 00-01	285,476	\$ 590.96	\$ 701.09	18.6%
Statewide	CHILD 01-05	1,203,670	\$ 168.27	\$ 181.77	8.0%
Statewide	CHILD 06-18	2,683,210	\$ 192.92	\$ 211.76	9.8%
Statewide	DUAL-MEDS	501,326	\$ 268.67	\$ 303.21	12.9%
Statewide	ABAD & OAA	558,557	\$ 1,337.27	\$ 1,484.62	11.0%
Statewide	CAF	175,389	\$ 545.17	\$ 576.84	5.8%
Statewide	ACA 19-44	2,344,262	\$ 422.20	\$ 443.73	5.1%
Statewide	ACA 45-54	711,729	\$ 744.81	\$ 785.38	5.4%
Statewide	ACA 55-64	681,631	\$ 804.07	\$ 867.46	7.9%
Statewide	BCCP	2,378	\$ 1,629.45	\$ 1,869.64	14.7%
Total (CY19 Net Quality Pool)		10,016,648	\$ 433.05	\$ 470.24	8.6%
Total (CY19 Gross Quality Pool)		10,016,648	\$ 448.20	\$ 470.24	4.9%

2.10 CCO 2.0 Rate Exhibits

OHA and **Optumas** provide CCOs exhibits during the CCO 2.0 procurement rate development process that occurs from April – September each year. The following are examples of the type of information a CCO will receive during each rate cycle:

- Triangulation and Validation Exhibits
- Statewide Base Data/Rate Model
- Behavioral Health Only Statewide Base Data Model (CCO-E/G)
- Maternity Case Rate Exhibit
- CCO-specific member level risk scores and encounter data (when available)

3. Appendices

Appendix I. Rate Certification Tables

Please see accompanying Excel document titled: "OR CCO 2.0 Procurement Rate Methodology Appendix I 2018.12.21.xlsx"

Appendix II. Prometheus Analytics

As part of the CCO 2.0 program, OHA will be introducing Prometheus Analytics to assist in evaluating the risk of the program. Prometheus Analytics uses claims data to analyze episodes of medical care and uncover solutions to key challenges facing the CCO program. Prometheus can be used to create value-based payment models, evaluate provider performance, identify care variations, and improve network efficiency.

The Prometheus tool was created by HCI3, which was acquired by Altarum. Altarum continually monitors and updates the tool to ensure that the clinical/coding information used by the tool remains relevant and stays current with medical practices. Altarum releases updated versions annually, with each update containing new episodes of care, enhanced clinical definitions surrounding episode definitions, and technical improvements related to the input and output files related to the software. **Optumas** partnered with Altarum in 2015 to explore opportunities for the application of the Prometheus tool, and became a Chartered Analyst for the Prometheus Analytics in 2016. In addition to Oregon, **Optumas** has introduced Prometheus Analytics to many Medicaid programs, including Colorado, Iowa, Kansas, Alabama, Ohio, Nebraska, and North Dakota.

Prometheus Analytics is comprised of clinical logic in which specific health care services provided to members are associated with one another, and grouped under episodes of care. This grouping allows for comparisons across the CCO program about costs of care at many different levels and may assist CCOs and providers to determine the appropriateness of procedures in managing their patients with certain conditions.

The core components of Prometheus Analytics provide a complete and accurate system from which decisions on incentive structures and new payment models can be made. Each of the components, have been rigorously tested and validated, and encompass valuable elements that apply to the overall goal of reducing costs and improving quality based on existing claims data analysis.

Why introduce Prometheus into the CCO 2.0 program?

- Offers new analytical capacity beyond traditional actuarial methods that use historical utilization and unit cost data (which is limited in measuring efficiency)
- Improves overall understanding of population/program risk, when used alongside risk adjustment
- Allows state agencies to identify specific subpopulations that require specific interventions and create Oregon specific episodes in the future
- Improves ability to identify efficiencies/inefficiencies across the program
- Greater level of detail as results can be summarized down to provider level, carrier level, and community level
- Transparent Clinical Tool (Episode information can be found on Altarum website, <http://www.prometheusanalytics.net>)

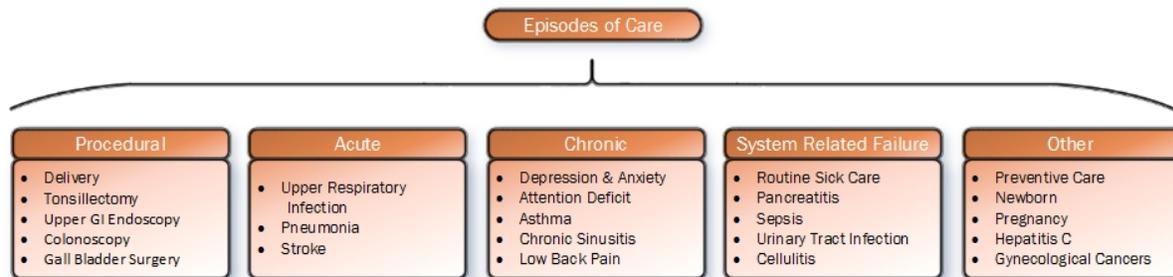
Prometheus Components

The Prometheus tool identifies 96 different episodes of care. Episodes are assigned at the member level and are based upon the detailed claims of each member within the input file. The input file must contain at least 24 months of historical detailed data along with 24 months of member eligibility. The output can then be tailored to focus on a specific time period or one year; however, the 24 months is needed to capture complete episodes from start to end.

Each of the 96 episodes are grouped into larger episode types of:

- Procedural
- Acute
- Chronic
- System Related Failure
- Other

Examples of each of type of episode are shown below:



Potentially Avoidable Complications (PACs)

Prometheus Analytics separates episode costs between “typical” and “potentially avoidable complications (PACs)”. For each episode assigned to each member, total episode cost can be expressed as follows:

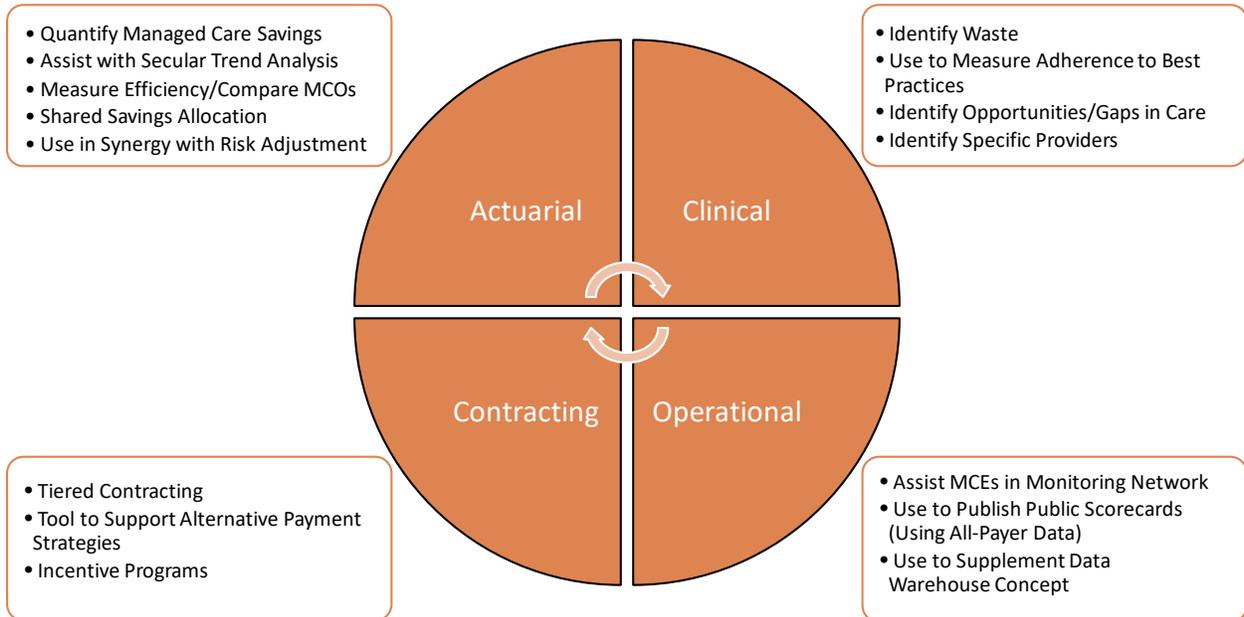
$$\text{Total Episode Cost} = \text{Typical Cost} + \text{PAC}$$

Separating the episode cost in this manner allows OHA, CCOs and providers to review and summarize episode costs by many different dimensions, which can identify areas of care through the lens of efficiency and quality. PACs are costs/services that may negatively impact patients and are generally controllable by providers. The separation of PAC from typical cost for each episode creates performance comparisons that can be used at many levels throughout the CCO 2.0 program. For example, high PAC rates can be an indicator of low quality care, while low PAC rates can be associated with high quality care.

Prometheus ability to measure and identify PAC-related costs will increase the level of information available to OHA and to CCOs and provide new tools to inform plan-level and program-level strategies to decrease overall costs while improving the quality of care.

Potential Applications

Prometheus Analytics can be utilized within the CCO 2.0 program many different ways. The chart below describes some potential applications in which the output can be utilized, both at the CCO level and state level.



OHA/**Optumas** plans to share summarized output from Prometheus Analytics with the CCOs, allowing CCOs to use the data to inform their internal processes.

CCO 2.0 Prometheus Application

OHA has made the policy decision to use Prometheus Analytics to inform the variable margin component (Performance-based reward policy option recommended by the Oregon Health Policy Board) of the CCO 2.0 program. As part of this policy, OHA intends to incent CCO’s to invest in Health Related Service (HRS) and Social Determinants of Health (SDoH) while striving to achieve levels of growth consistent with the defined sustainable rate of growth of 3.4% annually.

Methodology – Phase 1 (CY2022 rates only)

OHA will implement the following methodology to inform the variable margin component of the non-medical load within the CCO 2.0 rate development methodology in year 3 (CY22 contract period).

Step 1: OHA will evaluate the statewide rate of growth in the CY22 rates compared to the CY21 rates. This will be based on the growth of the CCO program expenditures from CY19 to CY20.

- If the rate of growth is **greater** than the sustainable rate of growth (3.4%) there will be no available funding for the variable margin, therefore, all CCOs will receive the statewide margin.
- If the rate of growth is **less** than the sustainable rate of growth (3.4%), the state will move forward with implementing the variable margin methodology (move to Step 2)

Step 2: CCOs will be evaluated on efficiency using Prometheus Analytics and Quality using existing quality metrics. In addition, CCOs will be evaluated on their Health Related Services (HRS) investments.

- If the CCO scores well on both efficiency and quality metrics and has achieved the level of HRS investment desired by OHA, the CCO will receive the full available amount of variable margin.
- If the CCO scores well on both efficiency and quality metrics and has not achieved the level of HRS investment desired by OHA, the CCO will receive a percentage of what they would have otherwise received, as described in first bullet.
- If the CCO does not score well on both efficiency and quality metrics, the CCO will receive the Statewide margin and not receive any variable margin.
- If the CCO scores well on either but not both metrics (efficiency and quality) and has achieved the level of HRS investment desired by OHA, the CCO will receive a portion of the available amount associated with variable margin.
- If the CCO scores well on either but not both metrics (efficiency and quality) and has not achieved the level of HRS investment desired by OHA, the CCO will receive a percentage of what they would have otherwise received, as described in bullet above.

OHA will determine what amount is available for variable margin annually. The amount may change to ensure that the CCO 2.0 program continues to be consistent with the sustainable rate of growth.

Methodology – Phase 2 (CY2023 and future)

OHA will implement the following methodology as phase 2 to inform the variable margin component of the non-medical load within the CCO 2.0 rate development methodology in year 4 (CY23 contract period).

Step 1: OHA will evaluate the statewide rate of growth in the CY23 rates compared to the CY21 rates. This will be based on the growth of the CCO program expenditures from CY20 to CY21.

- If the rate of growth is **greater** than the sustainable rate of growth (3.4%) there will be no available funding for the variable margin, therefore, all CCOs will receive the statewide margin.
- If the rate of growth is **less** than the sustainable rate of growth (3.4%), the state will move forward with implementing the variable margin methodology (move to Step 2)

Step 2: Each CCO will have their CCO specific rate of growth evaluated (CY20 to CY21), similar to Step 1 above.

- If the rate of growth is **greater** than the sustainable rate of growth (3.4%) the CCO will receive the statewide margin and not be eligible for variable margin.
- If the rate of growth is **less** than the sustainable rate of growth (3.4%), the CCO will be eligible for variable margin, moving into Step 3.

Step 3: CCO will be evaluated on efficiency using Prometheus Analytics and Quality using existing quality metrics.

- If the CCO scores well on both efficiency and quality metrics and has achieved the level of HRS investment desired by OHA, the CCO will receive the full available amount of variable margin.
- If the CCO scores well on both efficiency and quality metrics and has not achieved the level of HRS investment desired by OHA, the CCO will receive a percentage of what they would have otherwise received, as described in first bullet.
- If the CCO does not score well on both efficiency and quality metrics, the CCO will receive the Statewide margin and not receive any variable margin.
- If the CCO scores well on either but not both metrics (efficiency and quality) and has achieved the level of HRS investment desired by OHA, the CCO will receive a portion of the available amount associated with variable margin.
- If the CCO scores well on either but not both metrics (efficiency and quality) and has not achieved the level of HRS investment desired by OHA, the CCO will receive a percentage of what they would have otherwise received, as described in bullet above.

OHA will determine what amount is available for variable margin annually. The amount may change to ensure that the CCO 2.0 program continues to be consistent with the sustainable rate of growth.

Prometheus Metrics

OHA will work with the CCOs and **Optumas** to develop metrics associated with PAC cost that can be used within the methodology described above. OHA will be dedicated to working with all stakeholders in developing meaningful and actionable metrics from the Prometheus output during calendar year 2019.