

Methodology: 2015 Rate Redevelopment

For Coordinated Care Organizations

Introduction

The Oregon Health Authority (OHA) has contracted with Optumas, an actuarial consulting firm, to develop and certify capitation rates for the 2015 Rate Redevelopment. Capitation rates are predetermined per member per month payments that are dependent on an individual's Oregon Health Plan (OHP) eligibility status and are paid to Coordinated Care Organizations (CCOs) on a monthly basis dependent on enrollment. Both the State of Oregon and the Center for Medicaid and Medicare Services (CMS) fund the OHP program at varying levels depending on the eligibility group and services.

The following key concepts were considered when developing the rate methodology for Oregon CCOs:

- 1) **Rating Regions** – 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. These differences need to be considered when developing rating regions.
- 2) **Differences in Member Risk** – Having 16 unique CCOs serving the same populations results in a disparity in the underlying member risk when comparing one CCO to another within the same region. In other words, at a given time one CCO will have more patients with chronic disease than another. A risk score tool should be considered to assist in better quantifying each CCO's membership risk.
- 3) **Differences in Hospital Utilization** – There are two different types of reimbursement for hospitals in the Oregon Medicaid program: DRG reimbursement (DRG-based hospitals) and Cost to Charge reimbursement (Type A/B hospitals). The A/B hospitals are facilities that are rurally located, which are generally more costly than urban DRG hospitals. Depending on a CCO's member base, the mix of these facilities that make up the overall hospital utilization can be significantly different. To account for the inherent risk differences between CCO hospital costs, CCO inpatient and outpatient mix between DRG and A/B facilities needs to be considered.
- 4) **Differences in CCO Specific Contracting** – Each CCO may have different contracting agreements with its physicians and hospitals. Therefore, consideration needs to be given to the underlying differences in reimbursement between the CCOs.
- 5) **Data Quality** – Having 16 very different CCOs results in varying degrees of data quality with respect to reported expenditures. The actuary needs to explore any significant differences by each CCO and make appropriate adjustments to the base data.
- 6) **ACA Expansion Population** – Like most states that have expanded, Oregon has seen significant increases in their eligibility due to the number of members enrolling in the program under the ACA expansion cohort. This increase in membership has changed the risk landscape of the program. Given the fact that this is a new population, the underlying risk profile for these expansion members needs to be explored regularly by the actuary until a stable baseline can be established.

The rate methodology described below is centered around the idea of creating rating regions from which a regional benchmark was developed for each rating cohort (rating cohorts listed below). This regional approach is then supplemented with the development of CCO specific risk factors that reflect the unique risk of each CCO. These risk factors are applied to the regional benchmark resulting in CCO payment rates that are commensurate with the CCOs' unique risk within their rating region. The risk factors can push a CCOs payment rate higher or lower compared to the other CCOs within the region.

Populations covered within the CCO program are categorized into the rating cohorts shown 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
SNRG	Special Needs Rate Group (SNRG) - Members

Variability: Explained vs Unexplained

An overarching goal of the rate setting process was to limit unexplained variability in rates between CCOs while making appropriate adjustments for explained variation. The first method to control unexplained variability was to use a regional approach. Using rating regions provides credibility by aggregating base data from all CCOs within the region. Due to the small sizes of some CCOs, using CCO specific data to create CCO specific rates resulted in unexplained year-to-year variation, in large part due to credibility/rate cohort size.

The use of risk factors allows for adjustments to the regional rates that reflect CCO specific risk. These adjustments reflect differences in each CCO’s populations in terms of the health status of members and use of rural vs urban hospitals. Risk Score is necessary due to the fact that there is a difference in risk for the population, even within each rating cohort. Since there are 16 CCOs participating in program, the distribution of members with varying health risk varies across each CCO. Without using risk factors, it is difficult to match payment to risk, as one rate would not be appropriate for all CCOs.

Regional Approach

As part of the rate development process, Optumas has developed four rating regions within Oregon for the CCO program: Tri-County, Northwest, Southwest, and Central/Eastern (See attached map). The development of the 2015 rates relies significantly upon regionally aggregated base data. Meaning the experience of each CCO, as reported through their own financials, is aggregated to create the regional base data. The rating regions are intended to provide additional credibility, considering the small sample size of some CCOs within the program. Additionally, the regions are designed in a way that groups CCOs based on coverage in like-geographical areas.

Risk Adjustment

Adjustment factors consist of data driven considerations that appropriately translate the regional methodology into a payment rate that is CCO specific, and matches payment to risk and other considerations. The following are the adjustments that were taken into account:

Risk Score Adjustment: After consultation and feedback from CCOs and OHA, Optumas used CDPS+Rx as the risk score tool to assess the population risk at a CCO level. CDPS+Rx uses demographic indicators, diagnosis codes and pharmacy

data (NDC codes) to assess the risk of the population at a CCO level. The risk scores were provided to CCOs for review. Risk score adjustments were not applied to the ACA rate groups for 2015 rates due to lack of data and experience but will be applied in the future.

A&B Hospital Adjustment: . Differences in hospital costs across CCOs are captured through the adjustment called A/B Hospital Adjustment; this adjustment quantifies the impact of CCOs having varying mix of services between DRG and A/B hospitals. This is necessary, as A/B hospitals are generally much more expensive than DRG hospitals.

As discussed throughout the document, the general approach underlying the rate methodology is:

- 1) Development of a regional benchmark for each rating cohort for each rating region.
- 2) Development of a risk factor for each unique CCO for each rating cohort. This risk factor is applied to each payment rate chosen within the regional benchmark range to develop a CCO specific payment rate.
- 3) The risk factors are applied in a way which is budget neutral to the specific rating region, so no dollars are added or removed to the regional spend due to the application of the risk factors.
- 4) By applying the risk factors to the regional benchmark, the resulting payment rate better matches payment to risk for each specific CCO in that rating region.
- 5) Risk Factors are comprised of two components: CDPS+RX Risk Score and A/B Hospital Adjustment

ACA 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. As a result, the capitation rates were developed using a combination of CCO submitted cost templates and OHA assumptions surrounding the risk of the ACA population. This resulted in capitation rates that were conservative in nature and were higher than the actual 2014 experience, resulting in large rebates due to the minimum loss ratio in place.

Since across the country 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 reiterated by CMS and the Office of the Actuary in several technical assistance calls in both 2014 and 2015. The expectation from CMS is that appropriate adjustments to the rates – up or down – should be made as emerging data becomes available.

Given the guidance from CMS and lack of data available in the initial 2015 rate setting, Optumas assessed the ACA expansion population separately from the non-ACA population during the rate setting process and incorporated emerging experience from the ACA expansion population in the updated 2015 rates. These changes establish new ACA expansion population rates that better reflect actual experience. The redeveloped 2015 rates establish a more consistent baseline on which to base future predictable growth. On a statewide aggregate level, the ACA expansion rates were reduced by -5.9% when comparing the redeveloped rates with the original 2015 rates (See table below).

Region	Population	Change: 2014 to Revised Net	Change: 2014 to Revised Gross	Change: Original to Revised Net	Change: Original to Revised Gross
Statewide	Non-ACA	11.3%	9.8%	6.0%	5.7%
Statewide	Maternity	-5.9%	-4.5%	-7.6%	-6.1%
Statewide	Subtotal	9.9%	8.8%	4.9%	4.9%
Statewide	ACA	-14.2%	-14.0%	-5.9%	-4.7%
Statewide	Total	-3.6%	-3.8%	-0.8%	-0.1%

Payment rates

Once the rate ranges are developed, OHA determines the payment selection within the ranges. This selection is used to determine the capitation rates to be paid to the CCOs during 2015. The payment percentiles were selected to be the same for each region and thereby each CCO. The rationale behind each payment percentile is noted below:

Group #1: Risk Adjusted Rate Cohorts (non-ACA)

- TANF, Children 1-5, Children 6-18, ABAD/OAA without Medicare
- OHA chose the 20th percentile within Actuarial Sound Rate Range for all regions, which best accommodates sustainable growth rate and Waiver.

Group #2: Non-Risk Adjusted Rate Cohorts (non-ACA)

- PLMA, Children 0-1, DUALS, CAF
- OHA chose the 50th percentile, midpoint of rate range, for all regions. This is primarily due to the fact that these are smaller, less credible rating cohorts, and the midpoint is the best estimate.

Group #3: ACA population Rate Cohorts

- OHA chose the 70th percentile of rate range for all regions. Choosing above the midpoint reflects the fact that actual 2014 experience may be understated with respect to the underlying risk of population.

Results

When comparing the results of the redeveloped methodology with the original methodology, there are relatively large shifts in payment rates between the non-ACA, maternity and ACA populations. For example, the change reflects an overall increase in the non-ACA payment rates. For the ACA expansion population, the change reflects an overall decrease in payment rates (see table above).

Below are findings from the redeveloped rates:

- Some CCOs will be paid a higher per member per month amount and some lower for each rate cohort and in aggregate when the redeveloped rates become in effect. CCOs will experience shifts in per member per month amounts due to applying a new methodology, adding to the base data, and emerging data for the ACA population.
- There will be a shift of dollars between the ACA population to the non-ACA population, and between CCOs. In aggregate, the non ACA population payments will increase and the ACA payments will decrease due to emerging experience of the new population. In aggregate, original estimates of the cost of the costs related to the expansion population were overstated.
- Many CCOs gave positive feedback regarding the extensive transparency efforts and commitment employed by OHA and Optumas in the redevelopment process (for a more detailed description of the communication with CCOs during the process see the Background and Process document)

2016 rate setting and beyond

These newly developed 2015 rates lay the ground work for the 2016 rates, which will be developed using the same methodology with some minor modifications. The 2016 rates will be provided to the CCOs for review not less than 60 days before January 1, 2016.

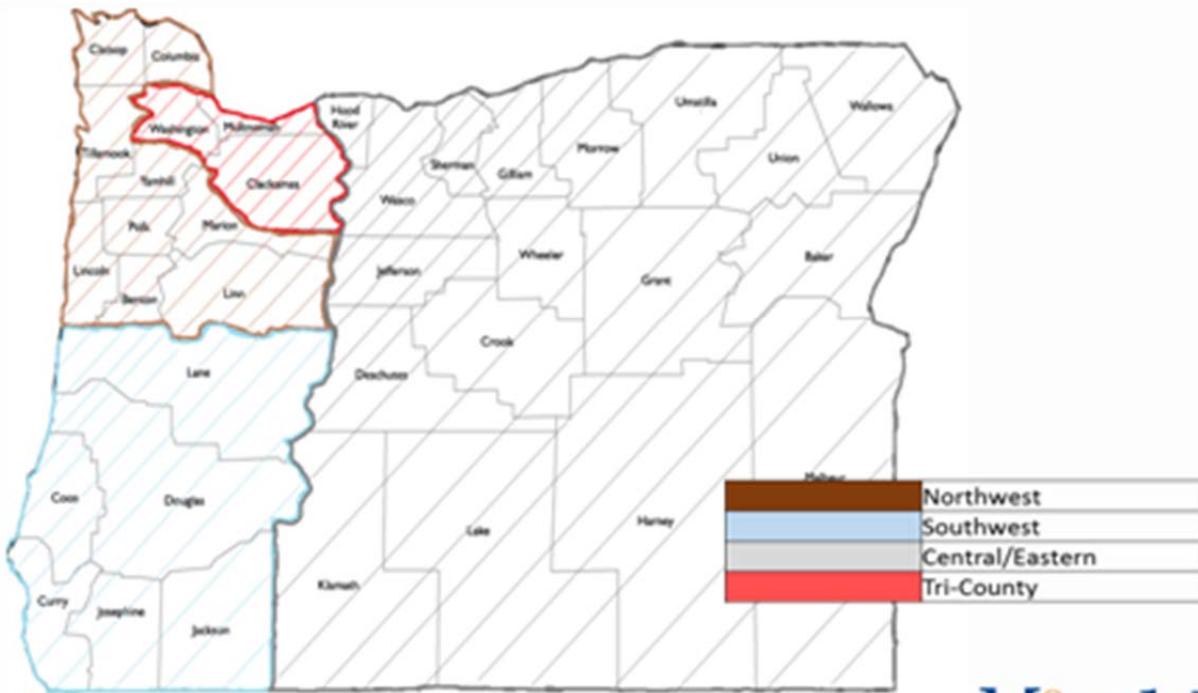
OHA and Optumas are committed to working toward the global budget as envisioned in the Waiver and meeting the requirements as specified by CMS and the Actuarial Standards Board. Concurrently, OHA is investigating alternate methods to be used in future rate setting to meet objectives of the Waiver that includes a global budget with a sustainable, predictable rate of growth. Discussion of how to include alternative payment more effectively in rate setting will begin this fall with CCOs.

For More Information

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Four Rating Regions



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