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To:	Oregon Health Authority
From:	Anne Karl, Manatt, Phelps & Phillips LLP
Date:	November 30, 2017
Subject:	Assessment of Process for Setting 2018 Rates for Coordinated Care Organizations

You have asked us to review the process used by the Oregon Health Authority (OHA or "the State"), working with its actuary, Optumas, to develop the calendar year 2018 capitation rates for Coordinated Care Organizations (CCOs) to evaluate whether the State's process complies with federal statutes, rules, guidance, and waiver terms (collectively, "federal requirements") and state law and regulations related to CCOs.[1]

Based on our review of the documents provided, conversations with OHA staff, and discussions with Optumas, we conclude that the State generally complied with the federal requirements, with the exception of a few minor areas. Specifically, the State did not consider medical loss ratio in the development of rates, and the Centers for Medicare & Medicaid Services (CMS) may require that the State resubmit the rates after taking into account historic and projected medical loss ratios. Additionally, the State did not comply with requirements in the special terms and conditions governing the State's waiver related to the development of the non-benefit component of the rate—namely, how it develops profit margins and how it accounts for flexible services. CMS may mandate minor adjustments to the rates to comply with these requirements, though it is unclear whether the requirements related to developing profit margins have taken effect. In addition to the two areas where CMS may conclude that the State did not fully comply with federal requirements related to developing rates, CMS may also request that the State submit additional documentation to describe in greater detail various adjustments and assumptions that Optumas made.

[1] We note that there were no state statutory or regulatory provisions directly affecting the CCO rate-setting process.

- Be adequate so that the MCO can meet the requirements to ensure adequate access to and coordination of services;
- Be specific to payments for each rate cell[33] under the contract;
- Not enable payments from one rate cell to cross-subsidize payments from another rate cell;
- Be certified by an actuary as meeting the applicable requirements;
- Meet any applicable special contract provisions;
- Be provided to CMS in a format and within a timeframe that meets CMS's requirements; and
- Be developed in such a way that the MCO would reasonably achieve a medical loss ratio standard of at least 85% for the rate year.[34]

Under the rules, payments must be actuarially sound for each rate cell under the contract between the MCO and the state. Further, actuarial soundness is evaluated based on whether the rates provide for all reasonable, appropriate, and attainable costs "for the operation of *the* MCO"[35] (emphasis added), suggesting that a determination of actuarial soundness must be made *for each MCO at the rate cell level.* The rules governing rate certifications found at 42 C.F.R. § 438.7 and discussed below in Section II.A.6 further specify that the actuary must certify "the final capitation rate paid per rate cell under *each* risk contract" and permits states to pay different rates to each MCO, "so long as each capitation rate per rate cell . . . is independently developed."[36] In sum, the state must ensure that rates are actuarially sound for each MCO.

Although states are required to ensure that rates are actuarially sound for each specific MCO, states are *not* required to account for all costs of each MCO when developing rates. Instead, states must ensure that rates provide for all "reasonable, appropriate, and attainable" costs. If a state determines that particular costs are unreasonable or inappropriate, the rate need not be sufficient to cover such excess costs, so long as the level of costs that the rate covers is attainable.

States have multiple tools for ensuring that rates are appropriate for each MCO and are not required to build rates specific for each MCO. For example, states may use risk adjustment models to account for variations in the health of enrolled populations across plans.[37] Risk adjustment models, by definition, look at the health status of enrollees across multiple plans, confirming that states may build statewide or regional rates that are then adjusted to take into account the

[33] A rate cell is defined as "a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area." 42 C.F.R. § 438.2.
[34] 42 C.F.R. § 438.4(b).
[35] 42 C.F.R. § 438.4(a).
[36] 42 C.F.R. § 438.7.
[37] 42 C.F.R. § 438.5(g).