Oregon's Coordinated Care Organizations—Health System Transformation or Managed Care Revisited?

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A greater focus on coordinated care, or global health management, is the direction that health care reform is driving the health care industry. Oregon's approach to global health management is to replace fully capitated health plans, physician care organizations, and mental health organizations with coordinated care organizations. Further, Oregon is proceeding in the direction of moving physical and behavioral health, as well as dental health under the coordinated care organization umbrella. The ultimate goal is to coordinate as much health care as possible under a global care structure that will facilitate the delivery of improved care to more people at a lower overall cost.

Introduction

"Health care reform" and "health system transformation" have been much discussed and much debated topics in the last few years. When the last *Insights*: Focus on Healthcare was published (in spring 2010), the federal Accountable Care Act[1] (ACA) had just passed by the narrowest of margins.

In the ensuing three years, the ACA has received much attention, generating litigation over some of its key provisions, including the individual mandate, and intense political debate over repeal or amendment of some of its provisions. Driving much of the discussion are underlying facts about the health care system in the United States:

- Health care spending growth has exceeded the growth of the economy for decades.
- The portion of the economy devoted to health care has grown from 5.2 percent of gross domestic product in 1960 to 17.9 percent in 2010.[2]
- The United States spends 48 percent to 90 percent more per capita on health care than other developed countries.[3]
- 18 percent of the under-65 population in the United States is uninsured, resulting in reduced access, poor outcomes, and a shifting of the cost of care to insured populations.[4]

In light of the underlying facts facing the health care system, a consensus has emerged about the need to deliver health care in a more cost-effective way. The ACA seeks to push the Medicare delivery system toward transformation by encouraging the development of accountable care organizations (ACOs).[5] The ACOs will replace "fee-for-service" payment models.

Fee-for-service payment systems compensate providers for each visit, procedure, test, item of equipment, or other service provided to a patient; the financial incentive is to provide more services and supplies.

The ACO program establishes a global budget for an identified population of beneficiaries, and promises to share "savings" with health care providers if actual expenditures are below the budget.

While much of the focus has been on the Medicare system, growing concern is focused on the Medicaid system. Although operated and partially funded by the states, the Medicaid system is a federal program governed by Title XIX of the Social Security Act.[6]

The federal government pays the states roughly two-thirds of the cost of health care services provided to Medicaid-eligible individuals.[7] State programs must be operated in accordance with federal requirements, unless a state obtains a waiver of specific requirements.[8]

Some of the facts driving increased focus on Medicaid include the following:

- The number of Americans covered by Medicaid has increased from approximately 41 million in 2000 to 55 million in 2011.[9]
- Medicaid accounts for about one-sixth of all U.S. health care spending.[10]
- Approximately 18 percent of the U.S. population is covered by Medicaid.[11]
- The spending on Medicaid has increased from $200 billion in 2000 to more than $400 billion in 2011.[12]

States across the country are seeking ways to address the fiscal challenges presented by Medicaid. According to the Kaiser Commission on Medicaid and the Uninsured, in fiscal year 2012, nearly every state focused on actions to control Medicaid costs.[13]

The recession has led to increases in the number of Medicaid enrollees as unemployment has risen, at the same time that tax state revenue has been in decline.

The ACA provides for expansion of the Medicaid program to cover individuals with incomes below 133 percent of the federal poverty level.[14] Although the federal government will provide most of the funding for the expansion population for the first three years, states are nevertheless concerned about the impact of the increased costs on state budgets.[15]

In Oregon, the state is now mid-stream in a process intended to transform health care delivery. Oregon seeks to deliver virtually all Medicaid services through "Coordinated Care Organizations" (CCOs) by 2014. At the time of this writing, Oregon is moving the delivery of physical and behavioral health care services into CCOs, to be followed by dental services by 2014.

The economic forces behind Oregon's reform efforts mirror national trends:

- Medicaid enrollment in Oregon has increased from 340,000 in 2006 to 630,000 today.
- After Medicaid expansion, enrollment is expected to increase to as many as 1,000,000 people by 2019.[16]
- The growth in Medicaid spending has exceeded, and is projected to exceed, increases in state revenues.

The Oregon Health Authority has presented the chart shown in Figure 1 to illustrate the problem.[17]

In the past, Oregon delivered care to the Medicaid population through a combination of managed care organizations and fee-for-service providers. In fact, managed care was introduced in 1994 as part of the original "Oregon Health Plan" effort to cover more people, reduce costs, and improve care.

The managed care organizations received capitated per-member per-month payment to provide services to their enrolled members. Fully capitated health plans (FCHPs) delivered all covered physical health care services, while physician care organizations (PCOs) provided outpatient services with the state paying for inpatient services on a fee-for-service basis.

Mental health organizations (MHOs) provided mental health services on a capitated basis, and dental care organizations (DCOs) continue to provide dental services on a capitated basis.

A substantial number of Medicaid beneficiaries remain on an "open card" system; they obtain services from any provider that has entered into a Medicaid participating provider agreement with the state and is willing to provide services. These providers are paid directly by the state on a fee-for-service basis.

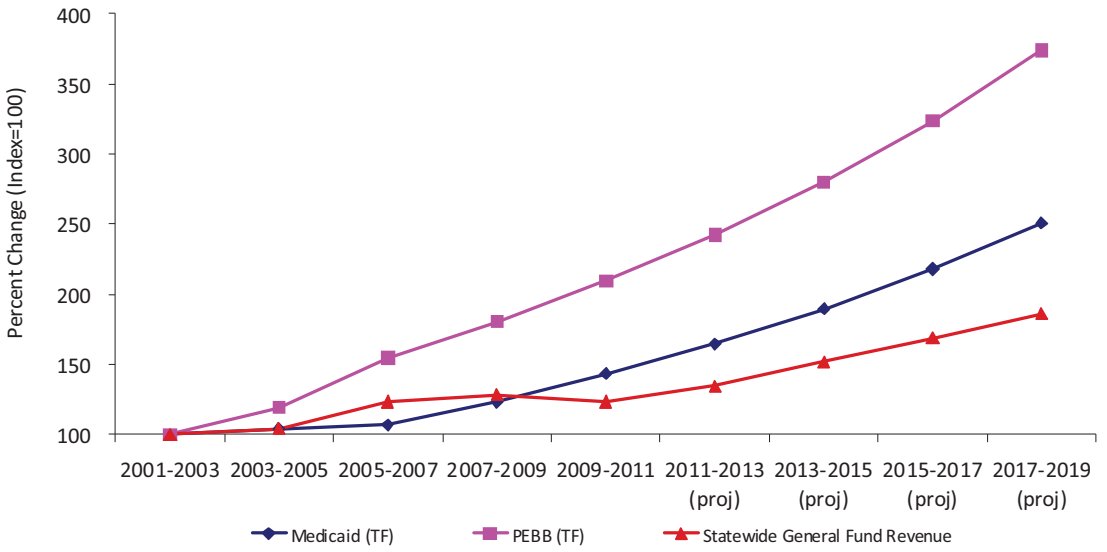
Under the Oregon plan for health system transformation, FCHPs, PCOs, and MHOs are being replaced by CCOs. The first CCOs went into operation on August 1, 2012, and the state continues the process of CCO certification.[18]

Most of the "open card" population is being transitioned to CCOs. By 2014, DCOs will also join the CCO program. State policy makers have suggested that they intend to move Oregon public employees into the CCO system within the next several years.[19]

CCO Characteristics

While managed care is not new, and several states have implemented or are implementing Medicaid

Figure 1
Comparing the Rate of Increase in Medicaid and PEBB Health Care Expenditures vs. Rate of Increase in State General Fund Revenue



Oregon Health Authority

managed care programs,[20] some elements of the Oregon program are unique, or at least uncommon. Some of these elements favor local managed care organizations with strong ties to local providers and local communities.

Governance

Oregon CCOs are required to have a governance structure in which "persons that share in the financial risk" must constitute a majority.[21] The "major components" of the health care delivery system must be represented, including at least one primary care provider and one behavioral health provider. In addition, at least two members must be drawn from the community at large and one from the "community advisory council."

The community advisory council (CAC) is an advisory body composed of a majority of health plan consumers. The CAC also includes representatives of county government. The CAC is charged with development of a community health assessment and health improvement plan.[22]

The CAC is also charged with identifying and advocating for preventive care practices to be utilized by the CCO, and publishing an annual report on progress on the community improvement plan.

The board governance requirements outlined by statute have left a number of unanswered questions. It is not clear what is required to qualify as a person who shares financial risk, particularly in the not-for-profit corporate structure that a majority of CCOs have chosen. It is not clear how the requirement for representation of the "major components" of the delivery system is to be interpreted; a broad reading could lead to unwieldy board sizes.

The introduction of a substantial "community" contingent on CCO boards may pose significant challenges to organizations previously accustomed to operating in a private, for-profit model. In practice, the CCOs certified to date present a range of organizational structures, and board sizes and compositions, including for-profit and nonprofit corporations and limited liability companies, and board sizes of less than 10 to more than 20.

About a third of the CCOs certified to date are for-profit entities, while the majority is not-for-profit.

Financial Requirements

Oregon has provided three methods for CCOs to demonstrate financial solvency.[23]

First, a CCO can be a licensed health care service contractor and meet the customary standards applicable under the Oregon Insurance Code. These are the same rigorous financial and reporting standards that apply to entities authorized to provide health benefits coverage in the group and individual commercial insurance markets.

Second, CCOs can elect to report to the Oregon Department of Consumer and Business Services, Insurance Division, while meeting financial requirements that are less demanding than those applicable to licensed health care service contractors. These "DCBS reporting CCOs" must maintain restricted reserves to cover incurred but not reported (IBNR) claims liability, plus capital and surplus of the greater of $2.5 million or the amount determined under a risk-based capital formula, plus $500,000.

CCOs that lack this level of initial capital can start with capital of at least 5 percent of annualized revenue but must increase capital by 1 percent of revenue each year to reach a 10:1 revenue to capital ratio in five years.[24]

The third financial solvency measurement is available only to "converting" managed care organizations, that is, CCOs that previously held a managed care contract as an FCHP, PCO or MHO, or were formed by one or more such organizations.

These "converting" CCOs can elect to be "OHA reporting CCOs" for their financial standards. They are required to maintain restricted IBNR accounts like other CCOs, but their capital requirements are less demanding. They must maintain net worth of approximately 5 percent of annualized adjusted premium revenue (20:1 ratio).

In addition, up to half of the required net worth can be used to fund initial transformation expenses if returned to capital within 24 months.[25]

While the Oregon Health Authority (OHA) had originally proposed that all CCOs would be required to increase capital over a period of five years to approximately a 10:1 revenue to net worth ratio, many questioned the ability of CCOs to meet program requirements to expand services and limit cost increases while also adding to capital reserves.

At least initially, OHA reporting CCOs will be held to financial standards similar to those that have applied to Oregon Medicaid managed care organizations for many years.

Operational Requirements

CCOs must credential and contract with adequate numbers and types of providers to meet patient access requirements and allow patient choice of provider. CCOs may not discriminate against providers based solely on licensure, but are also not required to contract with any provider willing to agree to CCO terms of participation.[26]

CCOs are required to develop relationships with the local public health authority and mental health authority to conduct a comprehensive community health assessment and engage community stakeholders.[27]

CCOs must contract with publicly funded providers to pay for certain point-of-contact services, including immunizations, STD treatment, family planning, and HIV/AIDs prevention.[28]

CCOs must also contract with the local mental health authority (which may be the local county or an entity designated by the county) to pay for services delivered through the local mental health authority to CCO members, such as the mental health crisis system.

CCOs are required to develop and implement a number of delivery system features to improve care coordination. Each member is to have "a consistent and stable relationship with a care team" which is responsible for care management in all settings.[29]

CCOs are required to develop "patient centered primary care homes" and individualized care plans for their members. Transitional care must be provided for members entering or leaving hospital or long-term care settings.[30]

Members must be provided assistance in navigating the health care delivery system and accessing services through personal health navigators, interpreters, community health workers or peer wellness specialists. Health information technology is to be used "to the greatest extent practicable" to link services and providers across the continuum of care.[31]

CCOs must meet significant data reporting requirements, including encounter data reporting and outcome and quality measure reporting to be developed by OHA.[32]

CCOs are encouraged to develop alternative payment methodologies designed to reward providers on the basis of outcomes, quality, and efficient care delivery rather than volume.[33]

In the waiver approving the Oregon application to allow implementation of the CCO program (the "waiver"), the Centers for Medicare & Medicaid Services (CMS) required Oregon to develop a bonus or incentive pool designed to reduce cost and

improve care. The incentives must be reflected in CCO provider agreements "to insure that the incentives are passed through to providers."[34]

Global Budgets = Transformation?

Given that much of the care provided to the Oregon Medicaid population in the past has been delivered through managed care organizations, what's new here? Prior to implementation of the CCO program, 78 percent of physical health care services for Medicaid beneficiaries were delivered through FCHPs, with higher percentages for mental and dental care. The CCO program has just been initiated, so its actual impact remains to be seen.

Certainly, it appears that the program seeks to require CCOs to implement an even broader range of care management and coordination efforts than has been required in the past. Payment to one organization for all services should allow better care coordination and reduce financial incentives for shuffling patients between physical and mental health care providers.

The waiver encourages CCOs to use payments for "flexible services," including services or items that would not otherwise be covered benefits, which may encourage CCOs to consider innovative ways to address member health needs.[35]

However, what may be really new is the apparent intention to shift the problem of health care cost inflation, at least in part, from the state and federal governments to the health care delivery system.

On a macro level, there are three major "levers" that can be pulled to adjust spending on a health care program:

1. The scope of services to be covered
2. The number of people to be covered
3. The amount to be paid for the services

In Oregon, on a macro level, the state intends to continue to maintain existing covered benefits and maintain or expand the covered population. However, Oregon intends to change the way it calculates the amount to be paid for services in the future by changing its method for determining the plans' payment rates—the so-called "global budgets."

It appears likely that this shift in how the state establishes plan payment rates will force the plans to either push the cost cuts down to the provider community or find ways to reduce the need for services.

Past Rate-Setting Methodology

To understand what is different about the state's global budget rate-setting methodology, one should first look at how the rates were established in the past.

Historically, between 2001 and 2009, payment rates for Oregon's Medicaid managed care plans were established by an outside actuary, PriceWaterhouseCoopers. The actuary engaged in a fairly traditional rate-setting methodology by first determining per capita "costs" incurred by the plans and projecting those costs into a two-year rate period using reasonable trending assumptions.

But there were several problems with the actuary's approach from a state government perspective.

First, the actuary did not have the plans' actual cost data available to it. Historically, the state asked plans to report "encounter data" that only reported billed charges, rather than actual costs. In the health care industry, billed charges can vary significantly from the actual payments made by the plans. This meant that the outside actuary had to first adjust the encounter data using estimated

cost-to-charge ratios developed from a number of sources to establish baseline costs.

The second problem was that the actuary's approach did not allow for adjustments to reflect budget constraints. The actuary trended the "costs" it had developed forward using cost trends experienced by the plans and CMS projections of cost trends for national health expenditures.[36]

Overall, the actuary's approach reflected the actuary's view that "[o]ver the long term * * * the Oregon Medicaid program costs [would] change at a rate comparable to the broader health care market."[37]

Thus, while the plans' rates were still substantially below commercial rates, Medicaid rate inflation generally exceeded the general inflation rate.

The rate-setting approach used by the outside actuary was intended to demonstrate the state's compliance with federal law. Federal law requires that states ensure that payments to Medicaid managed care plans be "made on an actuarially sound basis."[38]

Federal regulation defines what are "actuarially sound" rates primarily by reference to "generally accepted actuarial principles and practices."[39] In setting actuarially sound rates, states must apply specified elements, or explain why they are not applicable.

These elements include the following:

1. Base utilization and cost data derived from the Medicaid population or a Medicaid-comparable population
2. Adjustments to smooth data and account for factors such as medical trend inflation
3. Rate cells specific to the enrolled population, by eligibility category, age, gender, locality, and in some instances diagnosis or health status
4. Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims.[40]

Basing rates on actuarially sound cost data and trending this data forward based on medical inflation trends should result in rates that are adequate to ensure access to care without being overly generous. However, an actuarially sound approach does not take into account the budget constraints faced by the state in times of economic downturn.

As budget pressures increased, the Oregon actuary's reports reflected an increasing discomfort with the outdated data made available to the actuary for rate-setting, problems with the accuracy of the data, and what appears to be direction by the state to use assumptions that may not be actuarially sound.[41]

Recent Rate-Setting Methodologies

Effective for rates going into effect in October of 2009, Oregon ceased using the services of its outside actuary. Instead, the state began developing rates internally through the Actuarial Services Unit (ASU). The ASU relied heavily on the prior, and some would say outdated, expected cost analysis performed by the outside actuary. However, in establishing trend factors, the ASU practices became more opaque.

For example, in its December 2010 capitation report, the ASU included unspecified trending adjustments for "recent economic events," "recent encounter data," and "rate stability purposes in a cost neutral fashion."[42]

These trending practices and the continued use of old data resulted in a downward adjustment of 2011 statewide rates that were perceived by many in the community to be budget-driven.

It is not clear that the ASU rate-setting approach would have continued to produce actuarially sound rates in the future.[43]

Perhaps aware of this problem, in 2011, the ASU developed a Lowest Cost Estimate (LCE) process for rate-setting that it has carried forward to use in establishing CCO global budget rates. This process requires each CCO to project its lowest estimated costs for each rate cell, as though the CCO has engaged in its own rate-setting process.

One of the primary reasons put forth by the OHA for this new methodology was the state's perceived inability to establish accurate rates using encounter data that did not reflect the plans' actual costs. Thus, the new method explicitly addressed the state's first problem with the old methodology which relied on estimated costs derived from billed charges.

The ASU solution for the second problem—use of a trending factor tied to medical utilization, rather than state budget constraints—was more subtle. The LCE requires each CCO to make numerous certifications as to the sufficiency and accuracy of the costs contained in the LCE.

The CCO certifications that accompany the LCE include all of the major elements an actuary would need to certify the actuarial soundness of the rates to CMS based on CMS guidelines.

The ASU then reviews the LCE and certifications submitted by each CCO for reasonableness and consistency with federal guidelines, reserving the ability to make additional calculations to ensure

that CCO rates in aggregate meet the legislatively approved budget. Facially, this process appears to be nothing more than a bid process, which if done properly should result in actuarially sound rates.[44]

However, the state has made clear its intention to ensure that CCO cost submissions do not exceed legislatively approved budgets.[45]

Oregon implicitly recognized that its LCE methodology may raise an issue of compliance with the actuarial soundness requirement when making its waiver application for the CCO program. It asked CMS to consider whether the state needed a waiver of the regulation that contains the actuarial soundness requirement in order to allow the OHA the "[l]atitude to set a sustainable fixed rate of per capita cost growth within CCO global budgets."[46]

In the end, CMS did not grant a waiver of the actuarial soundness requirement; the final waiver document does not address the request. However, the waiver refers to the "global budgets" as compensating CCOs for the "cost of care" and to reductions in the growth rate as being solely a function of the CCO's decreased use of unnecessary and costly services.[47]

A reasonable interpretation is that CMS has not approved use of the LCE process to fix sustainable growth rates in payments to plans without regard to actual costs.

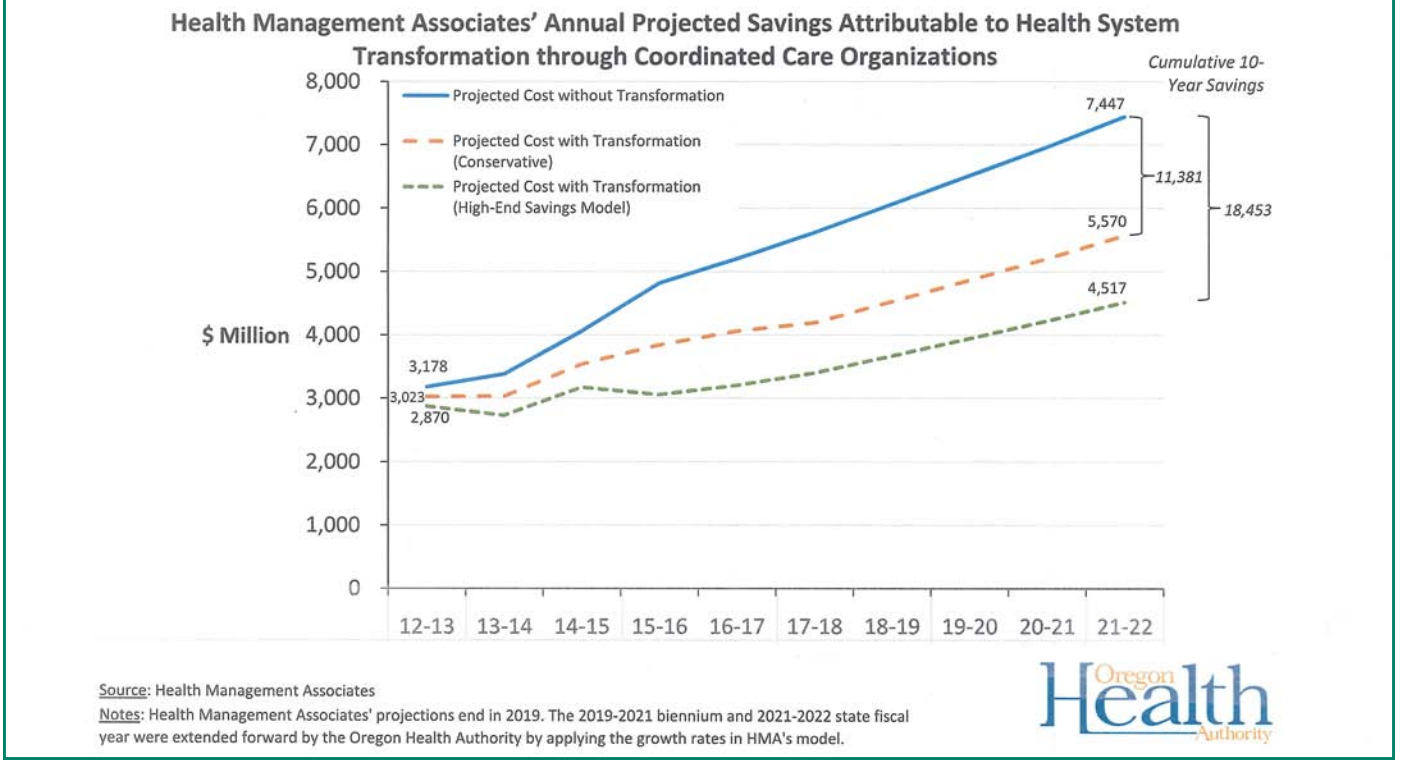
Nonetheless, Oregon appears intent on ensuring that it meets its health care transformation goals; it remains to be seen just how hard the state will push plans to meet its target growth goals. In its waiver application, Oregon promised CMS that it will reduce the rate of health care cost inflation from the national 5.4 percent base rate to 4.4 percent in the first full year and 3.4 percent in each of the next three years.

Figure 2 illustrates the savings that Oregon expects to achieve through the CCO program.[48]

CMS took Oregon at its word and has made achievement of the promised targets a measureable goal of the waiver. If the resulting anticipated savings are not achieved, Oregon stands to lose almost $200 million of additional federal funding CMS has agreed to provide to fund the Oregon health system transformation.[49]

Although the LCE process may enable the state to establish rates that meet the target projections, it will be up to the plans and the providers to determine whether the payments provided will be sufficient to maintain access while providing quality care and truly transforming the health care delivery system.

Figure 2
Health Management Associates' Annual Projected Savings Attributable to Health System Transformation through Coordinated Care Organizations



Source: Health Management Associates
Notes: Health Management Associates' projections end in 2019. The 2019-2021 biennium and 2021-2022 state fiscal year were extended forward by the Oregon Health Authority by applying the growth rates in HMA's model.

Summary and Conclusion

Like the Medicare system and other Medicaid programs across the country, Oregon's Medicaid program faces daunting financial challenges. Oregon is attempting to bring Medicaid cost increases in line with increases in state revenues by implementing the CCO program. Managed care is not new, and it has long been part of the Oregon Medicaid delivery system.

The CCO program seeks to increase the savings resulting from managed care by consolidating the delivery of more services and health care spending in new, larger Medicaid managed care organizations, and by allowing the new organizations greater flexibility in spending and service delivery.

The CCOs are required to implement a number of enhancements to care coordination and care management that are intended to reduce costs and improve quality.

One of the important elements of the program is the claim that it will reduce the rate of increase in health care costs per capita by about 2 percent. Historically, use of traditional rate-setting methodologies has resulted in rate increases substantially in excess of the goal of 3.4 percent set for the CCO program.

Although Oregon has successfully used a "Lowest Cost Estimate" process to limit rate increases in the last couple of years, it is uncertain that this methodology meets actuarial soundness requirements, or that the CCOs will be able to maintain access and quality on such a strict diet.

As the states and the federal government continue to struggle to find ways to control health care costs, Oregon's latest effort to improve its health care system will be worth watching.

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Notes:

1. Pub L No. 111-148, 124 Stat 119 (2010) and Pub L No. 111-152, 124 Stat. 1029 (2010) are collectively known as the Affordable Care Act.
2. *Health Care Costs: A Primer* (May 2012) Kaiser Family Foundation, pp. 5, 25. Available at www.kff.org/insurance/upload/7670-03.pdf.
3. Id., p. 7.
4. *The Uninsured: A Primer* (October 2012) Kaiser Family Foundation, p. 28. Available at http://www.kff.org/uninsured/7451.cfm.
5. 42 USC § 1395jjj.
6. 42 USC § 1396, et seq.
7. The federal government's share of Medicaid expenditures in each state varies in large part based on each state's average per capita income. The federal share ranges from 50% to 74.2%. *CMS Financial Report for Fiscal Year 2012*, p. 14 [hereafter referred to as "CMS Financial Report"]. Available at http://www.cms.gov/CFOReport.
8. Id., p. 7.
9. Report to the Congress on Medicaid and CHIP (June 2012) Medicaid and CHIP Payment and Access Commission, p. 78 [hereafter referred to as "MACPAC Report"]. Available at http://www.macpac.gov/reports.
10. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends* (October 2011) Kaiser Commission on Medicaid and the Uninsured, p. 10 [hereafter referred to as the "Kaiser Report"]. Available at http://www.kff.org/medicaid/upload/8248.pdf.
11. *CMS Financial Repor*t, p. 6.
12. *MACPAC Report*, p. 78.
13. Kaiser Report, p. 5.
14. CMS Financial Report, p. 7.
15. Kaiser Report, p. 5. For an in-depth look at the projected costs and savings that may result from Medicaid expansion, see *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (November 2012) Kaiser Commission on Medicaid and the Uninsured. Available at http://www.kff.org/medicaid/upload/8384.pdf.
16. *Application for Amendment and Renewal, Oregon Health Plan*, 1115 Demonstration Project, Appendix C [hereafter referred to as the "Oregon Application"]. Available at https://eco.health.oregon.gov/DraftDocuments/Documents/appendices.pdf.
17. *2011–2013 Budget Overview*, Oregon Health Authority, p. 5. Available at http://www.oregon.gov/ohs/budget/2011-2013/wm/overview.pdf.
18. As this article is being written, 14 CCOs have been certified, while one additional CCO has been conditionally certified and is in the process of completing organizational requirements.
19. See, e.g., Oregon Application, Appendix C, pp. 41-42.
20. Kaiser Report, pp. 8.
21. ORS 414.625(2)(o); SB 1580 § 20 (76th Oregon Legislative Assembly, 2012 Regular Session).
22. ORS 414.625(2)(i); SB 1580, § 13 (76th Oregon Legislative Assembly, 2012 Regular Session).
23. OAR 410-141-3345(4); *Oregon Health Authority, Oregon Health Plan, Health Plan Services Contract, Coordinated Care Organization*, Exhibit L [hereafter referred to as the "Wave 4

Contract Template"]. An earlier version of the contract is available at https://cco.health.oregon.gov/RFA/Documents/CCO_RFA_Appendix_G_-_Core_Contract_Final_3-18-12.pdf. However, Exhibit L was added in a later version of the contract that does not appear to be available on the web.

24. OAR 410-141-3350 to -3365.
25. Wave 4 Contract Template, Exhibit L.
26. OAR 410-141-3120(4).
27. OAR 410-141-3015(8).
28. ORS 414.153.
29. OAR 410-141-3015(16); OAR 410-141-3160.
30. The cost of long-term care is outside the CCO global budget.
31. OAR 410-141-3015(26).
32. OAR 410-141-3180, -3200.
33. ORS 414.653.
34. Centers for Medicare & Medicaid Services Amended Waiver List and Expenditure Authority, Numbers 21-W-00013/10 and 11-W-00160/10, pg. 61 [hereafter referred to as the "Waiver"]. Available at http://www.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf.
35. Waiver, pp. 58-59.
36. *Oregon Health Plan Medicaid Demonstration, Analysis of Federal Fiscal Years 2004-2005 Average Costs* (November 11, 2002) PricewaterhouseCoopers, pp. 25-26. Available at http://www.oregon.gov/oha/healthplan/data_pubs/rates-costs/pcc03-05.pdf.
37. *Oregon Health Plan Medicaid Demonstration, Analysis of Calendar Years 2008-2009 Average Costs* (September 22, 2006) PricewaterhouseCoopers ("2008-2009 Analysis of Costs Report"), p. 33. Available at http://www.oregon.gov/oha/healthplan/data_pubs/rates-costs/pcc2007-09report-final.pdf.
38. 42 USC § 1396b(m)(2)(A).
39. 42 CFR § 438.6(c)(1)(i)(A).
40. 42 CFR § 438.6(c)(3). Although there are no more definitive criteria for developing actuarially sound rates, in July 2003, CMS issued a checklist for its field offices to use as a guideline when evaluating the adequacy of state managed care rates. In addition, in 2005, the American Academy of Actuaries, Medicaid Rate Certification Work Group developed a Practice Note that provides commentary on the checklist [hereafter referred to as the "AAA Practice Note"]. It is available here: http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf. In addition, in January 2011, the American Academy of Actuaries published detailed responses to CMS questions regarding the Practice Note and certain related Actuarial Standards of Practice. It is available at http://www.actuary.org/files/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.4.pdf/American_Academy_of_Actuaries_Letter_on_Rate_Setting_Checklist_to_CMS.4.pdf.
41. *2008-2009 Analysis of Costs Report*, pp. 19-20, 27, 33, 35; Oregon Health Plan Medicaid Demonstration, Analysis of Calendar Years 2010-2011 Average Costs (September 15, 2008) PricewaterhouseCoopers, pp. 18, 24, 27, 30, 94. Available at http://www.oregon.gov/oha/healthplan/data_pubs/rates-costs/cap-rates/pcc-0911.pdf.
42. *Oregon Health Plan Medicaid Demonstration, Capitation Rate Development, January 2011-December 2011* (October 15, 2010) DHS Actuarially Service Unit, p. 176 (Appendix A-1, AA.3.10). The report is available at http://www.oregon.gov/oha/healthplan/data_pubs/rates-costs/cap-rates/cap-rate0111.pdf.
43. Although actuarially sound rates can be established using a range of reasonable assumptions, the assumptions cannot be chosen in order to respond to budgetary constraints. AAA Practice Note at 12; CMS Checklist, Item #AA.1.1 ("Actuarially sound" rates or rate ranges * * * are normally independent of budget issues unless benefits or populations change."); see also Rate Setting and Actuarial Soundness in Medicaid Managed Care (January 23, 2006). The Lewin Group, p. 2 (noting that the federal regulation defining actuarial soundness does not "tie the payment rates to whatever amount the state has budged for its Medicaid managed care program"), available at http://mhpa.org/pdf/misc/ACAP_MHPOAreport.pdf.
44. See AAA Practice Note, p. 8 (state may negotiate rates as long as the resulting rate falls within a range of rates that are actuarially sound).
45. Coordinated Care Organizations, Implementation Proposal, HB 3650 Health System Transformation, Oregon Health Policy Board, at 32 (January 24, 2012) (stating that OHA will make adjustments to CCO lowest cost estimate rates "to ensure that CCO rates in aggregate meet the 2011–2013 legislatively approved budget.").
46. Oregon Application, Appendix H, p. 1.
47. Waiver, pp. 57-59.
48. *Coordinated Care Organizations Next Steps*, Oregon Health Authority (November 2012), p. 21. Available at http://www.oregon.gov/oha/OHPB/meetings/2012/2012-0710-cco.pdf.
49. Waiver, pp. 69, 71-72.

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