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Actuarial Soundness in Final Medicaid Managed Care Regulations

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Webinar overview

1. Introduction
2. Rate ranges
3. Minimum MLR
4. Pass-through payments
5. Capitation Rate-Setting Process & CMS Review
Sections of Rule Relevant to Actuarially Sound Capitation Rates

- **438.4**: Actuarial Soundness
- **438.5**: Rate Development Standards
- **438.6**: Special Contract Provisions Related to Payment
- **438.7**: Rate Certification Submission
Actuarial Soundness
Definition

“Actuarily sound capitation rates are projected to provide for all *reasonable, appropriate, and attainable costs* that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP *for the time period and the population covered under the terms of the contract*” (§438.4(a))
Rate Ranges
Rate ranges – current practice

Practical uses
- Flexibility
- Reduce interim modifications

Concerns with ranges
- Size of range
- Reduced precision
Removal of Certified Rate Ranges

- Eliminate use of certified rate range
  - Actuary must certify to payments for each rate cell under the contract (§438.4(b)(4))
  - Certify final capitation rate for each risk contract (§438.7(c)(1))

- Enhance transparency and integrity

- CMS defines “de minimis” range of 1.5%
Action items

Still able to develop

• Actuary can determine and share with State
• Establish range of appropriate payments

Ability to utilize

• Choose rate within range
• Contract negotiations
• Has to meet requirements

Timing

• Rating periods on or after 7/1/2018
Minimum MLR
Minimum MLR Consideration

Develop rates with target

- Reasonably achievable
- 85% or higher

Calculate in accordance with §438.8

\[
\frac{\text{Claims} + \text{Quality Improvement} + \text{Fraud Prevention}}{\text{Premium} - \text{Taxes and Fees}} + \text{Credibility Adjustment}
\]

Does not require state to employ MLR-based refund
Practical Use of MLR in Rate Development

- Rates are certified prospectively
- Composite of all assumptions don’t always hit the mark
- Review of MLR can assist in future rate setting (“lookback study”)
- Codifies general practice already employed by many actuaries
Pass-through Payments
# Pass-through payments – current practice

## Typical provider classes
- Hospitals
- Nursing Facilities
- Physicians

## Practical uses
- Encourage provider access for Medicaid beneficiaries
- Retain critical funding stream to certain providers
- Avoid disruption of existing IGT or provider tax mechanisms

## Concerns with pass-through payments
- Diminished transparency in tracking payments from state to providers
- State-directed reimbursement to certain providers
Elimination of Pass-through Payments

- Varies by provider type
  - 10-year phase-down for hospitals
  - 5-year transition for physicians and nursing facilities
  - July 1, 2017: Any pass-through payments that exceed maximum allowable amount (§438.7(d))

- Potential solutions
  - Enhanced fee schedules for certain provider classes
  - Value-based purchasing
  - Adjustments to GME or DSH payments

- “New” pass-through payments during transition period
  - July 29, 2016 CMCS Informational Bulletin
Capitation Rate-Setting Process & CMS Review
### Capitation Rate-Setting Process

<table>
<thead>
<tr>
<th>Data</th>
<th>Trend</th>
<th>Non-Benefit Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Types</td>
<td>• Historical Program Experience</td>
<td>• Administrative expenses, Care coordination, Risk margin, Cost of capital, Taxes/Assessments/Fees, Other</td>
</tr>
<tr>
<td>• Age</td>
<td>• Actuarial Judgment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjustments</th>
<th>MLR</th>
<th>Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Program Changes</td>
<td>• Past MLR; Projected MLR</td>
<td>• Prospective or retrospective</td>
</tr>
<tr>
<td>• Enrollee health status</td>
<td></td>
<td>• Budget neutral</td>
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§438.2: “Rating period” is a period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS.
Rate Development and Certification Standards

- Provides general guidance on how different components of rate should be developed and documented in certification.

- Some aspects may be new or different than how components were developed in past:
  - Base data requirements
  - New requirements and documentation for risk adjustment processes
  - Non-benefit costs may require additional detail

- Actuaries and states should review how current rate development and certification applies to new requirements.
Actuarial Soundness
CMS Review

- Developed in accordance with defined rate development standards and generally accepted actuarial principles and practices
- Appropriate for covered populations and services
- Adequate to meet requirements defined for MCOs
- Specific to payments for each rate cell under the contract
- No cross-subsidization between rate cells
- Certified on behalf of the state by a qualified actuary
- Meet any special contract provisions
- Appropriate submission of documentation to CMS
- Developed such that the MCO would reasonably achieve a medical loss ratio (MLR) of at least 85%

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## Evolution of Actuarial Soundness

<table>
<thead>
<tr>
<th>What’s New</th>
<th>What’s New-ish</th>
<th>What’s Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate rate ranges and addition of +/-1.5%</td>
<td>Prescribed methodology</td>
<td>Actuarial soundness</td>
</tr>
<tr>
<td>Use MLR in rate dev</td>
<td>Documentation requirements</td>
<td>Rate certification</td>
</tr>
<tr>
<td>Phase out of pass-through payments</td>
<td>CMS actuarial review</td>
<td>Generally accepted practice</td>
</tr>
<tr>
<td>Age of base data</td>
<td>Binding standards on actuaries (ASOP)</td>
<td>Actuarial judgment</td>
</tr>
</tbody>
</table>
## Important Implementation Dates

<table>
<thead>
<tr>
<th>60 days after publication of rule (now)</th>
<th>Rating periods for contracts starting on or after July 1, 2017</th>
<th>Rating periods for contracts starting on or after July 1, 2018</th>
<th>Rating periods for contracts starting on or after July 1, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitions of actuarial soundness and other rate components</td>
<td>Most rate development standards – base data, trend, etc.</td>
<td>Certify to each rate per rate cell (no more ranges)</td>
<td>Rates should be developed so that plan can reasonably achieve an MLR of at least 85 percent</td>
</tr>
<tr>
<td>Appropriate for populations &amp; services covered</td>
<td>Certification provided in format and timeframe required in 438.7</td>
<td>Ability to change rate by 1.5%</td>
<td></td>
</tr>
<tr>
<td>No cross-subsidization of rates</td>
<td>Phase out of pass-through payments</td>
<td>Adequate to meet new requirements on health plans in 438.206, 438.207, 438.208</td>
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<td>Payments for plans for enrollees who are in IMDs</td>
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Additional Resources

  - Medical loss ratio (MLR) in the “Mega Reg”
  - Institution for Mental Disease (IMD) as an "in lieu of" service
  - Encounter data standards: Implications for state Medicaid agencies and managed care entities from final Medicaid managed care rule
  - Pass-through payment guidance in final Medicaid managed care regulations: Transitioning to value-based payments
  - Overview of guidance related to actuarial soundness in final Medicaid managed care regulations
Thank you

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