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Actuarial Soundness in Final Medicaid Managed Care Regulations

November 1, 2016

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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

"Actuarially 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

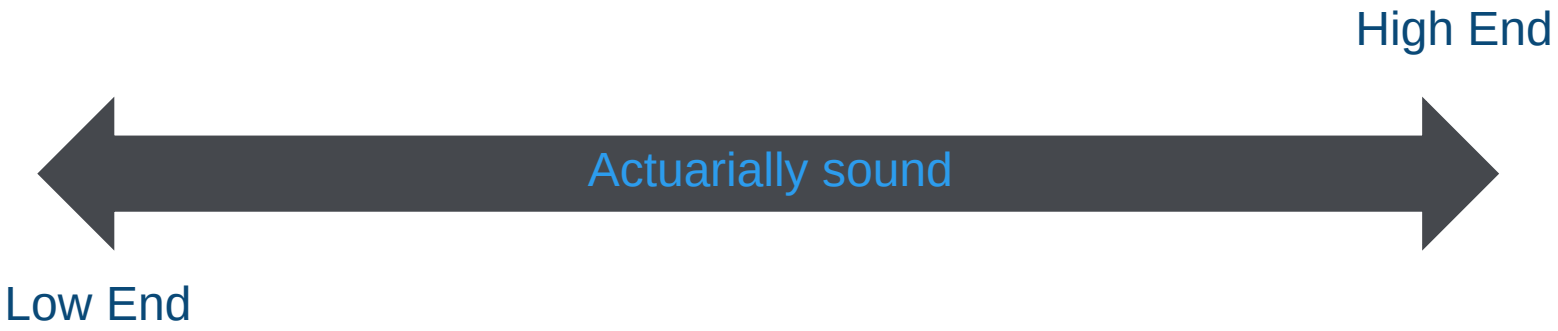
Rate ranges – current practice

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

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

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

Data	• Types • Age
Trend	• Historical Program Experience • Actuarial Judgment
Non-Benefit Cost	• Administrative expenses, Care coordination, Risk margin, Cost of capital, Taxes/Assessments/Fees, Other
Adjustments	• Program Changes • Enrollee health status
MLR	• Past MLR; Projected MLR
Risk Adjustment	• Prospective or retrospective • Budget neutral

§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%***

Evolution of Actuarial Soundness

What's New	What's New-ish	What's Not
▪Eliminate rate ranges and addition of +/-1.5% ▪Use MLR in rate dev ▪Phase out of pass-through payments ▪Age of base data	▪Prescribed methodology ▪Documentation requirements ▪CMS actuarial review ▪Binding standards on actuaries (ASOP)	▪Actuarial soundness ▪Rate certification ▪Generally accepted practice ▪Actuarial judgment

Important Implementation Dates

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

Additional Resources

- **http://www.milliman.com/medicaidmanagedcare/**
  - 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

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Thank you

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