MILLIMAN WHITE PAPER

Proposed updates to actuarial soundness

Creating flexibility and strengthening the requirements

Bradley B. Armstrong, FSA MAAA
Marlene T. Howard, FSA, MAAA
Christopher T. Pettit, FSA MAAA

Milliman

CMS released proposed updates to Medicaid managed care regulations with the goal of easing some of the regulatory burdens while increasing the requirement for transparency. These updates were issued in the November 14, 2018, Federal Register and offer more flexibility in developing, while at the same time placing more regulation on certifying actuarially sound capitation rates.

The 2016 final rule included many items impacting actuarial soundness and capitation rate certifications, which we summarized in a September 2016 paper.[1] The most significant changes related to actuarial soundness under the proposed authority are the reintroduction of certifying rate ranges and the considerations that must be given to assumptions applicable to rates under different federal financial participation (FFP) levels.

The reversal of the elimination of rate ranges from the 2016 final rule offers states and their certifying actuaries additional options, but also places more stringent requirements on documenting support for the developed rate ranges. The Centers for Medicare and Medicaid Services (CMS) commented that the reintroduction of rate ranges may be especially valuable to states that procure contracts through competitive bidding, which was a primary reason for reinstating them.

CMS also proposes clarifications related to the need to limit variance in assumptions among programs with different average FFP levels to valid rate development standards.

Background

ACTUARIAL SOUNDNESS: CURRENT ENVIRONMENT

In Medicaid managed care regulations published in the Federal Register on May 6, 2016 (the 2016 final rule),[2] CMS made modifications to the capitation rate certification process for various items often utilized by states and their certifying actuaries. Among those included were the elimination of the ability to certify a rate range as being actuarially sound,[3] consideration of an 85% minimum medical loss ratio (MLR), and requirements on data utilized in rate development. While passage of the rules phased in these changes over a period of time, advance consideration of any implications to previously applied processes was a necessity.

Our prior paper acknowledged that certain aspects of the 2016 final rule may impact development of managed care rates, which is once again consistent with the new proposed changes. While it is possible that states and their certifying actuaries may not have to alter any process updates that were required to comply with the final rule, it is prudent to review the proposed regulation, and understand any implications on current rate development and submission practices.

Certifying an actuarially sound rate range

Prior to the passage of the 2016 final rule, actuaries were permitted to certify a range of rates, with any rate inside that range being considered actuarially sound. This approach offered states the ability to modify rates over the course of a defined time period or to pay varying rates within the range to different managed care entities without having to recertify to different rates. Based on CMS comments included in the 2016 final rule, rate ranges had become too wide and brought into question how rates more than 5% below the midpoint of a rate range could be concurrently considered actuarially sound.

[1] Armstrong, B., Pettit, C.T., & Howard, M. (September 12, 2016). Overview of Guidance Related to Actuarial Soundness in Final Medicaid Managed Care Regulations. Milliman White Paper. Retrieved December 22, 2018, from http://www.milliman.com/insight/2016/Overview-of-guidance-related-to-actuarial-soundness-in-final-Medicaid-managed-care-regulations/.

[2] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final rule, 81 Fed. Reg. 27498 (May 6, 2016).

[3] Note that this requirement does not prevent varying rates among contracted managed care entities from being certified as actuarially sound.

Subsequent to passage of the 2016 final rule, actuaries are required to certify to an individual rate for each rate cell with sufficient support for assumptions supporting the rate development. Although this did not eliminate a state's ability to pay different rates to different managed care entities, it did increase administrative burdens in certain situations, such as a competitive bidding process. Additionally, under the final rule, de minimis changes of plus or minus 1.5% were allowed without recertification. This flexibility inherently created a rate range allowance of 3%, centered around the certified rate.

NEW PROPOSAL AND INTENT

Noting the administrative burdens and limited flexibility of certifying individual rates, CMS is offering an option to certify a rate range under the new proposed regulations. The reintroduction of the actuarially sound rate range offers states the ability to simplify documentation materials in situations such as a competitively bid environment.

PROVISIONS IN NEW PROPOSAL

The proposal allowing certification of a rate range comes with a higher need for transparency through additional supporting documentation. It also prohibits states that choose to certify a rate range from utilizing the +/- 1.5% de minimis bounds set forth in the 2016 final rule when changing the rates; if changes are made to the rate ranges after the initial certification, a new certification must be submitted, regardless of the magnitude. The specific parameters regarding the use of rate ranges are as follows:

- Assumptions, data, and methodologies supporting the upper and lower bounds of the range are documented in the certification
- The upper and lower bounds of the rate range are certified as actuarially sound consistent with part 438
- The upper bound of the rate range does not exceed the lower bound by more than a multiplier of 1.05
- Criteria for paying entities at various points in the range are documented in the certification and not tied to intergovernmental transfer agreements (IGTs)
- Compliance is met regarding the state's ability to pay managed care entities at various points

The certification must be submitted prior to the start of the rating period and any changes to contracted rates within the rate range must be accompanied by a recertification demonstrating the need to modify the original rate range.

IMPLICATIONS AND CONSIDERATIONS

While elimination of the use of rate ranges was designed to remove concerns regarding the wide span of previously certified rates, CMS believes the enhanced documentation requirements will lessen this risk with the reintroduction of actuarially sound rate ranges.

Although rate ranges will be allowed if the proposed regulations become final rule, actuaries are not required to utilize rate ranges and can still opt to maintain the use of the 1.5% de minimis bounds established by the 2016 final rule.

Assumptions supporting rates at varying levels of FFP

The 2016 final rule stressed that differences among capitation rates must be based on generally accepted actuarial principles and practices and should not vary simply based on the aspect that one rate may be paid at a different FFP level (e.g., standard vs. Patient Protection and Affordable Care Act [ACA] expansion FFP), thereby shifting funding from the state to the federal government. Although rates and covered services are allowed to differ by population and program, CMS implies in the new proposal that the goal of the 2016 final rule was that states would not be allowed to target higher capitation rates for populations associated with higher FFP percentages simply to reduce state spending and to take advantage of federal funding. Instead, any differences among capitation rates were to be based on valid rate development standards, strictly prohibiting higher underlying network provider reimbursement requirements or higher risk margin assumptions applicable to populations with higher FFP percentages.

PROVISIONS IN NEW PROPOSAL

CMS notes that additional clarity is being provided in the proposed regulations regarding language supporting the use of assumptions, methodologies, and factors utilized for development of rates at different FFP percentages. Additionally, a requirement is being added for states to evaluate differences underlying the assumptions, methodologies, and factors that may increase the federal portion of funding under varying levels of FFP. More specifically, a state's capitation rates would not be allowed to utilize a higher profit or risk margin, factor in additional cost associated with higher contractually required reimbursement, or use a lower MLR remittance threshold for populations with higher FFP levels than is utilized for populations with the lowest average FFP.

IMPLICATIONS AND CONSIDERATIONS

One key impact of this section of the proposed regulations will likely be on Medicaid expansion populations that currently utilize either higher reimbursement or risk margin levels than other historical managed care populations. In certain states where provider reimbursement has been maintained at higher levels for higher FFP populations, CMS is proposing that states modify these practices, as maintaining these higher levels of cost will result in violation of regulatory standards. CMS acknowledges that certain assumptions may vary, but that sufficient documentation will need to be included to support why the higher

reimbursement levels are necessary to operate a program that inherently shifts more cost to the federal portion of the funding. Additionally, CMS has not provided clarity on how the program with the lowest average FFP would be defined.

CMS states in the proposed regulation that it would prohibit certified capitation rates for a higher FFP population to have a larger risk margin or a lower MLR remittance threshold than those for the lowest FFP population "under any and all scenarios." However, there may be cases where these differences are aligned with generally accepted actuarially principles. For example, managed care programs with disabled members or long-term support services tend to have higher average MLRs than Temporary Assistance for Needy Families (TANF) or expansion populations, even though the latter may have a higher average FFP. Additionally, small populations with higher variance or newer programs with emerging experience may justify including a higher margin in the rates due to greater levels of uncertainty in expected costs. CMS may clarify some of these issues after questions and comments are received during the 60-day comment period.

Other aspects impacting rate development

Other aspects of the capitation rate development process that may be impacted by passage of the proposed regulation—but are not discussed in detail in this paper—include the following:

- Pass-through payment and preprint approval guidance: Additional clarification on options for pass-through payments and delivery system and provider payment initiatives are discussed in the paper available at http://www.milliman.com/uploadedFiles/insight/2018/proposed-updates-pass-through-payments.pdf.
- Base data standard compliance clarity: Ambiguity regarding the corrective action plan timeline for data is being tweaked to define the timeframe as the rating year in which the issue is identified plus two years
- Risk-sharing mechanisms must be documented in the rate certification in advance of the rating period, and no programs will be approved for concepts introduced after the beginning of the rating period.
- Effective for contract years beginning July 1, 2018, encounter data must include both allowed and paid amounts (required for states to receive FFP).
- CMS is required to provide annual guidance on rate certification documentation requirements.

Final thoughts

The proposed regulations outlined in this paper are not yet final as of this publication, and comments regarding the new proposals may be submitted to CMS by January 14, 2019. We encourage states to review the proposed rule in coordination with their actuaries and other managed care stakeholders in order to determine how their current capitation rate development processes may be affected.

About the authors

Bradley Armstrong, Marlene Howard, and Christopher Pettit are consulting actuaries with the Milliman Medicaid consulting group.

Acknowledgments

The authors gratefully acknowledge Paul Houchens and Shelly Brandel for their thoughtful peer review and contributions to this report.

Milliman

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT
Bradley Armstrong
brad.armstrong@milliman.com

Marlene Howard
marlene.howard @milliman.com

Christopher Pettit
chris.pettit@milliman.com