Overview of guidance related to actuarial soundness in final Medicaid managed care regulations

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With its publication of the final Medicaid managed care rule (final rule) in the Federal Register on May 6, 2016,[1] the Centers for Medicare and Medicaid Services (CMS) has underscored the importance of actuarial soundness in the capitation rate development process. Even in the introductory preamble to the rule, it is noted that the final rule "strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates." CMS has devoted significant sections of the rule to the process for developing capitation rates as well as considerations for developing the individual components that comprise the capitation rate. Many of the new requirements aim to hold the Medicaid rate certification process to a level of standards and detail that is similar to what is required in commercial rate filings and Medicare Advantage bids.

In §438.4(a) of the final rule, actuarially sound rates are defined as rates that "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." This definition is largely consistent with the prior iteration of the managed care regulations published June 14, 2002.[2] However, the final rule takes a much deeper dive into the capitation rate development and certification process. Some of the primary outcomes of the regulation are increases in transparency and accountability in the capitation rates, and the codification of many aspects of the process that have historically been accepted as standard practice. Additionally, several new requirements may complicate or lengthen the rate development and certification process for both the states and the health plans willing to participate in a Medicaid managed care program. This paper provides a summary of the final rule's significant impacts on the development of actuarially sound capitation rates and required supporting documentation; it also discusses action items for states and their actuaries, along with some gray areas where the new rule may present challenges in the certification of the rates.

1 Federal Register (May 6, 2016). Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Retrieved September 6, 2016, from **http://federalregister.gov/a/2016-09581**.

2 Federal Register (June 14, 2002). Medicaid Program; Medicaid Managed Care: New Provisions. Retrieved September 6, 2016, from **https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms2104f.pdf**.

Significant impacts on rate development

Historically, states and their actuaries have developed Medicaid managed care capitation rates using generally accepted actuarial principles and industry guidelines outlined in resources such as Actuarial Standard of Practice (ASOP) 49, and subregulatory guidance such as the Medicaid Managed Care Rate Development Guide. Through the final rule, CMS has defined standards for certain aspects of capitation rate development, where flexibility had previously existed. The following section presents a summary of these key items.

REMOVAL OF RATE RANGES

A rate range typically represents a range of capitation rates that are certified by the actuary and allow for variations within the underlying components of the rate development. While rate ranges have been employed for a variety of reasons, the most common uses were to provide strategic flexibility to the state in varying rates for managed care organizations (MCOs) or to allow for minor adjustments to paid rates without the need to recertify the capitation rates. The ability to use rate ranges in the managed care capitation rate development provides a fair amount of latitude to states in procurement and annual bid scenarios, and enables the state to implement minor policy and program changes within the certified rate range.

Under the terms set forth in the final rule, states will no longer be allowed to utilize certified rate ranges, and instead each paid rate must be certified as actuarially sound, with sufficient detail documented in the rate certification to understand the specific data, assumptions, and methodologies behind the rate development.

To support the removal of rate ranges, CMS has indicated that the potential for significant and unknown variation in the rate ranges posed a challenge in assessing the actuarial soundness of the capitation rates. There were instances where rate certifications included a range of 6% to 10% from the low end to the high end (3% to 5% on both sides of the paid rate). CMS does not believe that rates at either end of such ranges could both reasonably be considered as actuarially sound; however, they defined a permissible range that would continue to provide flexibility to states, but within specific parameters. The final rule

permits a 1.5% movement in either direction from the actuarially certified rate, without notification to CMS, inherently creating an overall 3% rate range. In the Q&A section of the regulation, the selection of a 1.5% range was supported by a CMS statement that this percentage is generally not more than the risk margin that is included in a typical rate-setting process.[3] Note that this variance is permitted at the capitation rate cell level and should not be evaluated in composite (paid rates within individual rate cells may not vary by more than 1.5% from the rate certification).

MINIMUM MLR CONSIDERATION

Historically, managed care plans have not been subject to a national medical loss ratio (MLR) standard for their Medicaid line of business. Unlike commercial and Medicare plans, where a minimum MLR has been a federal requirement for several years, Medicaid MCOs were only required to adhere to loss ratio standards if they were imposed at the state level, subject to each state's discretion. The final rule has instituted a requirement that certified rates must target an MLR of at least 85%. This MLR standard can be used to measure the cost-effectiveness of the managed care delivery system, but also to provide an appropriate level of quality care to enrollees. Because CMS recognizes that Medicaid managed care programs and associated policy fall under the state's purview, states are permitted to target MLRs that are higher than 85%. The federal benchmark is considered by CMS in its review of actuarial soundness of capitation rates and the state actuary is required to explain why experience for the rate-setting year will be expected to achieve at least an 85% MLR.

Many states already have minimum MLR requirements in their managed care contracts, which require a refund of the premium that causes the MLR to fall below defined thresholds. If a state chooses to employ an MLR-based refund stipulation in the contract, that threshold must also be at least 85%. While such minimum MLR thresholds are encouraged, the final rule does not require states to adopt them. Further detail of MLR standards contained in the final rule can be found in another recently released Milliman issue brief titled "Medical loss ratio (MLR) in the 'Mega Reg.'"[4]

TREATMENT OF PASS-THROUGH PAYMENTS

Pass-through payments are amounts paid to Medicaid MCOs as supplemental payments or "add-ons" to the base capitation rate. There is no risk to the MCOs for these reimbursement mechanisms, and they are required to pass through the add-on payment to designated providers, according to specific agreements between the state and the providers receiving the supplemental payments. Prior to the Medicaid managed care final rule, the inclusion of pass-through payments in the capitation rate-setting process was not specifically regulated. Several state programs incorporated one or more of these reimbursement adjustments into the capitation rates paid to contracted Medicaid MCOs. Although this practice occurs in both the fee-for-service (FFS) and managed care environments, the ability to track the course of the pass-through payments from the state to the providers is less transparent on the managed care side. Additionally, CMS requires that states should not direct provider reimbursement under managed care except under very specific scenarios. The final rule mandates the elimination of pass-through payments in the capitation rates via a 10-year phase-out period on hospitals, a five-year phase-out period on physicians and nursing homes, and removal of other non-qualifying pass-through payments for contracts beginning on or after July 1, 2017.

Further discussion of pass-through payment guidance contained in the final rule can be found in another recently released Milliman issue brief titled "Overview of pass-through payment guidance in final Medicaid managed care regulations."[5]

DEFINED CAPITATION RATE-SETTING PROCESS

CMS-2390-F broadly outlines the steps that the actuary must take in developing capitation rates. While they do not have to be completed in any specific order, they are all required to be addressed and documented by the actuary if a certain step is not followed.

At a high level, the rate development steps are:

1. The state must provide the certifying actuary with validated encounter (or appropriate FFS) data and audited financial reports for at least the three most recent and complete data years. The actuary must select the most appropriate data (no older than three years) to use as the basis for rates and explain why it was chosen in the certification.
2. The actuary should develop and apply trend factors to the base data. The factors should be developed from actual experience of the Medicaid population or from experience of a similar population.
3. The actuary must develop a non-benefit component of the rate that accounts for reasonable expenses related to the MCO's administration, taxes, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs associated with providing the services covered in the program.
4. If needed, the actuary should make appropriate adjustments to the base data to account for programmatic changes, changes to the base data, non-benefit components, or any other adjustment necessary to develop actuarially sound capitation rates.

3 Please see https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered#h-58 for a discussion of comments submitted to CMS regarding §438.4 of the final rule.

4 Brostowitz, J. et al. (June 2016). Medical Loss Ratio (MLR) in the "Mega Reg." Milliman Research Report. Retrieved September 9, 2016, from http://www.milliman.com/uploadedFiles/insight/2016/medical-loss-ratio-in-mega-reg.pdf.

5 Mytelka, C.M. et al. (May 2016). Pass-through Payment Guidance in Final Medicaid Managed Care Regulations: Transitioning to Value-Based Payments, Delivery System Reform, and Required Reimbursement. Milliman White Paper. Retrieved September 9, 2016, from http://us.milliman.com/uploadedFiles/insight/2016/2232HDP_20160518.pdf.

5. The actuary should review the MCOs' past MLRs when developing the capitation rates and projecting an MLR for the contract year.
6. If risk adjustment is applied, the actuary should choose a risk adjustment methodology that is generally accepted and apply it in a budget-neutral fashion across all participating MCOs in the program.

Additional information related to the rate development process and associated capitation rate certification requirements can be found in the appendix.

Gray areas: Actuarial judgment

While the new requirements highlight the transparency required in the rate-setting process, there may be instances where a significant amount of subjective decision making is still required. In the following sections, we explore some scenarios in which the new requirements may pose challenges during the rate-setting process.

NEGOTIATED RATE SITUATIONS

Currently, some states base their year-to-year capitation rates according to where each health plan bid within a range when the managed care contract was initially awarded. For instance, if Plan A bid at the very low end of the range in the bid rates, Plan A would be contracted at the low end of the rate ranges developed in subsequent rate settings; if Plan B bid at the 75th percentile between the low and high end of the range, Plan B would be contracted at that same point in future rate ranges.

With the release of the new rule, states will need to consider how to approach developing and certifying plan-by-plan rates in a bid scenario. First, although exact rates must be certified under the new rule (rather than rate ranges), the state may need to initially develop a rate range for each rate-setting analysis so that plans can be contracted at different points within the range. Second, the new rule requires that if rates differ by plan, those rates must be developed independently and in accordance with the new development and certification requirements. As a result, the actuary will need to consider how to develop and justify different rates to different plans and how to provide detail of the build-up of these rates in order to demonstrate that the rates are actuarially sound.

More discussion regarding managed care contracting alternatives and strategies were discussed in a Milliman issue brief titled "Fixed offer or competitive bid? Choosing the right Medicaid managed care contracting methodology for your state's needs," which was released in 2015.[6]

6 Damler, R. et al. (March 2015). Fixed Offer or Competitive Bid? Choosing the Right Medicaid Managed Care Contracting Methodology for Your State's Needs. Milliman Medicaid Issues Briefing Paper. Retrieved September 9, 2016, from **http://www.milliman.com/uploadedFiles/insight/2015/fixed-offer-competitive-bid.pdf**.

PROJECTING MLR

As part of the final rule, the actuary will be required to review past MLR experience for the contracted plans and make an adjustment to future capitation rates if the plans are reporting aggregate MLRs below the 85% target. This may require the actuary to reevaluate underlying assumptions that have been used in past rate settings; if the assumptions used in past rates were intended to target an MLR of at least 85% but the experience turned out to be lower, the actuary must determine whether these assumptions should be adjusted in order to ensure that the target MLR is actually achieved.

BASE EXPERIENCE DATA

While managed care programs have been implemented in a number of states for many years, the structure of the program within each state is rarely constant for an extended period of time. For example, the recent transition of complex populations to managed long-term care populations has introduced a population that has traditionally been served on an FFS basis. As a result, capitation rate-setting may become more challenging, based on the final rule's requirement that the past three years of data need to be assessed when this time period could involve a transition from FFS to managed care. The actuary will ultimately need to decide which portion of the historical data to utilize in establishing capitation rates.

NO CROSS-SUBSIDIZATION

The final rule requires that payments for a particular rate cell must not cross-subsidize any other rate cell. Additional guidance from CMS may provide clarification on how this requirement applies to certain components of the rate development that might not be specific to a rate cell level. For example, if a reimbursement adjustment is developed in aggregate for all children rate cells, the actuary will need to consider if the magnitude of the adjustment is appropriate for the mix of services associated with the entire spectrum of ages, such as newborns versus adolescents.

PROSPECTIVE TREND RATES

The final rule requires that trend factors used in the rate setting be "developed primarily from actual experience of the Medicaid population or from a similar population." However, in many instances, the historical trend for services can fluctuate significantly and may not be a good indicator of future trend rates. In the commentary section of the new regulation, CMS did acknowledge that prospective trends can differ materially from past trends and that the trends used in the rate should be a projection of future costs, but maintained actual experience should be a primary and important consideration. While the new rule does not prohibit the certifying actuary from consulting other sources when developing the trend factors (such as national trend projections), that actuary will have to think about how to justify the trends used in situations that differ significantly from past experience.

Additionally, the new rule states that trend factors should reflect changes in the utilization and price of services. In the commentary section of the rule, CMS clarified that the actuary does not necessarily have to set separate trend factors for utilization and price trends, but both components need to be considered before arriving at the final factors used in the rates. Because the new documentation requirements direct that the trend development be described in enough detail so that the trends can be evaluated for reasonability, the actuary will need to consider how to demonstrate that both of these components were taken into account in the trend factor development.

Action items for states

Although the implementation timing of many of the new requirements for rate development and certification uses a phased-in approach that generally corresponds with future rate-setting analyses, there are several points of the regulation that the states and their actuaries should consider now to decide whether preemptive solutions need to be developed.

TIMING OF THE RATE DEVELOPMENT

The new rule states that in order to ensure approval of rates by the effective date of the contract period, the proposed final contract and rate certification must be submitted to CMS at least 90 days prior to the beginning of the contract period. For states that require approval from CMS before rates can be paid, an appropriate rate-setting timeline should be developed so that this target submission date can be met. It should also be noted that many of the new requirements in the rule could potentially require additional resources to complete the rate-setting process, which will need to be considered when planning the rate development timeline.

BASE DATA REQUIREMENTS

The state must provide the certifying actuary with validated encounter (or appropriate FFS) data and audited financial reports for at least the three most recent and complete data years. If this requirement cannot be met, a corrective action plan must be submitted to CMS and the state must come into compliance within two years. States should begin thinking now about whether this data is available for all of their managed care programs and, if not, how this data can be obtained in a timely manner. Further detail of encounter data standards contained in the final rule can be found in another recently released Milliman issue brief titled “Encounter data standards: Implications for state Medicaid agencies and managed care entities from the final Medicaid managed care rule.”[7]

MLR CONSIDERATIONS

As mentioned previously, states that impose a recoupable MLR requirement must set the threshold at 85% or higher according to the new rule. Additionally, the new rule provides guidance on how the MLR formula should be calculated, with what components should be included in the numerator and the denominator. States or their actuaries should review the MLR formula outlined in the rule and compare it with how the MLR is currently calculated in their managed care programs. Differences in the calculation could have an effect on how any current minimum MLR threshold imposed by the state translates to the implied threshold under the new MLR calculation.

PASS-THROUGH PAYMENTS

With the mandate in the new rule that pass-through payments will eventually no longer be allowed in managed care contracts, states should discuss internally and with various stakeholders how existing pass-through payments should be phased out. Although the rule provides a timeline for when certain pass-through payments must be phased out, the state may wish to switch to an alternative approach sooner and in a different manner.

DISSOLUTION OF RATE RANGES

For states that currently use rate ranges as an integral part of their rate development and contracting process (for example, if health plans initially made a bid at a point between a low and high rate range at the beginning of the contract and are paid accordingly in subsequent years), they should strategize how the new requirement of certifying a specific rate for each plan will be achieved in the current contract. One possible solution would be for the actuary to still develop a rate range behind the scenes, place each plan at a rate according to the initial bid, and then certify each rate separately. However, in doing so, the actuary will need to make sure that these certified rates are actuarially sound for each plan and that they meet the other development and documentation requirements of the new rule. Challenges may occur for the certifying actuary if an MCO makes a business decision to bid at the low end of a rate range, which may result in an expected negative underwriting gain for the contract year. Because state actuaries do not typically develop capitation rates that yield a negative margin, the certifying actuary may have to consider if higher efficiencies can be achieved by the MCO in other areas of the capitation rate to ensure that the actuarial soundness of the capitation rate bid by an MCO can be certified. Additional guidance from CMS may provide clarification on how these types of scenarios should be addressed.

7 Cunningham, J. et al. (May 2016). Encounter Data Standards: Implications for State Medicaid Agencies and Managed Care Entities From the Final Medicaid Managed Care Rule. Milliman White Paper. Retrieved September 9, 2016, from **http://us.milliman.com/uploadedFiles/insight/2016/2232HDP_20160518.pdf**.

Conclusions

The final rule has many implications that may affect the development of managed care rates as well as the certification and documentation of those rates. Both state Medicaid agencies and contracting MCOs will need to assess how the new requirements might affect their current certification processes and begin to identify necessary changes or new tasks to ensure compliance for future rate development within the required time frames.[8]

Appendix

RATE DEVELOPMENT AND CERTIFICATION STANDARDS

The new managed care rule details a series of steps that a state's actuary must follow when establishing Medicaid capitation rates. Additionally, it also provides guidance that states wishing to have rates approved prior to specific dates must submit proposed final contracts and rate certifications to CMS at least 90 days prior to effective dates of the contracts.

In §438.5 of the final regulation, the process and requirements for developing capitation rates are outlined, while §438.7 describes the necessary documentation that must be submitted to CMS for review and approval of the rate certification. Although many aspects of the rate-setting and certification requirements were already widely used in practice and included in subregulatory guidance, such as the Medicaid Managed Care Rate Development Guide, the new regulations codify the process and set minimum requirements.

Figure 1 on page 6 summarizes the requirements for rate development and certification by rate-setting component; however, the certifying actuary should still refer to these sections of the regulation itself for clarification on specific points.

8 Please see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/implementation-dates.pdf for the required implementation dates of the provisions in the final rule.

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FIGURE 1: SUMMARY OF RATE DEVELOPMENT AND CERTIFICATION REQUIREMENTS

BASE DATA	▪ State must provide certifying actuary with validated encounter (or appropriate FFS) data and audited financial reports for at least the three most recent and complete data years. ▪ Actuary must select the most appropriate data (no older than three years) to use as the basis for rates and explain why it was chosen in the certification. ▪ If the data described above is not available or usable for rate setting, the state may request an exception from CMS, but must submit a corrective action plan and come into compliance within two years.
TREND	▪ Trends should be developed primarily from actual experience of the Medicaid or similar population, although other sources may be considered. ▪ In the certification, the actuary should include each trend factor along with enough detail that the calculation and reasonableness of each factor can be evaluated as well as an explanation of why trends differ among rate cells, service categories, and eligibility categories.
NON-BENEFIT COSTS	▪ The non-benefit costs assumed in the rates must include reasonable, appropriate, and attainable expenses related to the following: – Administration – Taxes, licensing, and regulatory fees – Contribution to reserves – Risk margin – Cost of capital – Other operational costs associated with the provision of services identified in Section 438.3(c)(1)(ii) to the populations covered under the contract ▪ The certification must include enough detail so that the reasonableness of each expense can be determined.
OTHER DATA ADJUSTMENTS	▪ Any adjustments included in the rate setting should be developed in accordance with generally accepted actuarial principles and reasonably support one of the following: – Development of an accurate base data set – Impact of appropriate programmatic changes – Reflection of the health status of the enrolled population – Reflection of non-benefit costs ▪ The documentation of the rates should include enough detail for each adjustment so that CMS or a reviewing actuary can understand and evaluate the following: – The process of developing each material adjustment and the reasonableness of that adjustment for the covered population – The cost impact of each material adjustment and the aggregate impact of nonmaterial adjustments – Where in the rate process the adjustment was applied – A list of all nonmaterial adjustments
RISK ADJUSTMENT	▪ Risk adjustment mechanisms must be developed in a budget-neutral manner, using generally accepted actuarial principles and practices. ▪ The certification must describe the methodology in enough detail so that CMS or a reviewing actuary can understand and evaluate the following: – The party calculating the risk adjustment – The data used to calculate the risk adjustment and any adjustments to the data – The model used to calculate the adjustment and any adjustments to the model – The method for calculating the relative risk factors and the reasonableness and appropriateness of the method – For prospective risk adjustment, the magnitude of the adjustment on each capitation rate per plan – For prospective risk adjustment, an assessment of the predictive value of the methodology compared with prior rating periods – For retrospective risk adjustment, the timing and frequency of the application of the adjustment – Any concerns that the certifying actuary has with the risk adjustment process

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