Department of HUMAN SERVICES

Rate Setting 101

Capitation Rate Development Process

November 30, 2018

Overview

- CMS Regulation and Actuarial Requirements
- Data Sources
- Base Data Validation
- Components of Capitation Rate Development
- Monitoring Process (MLR)

CMS Regulation and Actuarial Requirements

- In applying the regulation standards, CMS uses these three principles:
  - The capitation rates are reasonable and comply with all applicable laws (statutes and regulations) for Medicaid managed care;
  - The rate development process complies with all applicable laws (statutes and regulations) for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity;
  - The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR part 438 and generally accepted actuarial principles and practices

CMS Regulation and Actuarial Requirements

- Actuarial Soundness
  - Section 1903(m) of the Social Security Act and 42 CFR §438.4 (Final Rule) require that Medicaid capitation rates be actuarially sound
  - Actuarially sound - means that the 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 managed care plan for the time period and the population covered under the terms of the contract.

CMS Regulation and Actuarial Requirements

- Actuarial Soundness
  - **Is not…..**
    - a budget driven process
    - a methodology that has a pre-determined outcome
    - a process that eliminates all rate variance between Managed Care Organizations (MCOs)
  - **Is …..**
    - a methodology performed by a qualified actuary that is consistent across all applicable guidance and regulations and independent of any budgetary constraints
    - a process designed to evaluate risk within a program and assist in better matching payment to risk
    - a process that minimizes unexplained variance between MCOs and quantifies the explained variance

CMS Regulation and Actuarial Requirements

Final Rule has various effective dates for specific requirements:

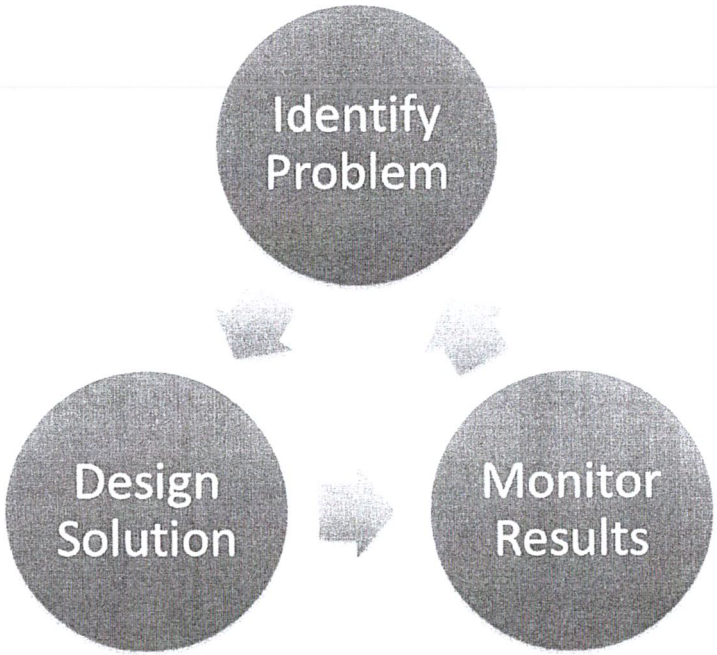
Already in effect	• MH parity | LTSS contract requirements | Actuarial soundness | IMD exclusion
July 1, 2017	• New OP Rx rules | Additional rate dev. requirements | Pass through payments | MLR standards | New state oversight regs.
July 1, 2018	• Certify by rate cell | +/- 1.5% rate adj. w/o re-certifying | Network adequacy standards | Provider screen / re-enroll
May 2019	• Quality ratings system (a la Medicare STARS program)
July 1, 2019	• CMS rate review for 85% MLR floor

CMS Regulation and Actuarial Requirements

- CMS Rate Review Process
  - Final Rule introduced a new level of review with respect to Medicaid capitation rate submission and approval
  - Rate review process is similar to CMS review of Medicare bid submissions
  - Actuary is required to provide substantiation for all actuarial assumptions used within the rate development methodology
  - This level of review has facilitated more transparency between Optumas/MCOs/State/CMS(OACT), resulting in a more rigorous/collaborative process

Components of Capitation Rate Development

Optumas/IME utilize the Actuarial Control Cycle to monitor and evaluate risk within the IA Health Link program



Data Sources

- Optumas uses multiple years of historical data to inform rate development:
  - Detailed Enrollment Data (multiple years) provided by IME
  - Detailed Encounter Data (multiple years) provided by IME
  - Supplemental Data Extracts (as needed) provided by IME and MCOs
  - Audited Financials and Financial Templates

Base Data Validation

- Optumas conducts rigorous validation to ensure that only appropriate reimbursement and utilization for covered services are included within the base data. Validation includes:
  - Durational Review over Time
    - ✓ Review Encounter Data – Dollars and units by month, to ensure consistency over time
    - ✓ Review enrollment by month, to ensure consistency over time
    - ✓ Discuss data validation with MCOs
  - Comparison of Encounter Data to Financials
    - ✓ Review for completeness of data and consistency between sources
    - ✓ Request supplemental data as necessary to understand alternative payment methodologies (APMs) for each MCO

Components of Capitation Rate Development

- Medicaid capitation rate development contains the following key components
  - Base Data Validation – Validation process is described in previous slide. Once validation is complete, Optumas recommends a base data time period to use as the starting point of the rate development
  - Impact of Policy Changes – Optumas works with IME to identify any policy changes surrounding the Health Link program. Optumas then conducts actuarial analyses to quantify the impact of the policy changes and includes the estimated impacts within the rate development

Components of Capitation Rate Development

- Components cont..
  - Development of Projection Factors Efficiency Adjustments – Optumas uses all available data to inform actuarial analyses needed to develop utilization trend, unit cost trend and IBNR. These adjustments are designed to project the base data into the contract period resulting in projected net medical cost
  - Development of Non-Medical Load (NML) – Optumas uses financial information from the MCOs to inform actuarial analyses designed to develop appropriate levels of NML to use within the rate development

Monitoring Process (MLR)

- Minimum Loss Ratio (MLR)
  - States must monitor MLR on a regular basis
  - Actuaries are expected to consider historical MLRs when developing capitation rates
  - *Numerator:* The numerator of an MCO's MLR for a MLR reporting year is the sum of the MCO's incurred claims, expenditures for activities that improve health care quality, and fraud reduction
  - *Denominator:* The denominator of an MCO's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the MCO's premium minus the MCO's Federal, State, and local taxes and licensing and regulatory fees
  - States <u>are not</u> required to implement rebates along with MLR

Monitoring Process (MLR)

- Misconceptions surrounding 88% MLR requirement
  - *Misconception:* States must align non-medical load assumptions with MLR requirement of 88%, implying a 12% NML.
  - *Intent:* Rates should be set such that there is not high probability of projection error resulting in MLRs that are unpredictable.
  - *MLR calculation is more complex than just taking traditional medical expenditures and dividing by revenue. Therefore, targeted NML does not directly correlate with the 88% MLR requirement*

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Questions?

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