Medicaid Health Plans: Ensuring Appropriate Rates in an Era of Rapid Expansion

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I. Introduction and Executive Summary

When Congress reformed several Medicaid payment rules under the Balanced Budget Act of 1997, it specifically included a provision requiring rates to Medicaid health plans be "made on an actuarially sound basis." This provision, included in Section 1903(m)(2)(A) of the Social Security Act,[1] was deemed essential to the ongoing viability of Medicaid managed care programs for the beneficiaries they serve. The importance of state compliance with this requirement continues to magnify. Use of the comprehensive capitated model in Medicaid through state partnerships with Medicaid health plans, also known as Medicaid managed care organizations (MCOs), is in the midst of a period of rapid growth. However, this growth poses significant rate-setting challenges as these expansions often involve new population groups for whom little, if any, relevant in-state cost experience exists. This is also a time period of considerable governmental fiscal constraints which is putting pressure on the viability of state rates for MCOs. Taken together, these dynamics place heightened emphasis on accurate, appropriate and sound MCO rate-setting activities.

During 2010, approximately $92 billion of Medicaid spending occurred via comprehensive MCO capitation payments, representing 27.3% of all Medicaid expenditures. The percentage of Medicaid spending paid via MCO capitation increased *every year* from 2000-2010.[2] While a more recent precise tabulation is not available, the role of MCO capitation contracting in Medicaid has clearly grown from 2010-2013 through large-scale expansions of programs in several states (including Florida, Illinois, Kansas, Kentucky, Louisiana, New York, and Texas). The large number of states currently ramping up their use of the capitated model for a comprehensive scope of benefits is evidence of a growing appreciation among state Medicaid policymakers that the capitated MCO model is delivering – and will continue to deliver -- better access, better quality (and quality measurement), and cost savings than can occur under traditional fee-for-service or alternative models of coordinated care. The following text, copied from the New York Department of Health's website, captures a sentiment that is now widely held in the Medicaid policymaking community.[3]

> The NYS Department of Health has established a goal of having virtually all Medicaid enrollees served in care management by April 2016. This initiative, deemed *Care Management for All,* began in SFY 11/12 as a Medicaid Redesign Team (MRT) proposal. It will improve benefit coordination, quality of care, and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability, and physical health care services. It will also redirect almost all Medicaid spending in the state from fee-for-service Medicaid (FFS), under which service providers bill directly to the state, to care management, under which a managed care organization, of one type or another, is paid a capitated rate by the state and is then responsible for managing patient care and reimbursing service providers.

[1] See also CMS regulations at 42 CFR §438.6.
[2] These statistics derived by Menges Group using the CMS MSIS data sets, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html
[3] The web reference is: http://www.health.ny.gov/health_care/medicaid/redesign/docs/care_manage_for_all.pdf

An additional large influx of new Medicaid MCO enrollees is virtually certain to occur during the upcoming two years due to the Medicaid coverage expansion provisions of the Affordable Care Act (ACA), through dual eligible capitation demonstrations currently being developed in over a dozen states, and under other state Medicaid initiatives.

Notwithstanding these growth dynamics, the sustainability of the win/win/win partnership the capitation model creates -- for the government (and US taxpayers), for Medicaid beneficiaries, and for the MCOs themselves -- is entirely dependent upon a sound rate-setting process. While federal requirements have been in place since 1997 requiring that Medicaid capitation rates be established in an actuarially sound manner, considerable state rate-setting challenges have existed for several years. This report describes many of these challenges. It is important that these longstanding rate-setting challenges be successfully addressed going forward. It is also at least equally important that emerging rate-setting challenges related to the new enrollee influx (e.g., dual eligible, LTSS and Medicaid expansion populations) be effectively met.

These challenges prompted AHIP to engage The Menges Group to prepare this report. This paper identifies key issues that should be considered in the development of actuarially sound rates and provides recommendations to improve enforcement of the standard. Adoption of the recommendations would ensure that:

- the actuarial basis for rate development is not undermined by adjustments to achieve fiscal targets that are not actuarially sound;
- rate setting processes are transparent and provide notice of rates to Medicaid health plans well in advance of the contract year;
- processes are established to ensure baseline data used for rate-setting fully reflect MCO costs;
- assumptions and factors used for rate adjustments, as well as bonus payment and withhold mechanisms, reflect reasonable expectations for Medicaid health plan performance;
- processes established for making mid-year rate updates reflect state Medicaid program changes that impact Medicaid health plan costs;
- implementation of medical loss ratio or similar statutory requirements is coordinated with assumptions and factors utilized in the rate setting process, and the ACA insurer fee is fully reflected in MCO rates;
- rate development challenges are addressed for populations newly covered by Medicaid health plans, such as expansion populations under the ACA, new subgroups of existing

Medicaid eligible individuals not previously enrolled in MCOs, and dually eligible beneficiaries; and

- federal enforcement of the actuarial soundness requirement is strengthened through improvements to the Centers for Medicare & Medicaid Services (CMS) Actuarial Soundness Checklist and more rigorous reviews of state rate-setting processes.

II. Rate-Setting Challenges That Can Compromise Actuarial Soundness

As described in the previous section, the nation is in the midst of unprecedented growth in the volume of persons enrolled in comprehensive, capitated Medicaid health plans. Numerous rate-setting challenges are involved in establishing appropriate capitation rates for the new enrollees and new benefits, including:

- existing Medicaid populations newly transitioning into Medicaid health plans from the traditional FFS setting, including the recent Medicaid MCO expansion initiatives in Florida, Illinois, Kansas, Kentucky, Louisiana, New York, and Texas;

- persons transitioning into Medicaid through the program expansion provisions of the Affordable Care Act (ACA);

- dual eligible capitation demonstration programs in up to 16 states; and

- additional services being added to the MCO benefits package, including the recent inclusion of prescription drugs in several states that had previously used a pharmacy "carve-out" model (e.g., Illinois, New York, Ohio, Texas, and West Virginia) and new MCO coverage of Long Term Services and Supports in states such as Delaware, Florida, Kansas, New Hampshire and New Jersey.

These issues are discussed at length later in this section. However, it is also important to acknowledge that many rate-setting challenges have persisted for several years involving mature Medicaid managed care programs and longstanding MCO-enrolled population subgroups. These ongoing challenges, which have occurred despite requirements enacted in the 1997 Balanced Budget Act that rates be established in an actuarially sound manner, are described immediately below.

A. Ongoing Rate-Setting Challenges to Actuarial Soundness

The following longstanding challenges, which are discussed in detail in this section, hinder development of actuarially sound rates and warrant changes in CMS oversight and requirements to ensure that states more effectively and consistently adhere to federal actuarial soundness requirements.

1. Assumptions used in rate derivation that are not actuarially based but "back in" to a predetermined fiscal target.

2. MCO capitation rate derivation processes that lack transparency and have an inadequate level of MCO involvement.
3. Savings factors and efficiency adjustments driven by insufficiently supported assumptions rather than sound evidence.
4. Rate-setting assumptions that assume combinations of cost savings that are not realistically achievable – such as lowering utilization in a certain service area and also assuming the average unit costs of the remaining services will remain steady or decrease.
5. Baseline data that may be incomplete, resulting in an under-counting of the true costs incurred during the base period.
6. Rates that are sometimes not determined and shared in a timely manner and payments that lag significantly behind service delivery.
7. State-enacted fee-for-service provider rate increases that increase MCO costs without corresponding mid-stream capitation rate adjustments.
8. State legislative action that may be inconsistent with actuarial soundness.
9. Inconsistent state adherence to actuarial soundness requirements.
10. Bonus payments and withholds that are not consistent with reasonable expectations for Medicaid health plan performance.

1. Assumptions used in rate derivation that are not actuarially based but "back in" to a predetermined fiscal target

Most states have been under severe fiscal duress throughout the past several years. While MCOs have been increasingly viewed as an important and valuable mechanism to create much-needed Medicaid savings while maintaining quality, states nonetheless are under considerable pressure to minimize all aspects of their Medicaid spending -- including their MCO capitation rates.

Instead of working with Medicaid health plans in a transparent manner through the rate development process to establish rates that are both actuarially sound and meet fiscal goals, states may pursue steps that are inconsistent with the federal actuarial soundness standard. Clearly, actuarially sound rate-setting does not occur when the rate-setting process and underlying assumptions are constructed to meet a pre-determined budget target. For example, in the past, states have applied budget factors to reduce the Medicaid health plan rates derived on an actuarial basis through the rate-setting process to meet these targets. Other states may include assumptions in the rate development process that do not have a sound, data-driven basis and reflect unreasonable expectations for MCO performance in order to reduce rates to fit within budget parameters. Such steps are in conflict with actuarial soundness which requires Medicaid health plan rates to be appropriate for the populations and scope of services covered under the state's contract with plans. Dialogue between states and Medicaid health plans is necessary to ensure the development of rates in an actuarially sound manner while also fitting within state budgetary goals.

Medicaid MCO concerns in this area are fueled by the fact that the actuaries deriving the capitation rates and attesting to the soundness of the derivation process are generally employed by consulting firms under contract with the state Medicaid agency. As such, these consulting firms' rate-related assumptions are developed under the terms established by their customer, the state Medicaid agency. While actuarial soundness provisions ostensibly protect against this concern, the severity of states' fiscal situation can trump the requirements and expectations that exist surrounding actuarial soundness. This concern existed *before* the most recent recession and related state fiscal crises had occurred, as documented in a 2006 Lewin Group report on actuarial soundness.[4] One of the key findings of this report was that "budget considerations play a role and sometimes override actuarial principles."

A 2006 AHIP report also directly discussed the issue of budget-based rate setting activities that do not appear consistent with actuarial soundness requirements.[5] This report included the following excerpt referencing work conducted by the American Academy of Actuaries:

> In August 2005, the American Academy of Actuaries issued a practice note to provide guidance to actuaries when certifying whether Medicaid health plan payment rates meet the federal standard. The practice note includes the following definition:
>
> Actuarial Soundness – Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and government stop-loss cash flows, government risk adjustment cash flows, and investment income, provide for all **reasonable, appropriate and attainable costs**, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital. (emphasis added)
>
> The Academy goes on to state that "(b)udgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving final premium rates." Therefore, under the guidance issued by the Academy, rate reductions applied at the end of the rate-setting process purely for budgetary reasons would be inconsistent with the actuarial soundness requirement.

These longstanding concerns have been exacerbated by the lingering effects of the recent recession. According to a 2013 report prepared by the National Governors Association and the National Association of State Budget Officers, the combined state fiscal year spending for the 50 states "is still below the fiscal 2008 pre-recession peak after accounting for inflation" indicating that "state budgets are not growing quickly enough to make up for recession induced declines

[4] "Rate Setting and Actuarial Soundness in Medicaid Managed Care," Prepared for the Association for Community Affiliated Plans &Medicaid Health Plans of America by The Lewin Group, January 2006.

[5] "The Importance of Ensuring State Compliance with the Actuarial Soundness Standard and the Importance of Enforcing the Standard" AHIP, May 2006.

and inflation."[6] With Medicaid representing the single largest portion of total state spending at almost 25 percent, many states will continue to target the program for budget savings during this difficult state fiscal environment.

2. MCO capitation rate derivation processes that lack transparency and have an inadequate level of MCO involvement

The preceding point highlights the importance of a transparent rate-setting process to ensure mutual goals are met. The MCOs often have valuable insights and input to offer to the rate-setting process. While states may perceive that participating health plans will be likely to offer arguments that will push their capitation rates northward, the health plans are the most "inside the tent" organizations in a state's Medicaid managed care program. The MCOs can thus offer uniquely knowledgeable perspectives.

The previously cited 2006 Lewin Group report also found the following:

> "Thirty-nine percent of the plans (representing 5 of the responding states) say that the state generally is not responsive to their concerns about the rate-setting process, and that the final rates often do not reflect all the factors that could have a material impact on the plans' cost of providing benefits. Plans in 4 of the Responding states (21 percent) have, at best, only limited opportunities to participate in the rate-setting process. Furthermore, plans in one-half of the states indicated that payment rates are either explicitly budget-driven or are indirectly affected by budget constraints through the trend assumption or the choice of a specific rate within an actuarially sound range."

A related issue is that when data books are provided to MCOs in competitive procurement situations, they are often shared too late in the process for the MCOs to provide constructive input. The data may be incomplete and limited in content without including all relevant Medicaid costs or accurate assessments of likely MCO enrollment under the state contract.

3. Savings factors and efficiency adjustments driven by insufficiently supported assumptions rather than sound evidence

Rate-setting assumptions in recent years have tended to make increased use of "managed care savings" or "efficiency adjustments." In many cases, the rigor behind these assumptions and factors either has not existed or has not been shared with or demonstrated to the MCOs. Actuarially sound managed care savings factors and efficiency adjustments should have an accompanying analysis showing where inappropriate care can be avoided or other efficiencies

[6] "The Fiscal Survey of States: An Update of State Fiscal Conditions," National Governor's Association and the National Association of State Budget Officers, Spring 2013. This report can be downloaded at http://www.nasbo.org/sites/default/files/Spring%202013%20Fiscal%20Survey%20of%20States.pdf

can be introduced (e.g., alternative sites of care) to provide the opportunity for the health plan(s) to achieve the savings.

Percentage savings factors also need to accurately take into account the baseline environment against which the savings are expected to occur including MCO activities to preserve ongoing patient-provider relationships during beneficiary transitions to managed care that may affect achievable short-term savings. Very different savings opportunities exist against an unmanaged FFS baseline versus a mature MCO baseline, for example. Also, accurate efficiency adjustments for an MCO should consider operational dynamics such as the contracting outcomes that can be realistically achieved with providers in a given community. Further, states may include in the rate-setting process unrealistically low administrative cost allowances that do not reflect plan experiences and may be inconsistent with the actuarial soundness requirement.

4. Rate-setting assumptions that assume combinations of cost savings that are not realistically achievable

A 2010 Society of Actuaries presentation by three individuals closely involved in Medicaid capitation rate-setting across several states identified numerous challenges to actuarial soundness.[7] Among the issues and concerns articulated were that inter-relationships exist that make it inappropriate to simultaneously deploy low-cost assumptions in certain areas.

One issue cited is that achieving optimal net medical costs requires an extensive array of administrative investments in medical management, care coordination, outreach, information technology, etc. Therefore, low medical costs and low administrative costs are not likely to be simultaneously achievable.

Another concern cited in this presentation was that aggressive utilization reductions and low average unit prices cannot be jointly achieved in situations where the lower-intensity services are most likely to be eliminated. One example of this dynamic involves average per diem cost of maternity and surgical admissions. The length of these inpatient stays can often be reduced through effective care coordination, but the hospital's costs for the major procedure day (preparation, anesthesia, surgery/delivery room time, recovery room, etc.) remain intact and drive up the average cost per day for these admissions when the lower-cost post-operation and post-delivery days are reduced.

The aggressively low assumption combinations that have sometimes been used are likely driven by the first issue cited earlier – that budget targets are driving the rate-setting process. Addressing this issue, one of the key slides in the previously referenced 2010 Society of Actuaries presentation was limited to two concise statements:

[7] The presentation can be downloaded at: www.soa.org/Workarea/DownloadAsset.aspx?id=5750

- Budgetary concerns should not influence assumptions – PERIOD.
- Actuaries should not work toward a target.

Another key issue arises when providers demand excessive payments for out-of-network services. When a Medicaid health plan enrollee needs services from an out-of-network provider Medicaid health plans are often faced with bills for full charges that far exceed amounts that would be paid for the same services under FFS Medicaid. Such situations undermine the efforts of Medicaid health plans to provide high quality health care for beneficiaries, while at the same time contributing to state budgetary goals.

5. Baseline data may be incomplete, resulting in an under-counting of the true costs incurred during the base period

The baseline data captured from MCO encounter data that is used to establish rates is more likely to underestimate costs than to over-estimate them. One reason is that some of the encounter data submitted by MCOs are rejected or disregarded due to the state's data screening process – even though these were valid claims paid by the MCO. This may occur because, for example, the information submitted by the provider is incomplete according to the state's rules for acceptable claims even though the provider's claims include all elements necessary for plan payment. States may reject encounter data if a plan's network provider does not participate in the FFS program even though the provider is appropriately included in the plan's network. Rejections may also occur if the state and health plan claims edits are not aligned. Another circumstance faced by MCOs is that network providers who themselves are paid on a capitation basis may not have submitted complete encounter data to the MCO because their payments are not affected by incomplete reporting of each service provided. Also, MCO encounter data would not include services for which the health plan incurs costs that are not reported on claims (e.g., case management provided by a salaried health plan employee). All of these issues contribute to undercounting of legitimate MCO costs that serve as the basis for rate-setting assumptions.

6. Rates that are sometimes not determined and shared in a timely manner and payments that lag significantly behind the service delivery

Multiple challenges have arisen with payment timing. In some situations, the capitation rates for a given contract period have not been disclosed/established until the rate period is already several months underway. At that point, if it is apparent to an MCO that its rates are not adequate, the health plan has already absorbed several months of losses with no opportunity to take steps to mitigate them. Another payment timing issue involves states delaying their capitation payments to the health plans further and further to create a one-time cash flow savings. In some instances, states are repeating this approach such that MCOs are now being paid months later than the

month to which the capitation rate applies. One state proposed a three month lag in payments, for example, with no offer to increase the capitation rate to address the cash flow and interest burden that has been shifted to the MCO.

7. State-enacted fee-for-service provider rate increases that increase MCO costs without corresponding mid-stream capitation rate adjustments

A rate-setting timing issue related to the issue above is that many MCOs' rates are tied to Medicaid fee-for-service (FFS) pricing levels, and states often increase their FFS payment rates midstream in an MCO rate period without making an appropriate adjustment in the MCOs' capitation rates. For example, a state may implement a mid-year increase in Medicaid hospital payments which was not anticipated in the MCOs' capitation rate derivation, and which translates into increased costs for MCOs when their negotiated hospital payment rates are tied to Medicaid FFS pricing. In some cases, these provider rate increases are made effective retrospectively, exacerbating the MCOs' unanticipated costs.

8. State legislative action that may be inconsistent with actuarial soundness

In some cases state legislatures are seeking to mandate maximum amounts that Medicaid MCOs can expend on administrative costs and/or operating margins. Once enacted, the administrative limits may not be updated to reflect changes in costs or the populations covered in Medicaid health plans. State legislatures may also enact medical loss ratio (MLR) requirements that do not reflect the care and service delivery costs and administrative costs associated with meeting the unique needs of Medicaid beneficiaries and are not reasonably attainable by Medicaid health plans. Further, in some cases Medicaid health plan rates have been specified in statute. Such requirements do not necessarily have any bearing on what qualified actuaries will deem to be actuarially sound – and can easily directly conflict with the allocations, assumptions, and data that need to be incorporated in an actuarially sound rate development effort.

9. Inconsistent state adherence to actuarial soundness requirements

As identified in a 2010 General Accounting Office Report titled "Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement," the required actuarial soundness review process has sometimes not been followed by states or actively enforced by CMS.[8] To better guard against this concern, GAO provided a series of recommendations as shown below.

[8] This report is available at: http://www.gao.gov/products/GAO-10-810

To improve oversight of states' Medicaid managed care rate setting, and to improve consistency in the oversight of states' compliance with the Medicaid managed care actuarial soundness requirements, the Administrator of CMS should:

implement a mechanism for tracking state compliance, including tracking the effective dates of approved rates;

clarify guidance for CMS officials on conducting rate-setting reviews; and

make use of information on data quality in overseeing states' rate setting.

These recommendations reflect longstanding concerns by Medicaid health plans that CMS is not rigorously reviewing state rate-setting processes for compliance with the actuarial soundness requirement. As noted above, CMS appears to rely upon certifications by actuaries employed by states and it lacks the staff resources to perform its own detailed review to determine if the assumptions and projections behind the rates are reasonable. Moreover, the agency's review process does not provide an opportunity for Medicaid health plans to raise concerns that could identify issues that would enhance the agency's review of actuarial certifications.

10. Bonus payments and withholds that are not consistent with reasonable expectations for Medicaid health plan performance

Within incentive arrangements (e.g., pay for performance mechanisms), performance thresholds for some measures are responsible for disproportionate overall revenue impacts of several percentage points. While performance-based payments and withholds have a valuable role in motivating and rewarding desired care coordination and other performance goals, this is also an area where the rewards and penalties can produce excessive consequences that are not linked to meaningful statistical measures of performance. For example, one state recently established withholds of 3% in Year 1 and 5% in Year 2 for metrics that were not completely defined in the request for proposals (RFP). Arrangements like these severely compromise the actuarial soundness of the rate-setting process.

B. Rate-setting challenges for new enrollee populations

Several additional rate-setting issues described below are specific to the populations newly joining Medicaid MCOs.

1. Newly covered subgroups

Beginning in January of 2014, several million individuals will be newly eligible for the Medicaid program in a number of states, and many are likely to enroll in Medicaid MCOs through the ACA's Medicaid expansion provisions. Across the numerous challenges facing actuaries

involved in MCO capitation rate-setting, probably none is greater than accurately predicting medical costs for this large population – predominantly comprised of non-disabled adults -- that is about to obtain Medicaid coverage. The specific challenges associated with this subgroup include:

- Obtaining credible baseline data for a similar demographic group. It will be difficult to obtain valid data for a population parallel to the expansion population because most of these individuals are currently uninsured[9] and those with coverage are spread across many different commercial health plans where no systematic data capturing mechanism exists. In many situations, the baseline population data needed for rate-setting purposes will reside in other states (e.g., those with waivers that expanded coverage to additional eligibility categories, such as childless adults). Notwithstanding the difficulties of making appropriate geographic adjustments when the target population resides in a different area than the source of available baseline information, the external data will require extensive adjusting to match up with the specific provider pricing and Medicaid benefits structure of the target state.

- Predicting pent-up demand. Baseline data are typically available only for persons with health care coverage. However, it is also important for the expansion population rate-setting effort to acknowledge that much of – and probably most of – the Medicaid expansion population will be *newly* covered. In this situation, the potential is great for relatively high initial year costs to occur due to the "pent up demand" dynamic. A 2009 Briefing Paper prepared by Milliman identified that in one state, costs for previously uninsured persons moving into coverage were well above average across the initial four months of enrollment.[10]

2. Previously covered Medicaid subgroups newly enrolling in MCOs

As noted earlier, state reliance on Medicaid health plans is likely to continue to increase in the next several years. Much of this enrollment growth is expected to occur from existing Medicaid populations that are being transitioned into the capitated MCO model. These include state-specific expansions of Medicaid MCO initiatives, and the dual eligible demonstration initiatives.

[9] Based on a November 2012 Urban Institute Study, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," 10.2 million of the 15.6 million persons who will newly become eligible for and enrolled in Medicaid are currently uninsured. This study is available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf

[10] Experience Under the Health Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured." This report can be obtained at: http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf

For these subgroups, baseline data usually exists although it is typically from the fee-for-service coverage environment.

A key actuarial challenge, therefore, is developing achievable assumptions on which to base MCO rates without experience with health plan coverage of these populations. As described in Issue #A.2. above, it is crucial that states share their assumptions with Medicaid health plans, and that these assumptions are grounded in reasonable and defensible estimates of anticipated costs and enrollment. Also, as described in Issue #A.3. previously, it is important that the care coordination savings factors be grounded to the greatest possible extent in documented experience with similar subgroups (when those groups have transitioned into MCOs). Once programs are underway, states should assess on a timely basis whether their assumptions are consistent with program experience and work quickly to adjust rates where appropriate.

One issue that warrants consideration is that much of the MCO growth involves high-need subgroups who have been in established treatment plans and have ongoing relationships with their providers. MCOs are typically striving to preserve, not disrupt, existing courses of treatment and effective patient-provider relationships – and state Medicaid agencies increasingly require continuity of services. These dynamics limit the level of cost savings that MCOs are able to achieve during the first year of serving these subgroups.

Another first-year issue with newly enrolled, high-need subgroups involves the considerable administrative activities that are required to occur during the initial months of enrollment. These include new enrollee orientation activities, health risk assessments, data analyses on pre-enrollment claims history, development of an initial individualized plan of care document (sometimes working in concert with an interdisciplinary care team formulated specifically for a given enrollee), and other activities. These intensive required administrative activities create, with certainty, heightened administrative costs during the first months of enrollment that will, on average, subside considerably thereafter. A strong argument can be made that administrative payment allocations should be increased substantially for certain enrollee subgroups during the first few months of enrollment.

3. Savings targets for dual eligibles under Medicare-Medicaid demonstrations

The Capitated Financial Alignment Demonstration raises issues similar to those discussed above for other initiatives in which new populations are transitioning into the capitated model. Just as adherence to actuarial soundness principles for rate-setting is critical to the sustainability and stability of Medicaid program participation by MCOs, it is also critical to the viability of Medicare-Medicaid Plan (MMP) participation under the Demonstration. The government savings targets included in the Demonstration for the states that will be implementing these projects (e.g., targets of 1% in Year 1, 2% in Year 2, and 4% in Year 3) raise concerns about

how actuarial soundness of Medicaid rate-setting will be evaluated in the context of the Medicaid and Medicare payment streams that comprise total payments. As with other program start-ups, concerns about the soundness of rates are magnified by uncertainties such as the reliability of cost estimates when data from previous experience with the covered populations is not available. In addition to ensuring that rate-setting follows sound actuarial principles, mitigation steps such as risk corridors may be necessary to establish a stable foundation for health plan participation.

4. Rate-setting for persons utilizing long-term services and supports

States are increasingly looking to MCOs to serve individuals with disabilities and provide medical coverage, as well as coverage of long term services and supports with an emphasis on opportunities for independent living in the community. In some states, these programs are being implemented under state Medicaid programs, while other states are initiating them through Medicaid-Medicaid Plans (MMPs) under CMS' Capitated Financial Alignment Demonstration Program. Moving expenditures for long term services and supports, as well as nursing home services, to capitation raises rate-setting challenges similar to those for other Medicaid managed care expansions to new populations. As states pursue savings goals, it is critical for rates to be sufficient for MCOs to cover the array of costs for medical services, long term services and supports, care coordination, and related administrative costs under these programs. Providing sufficient funding for MCOs to make available the supports necessary to successfully transition individuals into the community is critical. However, in some states funding is inappropriately reduced below the level that would be available under the "Money Follows the Person" program. MCOs also have expressed concerns that the existing risk adjustment models are not geared towards the provision of long term services and supports. It is also important that credible estimates be made as to how much "rebalancing" between nursing homes and community-based care can occur in a situation where the upcoming year's nursing home spending is largely tied to people who have already spent down and reside in institutions. Another factor that diminishes the percentage nursing home savings achievable is that a large portion of the new nursing home residents a Medicaid program covers in a given year have resided in institutions and spent down prior to obtaining Medicaid coverage. In these situations, there is no opportunity for a Medicaid MCO to prevent the institutionalization.

C. Additional Rate-Setting Challenge

ACA Insurer Fee

The implementation of the ACA imposes a new fee on most health insurers (aka, insurer tax) that will be collected starting in 2014. The amount of the fee to be paid by each insurer will be based on the proportion of its premiums in the prior year to total premiums for all covered entities in that year multiplied by the aggregate amount of the tax that must be collected as specified in the

statute. The Congressional Budget Office and the Joint Committee on Taxation have described the fee as an excise tax, which can be passed on to consumers. However, MCOs collect their premiums primarily through payments from states, which determine how they will incorporate such fees into their state Medicaid rate-setting processes.

Under state rate-setting methodologies, fees such as this are typically reflected in Medicaid MCO rates. However, since the fee is assessed in the fall and is dependent on the determination described above based on prior year premiums, during the rate-setting process only estimates of the fees will be available. Further, the fee cannot be deducted from an entity's income tax which increases the liability associated with the fee. States are considering how to address the fee in MCO rate-setting, and it will be important for the full liability associated with the fee to flow through in a timely and predictable way. This is an area where additional CMS guidance may be warranted to ensure the lost tax deductibility, as well as the fee, is reflected in actuarially sound rates.

III. Recommended Action Steps

To ensure that actuarial soundness principles are more fully and consistently honored in the state rate-setting process, six action steps are recommended to address the challenges described in the previous section of the report.

1. **Requiring All Components Used in Medicaid MCO Rate Derivation to be Actuarially Sound and Prohibiting Assumptions that "Back In" to a Predetermined Fiscal Target**

CMS should explicitly confirm that all aspects of state Medicaid MCO rate-setting processes must be actuarially sound, and incorporating factors driven by state budget targets rather than actuarial practice is prohibited. The agency should also adopt in its Actuarial Soundness Checklist (see below) a definition of actuarial soundness consistent with the American Academy of Actuaries' recommendation[11] to promote the development of Medicaid MCO rates that reflect sound actuarial principles.

2. **Implementing Transparent and Timely State Medicaid MCO Rate-Setting Processes and Improving CMS Oversight of Actuarial Soundness**

CMS should issue guidance that directs states to be transparent during the rate-setting process. This guidance should require states to disclose to MCOs sufficient information including data underlying state assumptions to permit plans to replicate the state rate-setting methodology and respond in a timely manner to MCO questions about this information during the rate-setting process. States should be required to give MCOs notice of rates well in advance of the payment year and the deadline for signing contracts or contract renewal. CMS should also establish processes to allow Medicaid MCOs to submit to CMS Regional Offices issues that call into question the actuarial soundness of state rate-setting methods. The guidance should clarify that the Regional Offices are responsible for pursuing and responding to actuarial soundness issues raised by MCOs in a timely manner (e.g., 10 days or more quickly depending upon the status of rates/contracts).

[11] "Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs", American Academy of Actuaries, August 2005.

3. Revising the CMS Actuarial Soundness Checklist

CMS has issued an Actuarial Soundness Checklist for use by CMS Regional Offices for evaluating the overall process used to develop Medicaid MCO capitation rates. Revisions should be made to address the issues raised in this paper, including:[12]

- Managed Care Efficiency Adjustments: The checklist should require that assumptions for managed care efficiencies and trends in their totality must be reasonably achievable based upon documented past experience of the Medicaid health plans that participate in the state's Medicaid managed care program. The checklist should require states to make available to Medicaid health plans during the rate development process the assumptions underlying efficiency adjustments that are included in the rate.

- Trend Factors: States should be required to demonstrate that projected medical cost and utilization trend inflation factors reflect local experience specific to the Medicaid populations enrolled in Medicaid health plans in the state. They should also be required to demonstrate that trend factors are calculated net of any managed care or efficiency adjustments which may artificially reduce the trend likely to be experienced by Medicaid health plans. Additionally, trend factors should reflect the impact of increased intensity on average cost.

- Mid-year Program Changes: CMS should require states that make midyear changes during the course of the contract year (e.g., increases in physician or hospital rates) to notify CMS of these changes and either certify that cost trend assumptions remain valid or provide an updated actuarial certification.

- Data Use and Validation: CMS should require that, wherever possible, states should use Medicaid health plan data instead of FFS data as the basis for assessing the actuarial soundness of MCO rates. States should establish a process for review of Medicaid health plan encounter data completeness that includes Medicaid health plan review of reports on data accepted and stored by the state. Appropriate adjustments should be made for incomplete data. Where sufficient Medicaid health plan data is not available as a basis for rates, risk mitigation mechanisms should be considered (see item 5 below).

- Changes to Federal and State Laws: The checklist should require that federal and state requirements that have the potential to conflict with the allocations and assumptions used in state rate-setting (e.g., MLRs) must be identified and accounted for in the development of actuarially sound rates. Revisions should include modifying the checklist to direct

[12] The following recommendations are based upon recommendations made by AHIP to CMS to improve the Checklist.

states to incorporate the full liability -- including the value of lost tax deductibility -- of the ACA health insurer fee in Medicaid health plan rates.

- Bonus and Withholds: The checklist should require bonus and withhold arrangements to be consistent with actuarially sound rates. The criteria for meeting applicable thresholds should be well defined in the MCO's contract with the state. States should not be permitted to utilize thresholds for withholds that are not aligned with reasonable expectations for plan performance but rather are designed to meet budget targets.

4. Strengthening CMS Enforcement of the Actuarial Soundness Standard

CMS should strengthen enforcement of the actuarial soundness standard. Specific recommendations include:

- CMS should conduct detailed reviews of state rate-setting methodologies, including thorough analyses of the soundness of and process for updating assumptions, the basis for actuarial certifications, and the reasonableness of each component of the methodology including administrative costs.
- CMS should require corrective action in the case of non-compliance.
- CMS should clarify that signed contracts and actuarial certifications alone are not sufficient indicators of state compliance with actuarial soundness requirements and are not a sufficient basis for CMS approval of MCO rates.

5. Using Risk Corridors to Reduce the Risk of Poor Rate Outcomes for Newly Enrolled Subgroups

Initial implementation of Medicaid health plan coverage of Medicaid expansion populations raises significant challenges due to the lack of baseline data on the specific target population that will be enrolling. Strong potential exists for the initial rates to misfire in predicting an MCO's expansion population costs during 2014 and 2015. With the Federal government funding 100% of the expansion population's costs during these years, the principal financial risk as a result of these difficulties with initial capitation rate-setting efforts, which may be substantial, will be borne by Medicaid health plans and the federal government rather than the states. In the absence of back-end settlements to actual cost experience in the early years of operations, potential savings to the state and Federal government could be jeopardized. Conversely, if the initial rates are set too low, the program may not be viable for MCOs, jeopardizing the successful public-private partnerships that have served beneficiaries and states well. Risk corridors around the capitation rates, and other mechanisms that adjust MCO rates to (or at least towards) actual costs

creates a truly aligned financial partnership. Similar risk exists under the dual eligible Capitation Financial Alignment Demonstration.

For both the Medicaid expansion and dual eligible demonstrations populations, we therefore recommend that states and their consulting actuaries utilize risk corridors so that these programs' financial outcomes ultimately ensure a strong match between each MCO's actual medical costs and the costs predicted to occur in the rate-setting effort.

6. Establishing Out-of-Network Provider Payment Maximums

State governments clearly need to manage the Medicaid program's outlays within the context of their fiscal climate and associated budgetary constraints. Numerous studies have demonstrated that Medicaid health plans have achieved improvements in quality and access for Medicaid beneficiaries while achieving cost-savings for states.[13] As noted earlier in this paper, Medicaid health plan activities and state savings goals are undermined when providers demand excessively high payments for out-of-network services. To address this concern, a federal requirement should be established to provide that out-of-network providers must accept Medicaid rates as payment in full.

[13] The Lewin Group. *Medicaid Managed Care Cost Savings: A Synthesis of 24 Studies*. (March 2009)

IV. Conclusion

This paper has identified concerns with actuarial soundness adherence in Medicaid MCO capitation rate-setting, as well as emerging concerns specific to the new populations that are enrolling in MCOs. As the paper recommends, it is important to implement policy and program changes at both the federal and state levels to address these concerns and support successful implementation of state and federal strategies that reflect a growing reliance on Medicaid MCOs to achieve quality improvements and better cost-effectiveness in Medicaid programs.