Capitated Rate Development Division

Presenters:

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Purpose of Presentation:

- To provide an overview to DMHC concerning the Federal and State requirements for rate setting for Medi-Cal Managed Care Organizations.
- To provide details concerning the actual rate setting process for Medi-Cal Managed Care Plans.

CMS Contract Approval Details For Medicaid Contracting Entities-***Overview***

Code of Federal Regulation (CFR) Title 42, Chapter IV, Subchapter C, Part 438, Subpart A, Section 438.6 -Contract Requirements

CMS Contract Approval Details For Medicaid Contracting Entities-***Overview***

- CMS must approve PIHP, PAHP and MCO contracts.
- Entities eligible for risk contracts: MCOs, Community Health Centers, certain HIOs.
- Risk (Capitation) contracts must have actuarially sound rates.
- The State must maintain documentation of ratemaking process and certain policy details.

Comprehensive Risk Contracts Require CMS Review

- A capitated rate is a fixed payment made per member in advance to cover all claims costs in a future period.
- Contracts with capitated rates must be reviewed by CMS.
- Capitated rate contracts are typically used by MCOs, Pre-Paid Plans and certain types of Community Health Centers and Health Insurance Organizations.
- Capitated rate contracts put the contracted entity at risk and encourage providers to manage the cost of care.
- Substantial actuarial analysis and judgment is needed to develop capitated rates.
- Inadequate analysis and/or poor actuarial judgment may lead to substantial financial loss.

Actuarial Development Of Capitated Rates

- CMS requires that capitated rates are “Actuarially Sound”.
- Capitation rates that are actuarially sound means that:

1) Rates have been developed in accordance with generally accepted actuarial principles.
2) Rates are appropriate for the covered population and the services covered under the contract.
3) Rates are certified by an actuary who has met the qualification standards established by the American Academy of Actuaries and follows the standards prescribed by the Actuarial Standards Board.
4) To become a certified actuary applicants must pass a series of examinations, have at least 3 years of responsible actuarial work experience and stay up to date on continuing education requirements.

Additional Considerations For Actuarial Soundness

- Data that is specific to the Medicaid population must be used to develop the rates, or other types of data may be used and then adjusted to fit the Medicaid population.
- Data that is used in ratemaking should be smoothed to eliminate the effect of one-time events (such as outliers).
- Other adjustments are also made for changes in utilization, medical cost inflation, contract changes or other items that are expected to change in the rating period.
- In addition some contracts undergo a risk adjustment process to improve the projection results. At DHCS a risk scoring model developed by UC San Diego is used for this approach. This Risk scoring model is called Medicaid-Rx and it utilizes demographics (age/sex) and NDC codes to determine risk.

Additional Considerations For Actuarial Soundness-Continued

- Once adjustments to the data have been completed rate cells are created for the population.
- The rate cells are divided according to:

1) Eligibility category
2) Age
3) Gender
4) Locality region
5) Risk adjustments used (if any)

- Dividing the population into risk categories helps to better quantify the risk and uncover any problems.
- Other payment methods that are used for chronic or high-cost members should also be isolated and examined.

Documentation Needed For Ratemaking Process

- The state must keep documentation on file about the ratemaking process in order to verify the actuarial soundness of the rates and the methodology and data used in the process.
- An actuarial certification of capitated rates must be kept on file with the state.
- The state must also give an assurance that the rates are only based on

1) Services covered under the state plan.
2) Services provided under the contract to Medicaid individuals.
3) The state's projection of expenditures under the previous year's contract compared to the proposed contract.
4) Any adjustment for risk-sharing arrangements (stop-loss, reinsurance or other arrangements).

Contracts With Special Risk Provisions

- Provisions for reinsurance, stop-loss or any other risk sharing methodologies must be computed on an actuarially sound basis.
- Contracts with incentive arrangements may not pay more than 105 percent of the approved capitation rate for the covered population.
- For all incentive arrangements the contract must state that the arrangement is for.

1) A fixed period of time.
2) Not to be renewed automatically.
3) Available to both public and private contractors.
4) Not conditioned on intergovernmental transfers.
5) Necessary for the specified activities and targets.

Documentation Needed For Ratemaking Process

- Documentation must be kept on file with the state that demonstrates the actuarial soundness of capitated rates, risk sharing provisions and incentive arrangements made with providers.
- The state may be audited to determine the actuarial basis of rates.
- Lawsuits against the state often require documentation surrounding the actuarial basis of rates and the methodology used.
- Ultimate goal of ratemaking process is to match the risk assumed by the health plan with an appropriate payment to compensate for the risk.
- For a more comprehensive summary of the federal laws regarding Medicaid rates, read the following link: http://www.law.cornell.edu/cfr/text/42/438/6

Medi-Cal Rate Setting Process

- Rate setting process must follow Ca. Welfare and Institutions Code Section 14301.1
- Code specifies that Medi-Cal must pay capitated rates to health plans participating in managed care.
- Capitated rates must be developed using actuarial methods. Medi-Cal must utilize a county and model specific rate methodology to develop the rates.
- The rate development process uses plan specific data that is submitted by the health plans to Medi-Cal.
- If plan specific data is not available other substitutes can be used (similar health plans, county specific fee for service data, etc).

Features of Data Used in Rate Development

- List of possible data elements used in rate setting:

1) Health plan specific encounter and claims data
2) Supplemental utilization and cost data submitted by the plan.
3) Fee for service data submitted by the underlying county.
4) DMHC financial statement data specific to Medi-Cal operations. DHCS has an inter-agency agreement with DMHC to perform MLR audits. MLR data is also used in conjunction with financial statements for rate setting.
5) Other demographic data or data than can be used in risk adjustment.

- Rates that are developed by must include loads for admin. Expenses (4-5% plan specific for COHS, 7.7% for GMC and 2-Plan), contingencies, risk, plan changes and detailed review of health plan financial statements to reconcile and validate costs.
- Rates must also contain actuarially supportable trends.

Medi-Cal Rate Setting Process

- Once data elements are obtained from the plans or other sources they are loaded into a rate template and evaluated by DHCS (COHS plans) or Mercer (2-Plan and GMC).
- DHCS must communicate with the health plans on how the capitated rates were developed, including rate sheets for that are health plan specific and provide the opportunity to consider additional information.
- Health plans must periodically provide financial and utilization data as deemed necessary by DHCS to establish rates.
- Rates are to be distributed typically by the first week of the Budget Year.
- Plan specific financial and utilization used for rate setting is confidential.

Rate Development Template-Example

Medi-Cal Managed Care

Contract Year 12/13 Rate Development

Utilization Cost Experience January 2010 through December 2010

Fill out one for each COA group and county (if applicable)

Medi-Cal Member Months: 5,303,518 (Enter Member Months information in Schedule 1-C)

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
	Fee-For-Service								Capitation		
	ption of Units (e.g., days, claims, units	Total Gross Cost	Total Units	Annual Units per 1,000 Members	Gross Cost per Unit	Total Copayments	Net Cost per Unit	Net Cost PMPM	Total Cost	Total Encounters Units of Service	Cost PMPM
All State-Plan Health Care Services(1)											
Inpatient	Days	$15,021,715	10,274	23.25	$1,462.17		$1,462.17	$ 2.83	$ 80,121,540	80,161	$ 15.11
Outpatien	Visits	$806,552	2,172	4.91	$ 371.36		$ 371.36	$ 0.15	$ 4,215,826	37,216	$ 0.79
Emergenc	Visits	$3,550,784	24,364	55.13	$ 145.74		$ 145.74	$ 0.67	$ 19,142,306	142,097	$ 3.61
Long-Tern	Days	$290,292	1,297	2.94	$ 223.76		$ 223.76	$ 0.05	$ -	2,028	$ -
Physician	Visits	$562,527	6,066	13.73	$ 92.73		$ 92.73	$ 0.11	$ 72,101,585	1,478,554	$ 13.60
Physician	Visits	$818,869	2,913	6.59	$ 281.14		$ 281.14	$ 0.15	$ 26,782,143	225,379	$ 5.05
FQHC	Visits	$24,576	119	0.27	$ 206.45		$ 206.45	$ 0.00	$ 19,607,863	24,255	$ 3.70
Other Me	Servic	$1,910	34	0.08	$ 55.55		$ 55.55	$ 0.00	$ 1,193,479	38,598	$ 0.23
Pharmacy	Scripts	$54,289,689	2,416,134	5,466.86	$ 22.47		$ 22.47	$ 10.24	$ -	4,447	$ -
Laborator	Proced	$18,369	1,186	2.68	$ 15.49		$ 15.49	$ 0.00	$ 7,948,736	1,256,674	$ 1.50
Transport	Trips	$694,973	11,715	26.51	$ 59.32		$ 59.32	$ 0.13	$ -	27,823	$ -
Other	Servic	$959,747	5,844	13.22	$ 164.23		$ 164.23	$ 0.18	$ 941,654	289,197	$ 0.18
Global Subcapitation Expenditures									$ 139,563,632		$ 26.32

Sample Rate Sheet

		October 01, 2011 - September 30, 2012									
	Lower Bou	Midpoint	Upper Bound								
	$131.52	$136.13	$140.97				Time Periods				
							Base Data Midpoint		Contract Midpoint		Trend Months
nonths represent an estimate of SFY11/12 based on budget forecast.							1-Jul-09		1-Apr-12		33
		Projected MC			MC Adjustments		Managed Care				
(F)	(G)	(H)	(I)	(J)	(K)	(L)	(M)	(N)	(O)	(P)	(Q)
Util Program	U.C. Progr	Util/1,000	Unit Cost	PMPM	Util/1,000	Unit Cost	Util/1,000	Unit Cost	Pre-MAT	MAT ca	Post-MAT PMPM
0.00%	2.90%	230	$2,006.14	$38.43	1	1	230	$2,006.14	$38.43	($9.99)	$28.44
0.00%	1.50%	519	$174.85	$7.56	1	1	519	$174.85	$7.56	($0.01)	$7.54
0.00%	1.70%	625	$148.64	$7.75	1	1	625	$148.64	$7.75	$0.00	$7.74
0.00%	0.30%	17	$287.20	$0.41	1	1	17	$287.20	$0.41	$	$0.41
0.00%	-0.20%	4,296	$57.72	$20.66	1	1	4,296	$57.72	$20.66	($0.77)	$19.89
0.00%	-0.20%	1,599	$83.04	$11.06	1	1	1,599	$83.04	$11.06	($0.70)	$10.37
0.00%	-0.20%	784	$53.35	$3.49	1	1	784	$53.35	$3.49	($0.05)	$3.44
0.00%	0.40%	530	$53.66	$2.37	1	1	530	$53.66	$2.37	($0.02)	$2.35
0.00%	0.00%	7,969	$26.99	$17.92	1	1	7,969	$27.03	$17.95	$	$17.95
0.00%	0.50%	1,488	$21.09	$2.61	1	1	1,488	$21.09	$2.61	$	$2.61
0.00%	1.10%	101	$128.16	$1.08	1	1	101	$128.16	$1.08	($0.01)	$1.07
0.00%	1.10%	1,684	$37.06	$5.20	1	1	1,684	$37.06	$5.20	$	$5.20
				$118.55					$118.57	($11.56)	$107.02

Rate Development Template-Example (2-Plan)

Two-Plan 12 Month Capitation Rates Summary (Prior to Risk Adjustment and Without AB 1422)

(October 01, 2011 - September 30, 2012)

			Final Display	MERCER DEVELOPED RATES			10-11 Rates	Percentage Change		
HP#	COA ID	Category of Aid	Mem. Months*	Lower Bound	Midpoint	Upper Bound	LOWER BOUND	Lower Bound	Midpoint	Upper Bound
300	AFM	Adult & Family	1,116,990	$ 119.73	$ 124.27	$ 129.04	$ 121.76	-1.7%	2.1%	6.0%
300	ADMC	Aged/Disabled/Medi-Cal Only	114,947	$ 535.27	$ 551.96	$ 569.36	$ 512.47	4.4%	7.7%	11.1%
300	DSD	Disabled/Dual Eligible	36,061	$ 123.98	$ 128.63	$ 133.52	$ 136.33	-9.1%	-5.6%	-2.1%
300	AGD	Aged/Dual Eligible	31,568	$ 119.96	$ 124.50	$ 129.28	$ 131.15	-8.5%	-5.1%	-1.4%
300	BCC	BCCTP	216	$ 708.94	$ 730.51	$ 752.96	$ 788.73	-10.1%	-7.4%	-4.5%
300	AID	AIDS/Dual Eligible	384	$ 195.93	$ 202.44	$ 209.25	$ 203.14	-3.5%	-0.3%	3.0%
300	AIMC	AIDS/Medi-Cal Only	4,392	$ 696.70	$ 718.22	$ 740.66	$ 806.12	-13.6%	-10.9%	-8.1%
300	MAT	Maternity	2,533	$ 6,627.48	$ 6,822.00	$ 7,023.72	$ 6,196.68	7.0%	10.1%	13.3%
300	**TOTAL**	**All Categories of Aid**	**1,304,558**	**$ 171.397**	**$ 177.447**	**$ 183.790**	**$ 171.284**	**0.1%**	**3.6%**	**7.3%**
300		**TOTAL REVENUE**		**$ 223,597,681**	**$ 231,489,832**	**$ 239,764,375**	**$ 223,449,345**	**0.1%**	**3.6%**	**7.3%**
340	AFM	Adult & Family	315,350	$ 124.58	$ 129.25	$ 134.16	$ 116.80	6.7%	10.7%	14.9%
340	ADMC	Aged/Disabled/Medi-Cal Only	24,353	$ 594.78	$ 613.22	$ 632.43	$ 551.14	7.9%	11.3%	14.7%
340	DSD	Disabled/Dual Eligible	5,825	$ 132.56	$ 137.36	$ 142.41	$ 127.88	3.7%	7.4%	11.4%
340	AGD	Aged/Dual Eligible	2,366	$ 109.16	$ 113.36	$ 117.77	$ 106.08	2.9%	6.9%	11.0%
340	BCC	BCCTP	12	$ 691.67	$ 712.83	$ 734.87	$ 722.50	-4.3%	-1.3%	1.7%
340	AID	AIDS/Dual Eligible	12	$ 196.85	$ 203.38	$ 210.22	$ 193.59	1.7%	5.1%	8.6%
340	AIMC	AIDS/Medi-Cal Only	12	$ 704.58	$ 726.04	$ 748.40	$ 833.90	-15.5%	-12.9%	-10.3%
340	MAT	Maternity	817	$ 6,627.48	$ 6,822.00	$ 7,023.72	$ 6,196.68	7.0%	10.1%	13.3%
340	**TOTAL**	**All Categories of Aid**	**347,930**	**$ 173.121**	**$ 179.215**	**$ 185.603**	**$ 161.916**	**6.9%**	**10.7%**	**14.6%**
340		**TOTAL REVENUE**		**$ 60,234,056**	**$ 62,354,267**	**$ 64,576,978**	**$ 56,335,564**	**6.9%**	**10.7%**	**14.6%**

Medi-Cal Rate Setting Process

- Two plan model and Geographic Managed Care model rates are risk adjusted (Family/Adult and SPD Medi-Cal Only rate categories) using Medicaid RX software.
- The risk adjustment is applied to 35 percent of the county specific rate developed annually for each Two-plan and GMC county.
- Details concerning county averaging and Medicaid RX risk adjustment can be found at the following link:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/CA_RAROverview_4-1-09.pdf

Medi-Cal Rate Setting Process

DHCS also uses another risk adjustment mechanism to control adverse plan selection by pregnant beneficiaries and as incentive to the plan to retain the beneficiary within managed care. Details of this risk adjustment mechanism can be found at the following link:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/AllPlanMeetingMaternityKickPayment.pdf

Medi-Cal Rate Setting Process

- Value based purchasing practices have also been implemented/ or in the process of implementation by DHCS and Mercer in respect to pharmacy purchasing practices (MAC Pricing Adjustment) and Potentially Preventable Hospital Admissions (PPA).
- Details concerning the methodologies can be found at the following links:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/CA_DHCSAllPlanMtgPres_072111.pdf

Other Reports such as Actuarial Certifications and Actuarial Presentations over the years can be found at the following link:

http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx

Medi-Cal Rate Setting Process

- Intergovernmental Transfers (IGTs) are used as a mechanism to enhance rates.
  - County entities typically contribute the non federal share of the rate enhancement.
  - Rate range or an increase is base data is used to enhance the rates.
  - Approximately $800 M annually in IGTs.
- Hospital Quality Assurance Fees are also used to enhance rates.
  - Base costs for Inpatient, Outpatient, and Emergency services are increased.
  - Hospitals contribute the nonfederal share of the rate enhancement.
  - Enhancements are projected at $1.5 to $1.7 Billion annually.

  MCO Tax
  - Capitation rates are enhanced in advance by 2.35 percent to cover the cost of the tax.
  - Plans pay the tax of 2.35 percent to the Department of Insurance and file quarterly and annual returns with Board of Equalization.
  - DHCS is reimbursed for the nonfederal share of the tax enhancement (1.175 percent)
  - The remainder goes to the Healthy Families Program.
  - Tax currently scheduled to sunset June 30, 2012, however legislation to extend to extend into indefinitely is current on the table.

Items For Future Discussion

- SPD rate setting process.
- CRG based analysis.
- Rate setting for dual eligibles.

Medi-Cal Rate Setting Process

Questions and Comments