The LEWIN GROUP

Collaboration in Medicaid Managed Care Rate Setting

Prepared for:

Association for Community Affiliated Plans &
Medicaid Health Plans of America

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The Balanced Budget Act of 1997 (BBA) required that Medicaid programs ensure the "actuarial soundness" of the rates paid to Medicaid managed care plans. The Lewin Group was engaged by the Association for Community Affiliated Plans (ACAP) and Medicaid Health Plans of America (MHPA) to conduct a study of how states are implementing the BBA's actuarial soundness requirements.

In the initial phase of this project, Lewin conducted a survey of states and plans to assess their processes and level of collaboration. The full survey report is available at http://www.communityplans.net/. Findings included:

- Thirty-nine percent of the responding plans said 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 four of the responding states (21 percent) had limited opportunities to participate in the rate-setting process.
- 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.
- More than 75 percent of states provided plans with the trend factors used in the rate-setting process, broken out by category of service. Thirty-seven percent of the states provided at least some information on the data and methods used to determine trends, but only five percent provided detailed information on these topics.
- The most frequently indicated source of data on base year medical costs was MCO financial statements. Encounter data and fee-for-service claims data also were cited by a majority of respondents.

While the regulations now require actuarial soundness, it is clear that managed care plans perceive that state budget considerations continue to influence Medicaid rate setting. In addition, plans in some states have limited opportunities to participate in the rate setting process. In many states, plans perceive that the state is not responsive to all of the plans' concerns and that not all of the factors that affect costs are taken into account in the final rates.

In the second phase of this project, Lewin interviewed a Medicaid managed care plan in each of three states to learn more about the plans' perceptions of the rate setting processes in those states and about the level of collaboration between states and participating plans. The states selected for these plan interviews represent differing levels of collaboration between the state and the participating health plan(s), as identified in the survey conducted in phase 1 of the project. The selected states also differ in size (area and population), geographic region, and population density.

For this case study, we interviewed representatives from the three selected Medicaid managed care plans. The case study did not include interviews of state officials in any of the states. Following are a brief description of our overall findings as well as some best practices and challenges that were identified.

General Findings

The level of collaboration depends on the people involved at the state level. In one state, the plan interviewed finds that in some years the process is more collaborative than in others and that the circumstances and opportunities around collaboration in Medicaid rate setting change every year, especially as the state experiences personnel changes.

In some states, the health plans are very involved in the process but their input may or may not lead to any changes in the rates. According to the plan interviewed in another state, plans' concerns often do not have an impact on the rates, though the process is quite collaborative.

In other states, the Medicaid managed care rate-setting process has become more collaborative in recent years. This is the case in a third state, according to the plan interviewed there.

Best Practices

The major best practice area identified in the interviews with plans in three different states is open and regular communication with the states during the rate-setting process.

Regular Meetings and Open Communication

The three plans interviewed for this project agreed that regular contact, whether formal or informal, and open communication between states and plans is crucial to the Medicaid managed care rate setting process. However, even with regular communication, plans perceive that not all of the concerns they raise or the data they provide are taken into consideration by the states.

During the rate-setting process in one state, plans submit encounter data to the state and then discuss with the state the data's completeness and accuracy. A draft of statewide rates is shared with all plans, and plan-specific rates are shared with each individual plan. The state shares a packet of data with each plan showing the utilization and cost trends that are assumed in their numbers. This includes only the individual plan's data, along with aggregated trend charts with information from all the plans. The plans then provide feedback and ask questions. Until recently, monthly meetings of a workgroup offered additional opportunities to discuss outstanding issues. Additional meetings also are held as necessary, and state staff respond to questions via email.

This state's workgroup has been replaced by two sub-groups, which serve as forums to ask questions and provide input. While active, the workgroup met every month year-round, with longer and more intensive meetings leading up to and during the rate-setting period. In the meetings during other times of the year, the group discussed items such as managed care trends and legislative activity. The plan interviewed for this project generally sent its controller to the meetings of the workgroup, and the CFO and/or CEO attended larger or more important/contentious meetings as well. The meetings always include a representative from the state's Medicaid office, and when requested by the plans the Medicaid director attended as well.

However, while there is a great deal of communication between the state and plans around Medicaid rates in this state, with structured meetings of the workgroup and responsiveness on the part of the state to informal communications as well, the plan interviewed for this project perceives that the state generally does not act on the information provided. The state listens when the plans submit data, and it allows its actuary to respond to the plans' questions, but the plan does not view the process of reaching the actual rates as collaborative. In fact, at a recent meeting, the new head of Medical Assistance for the state reiterated the non-democratic nature of the rate-setting and contracting process. With this open acknowledgement by the state, plans wonder if they may see fewer opportunities for communication in the coming year.

Even with this perception that the information provided generally does not lead to state action, in a rare move this past year the state re-reviewed recent data and adjusted the rates for one eligibility group. As in many states, the encounter data this state uses to set rates are several years old. The plan asserted that the historical trends the state used to establish the rates did not adequately account for the cyclical nature of health care costs, and the state responded to more recent data with a change. This was the only time in the past four years that rates have been adjusted after the plans provided additional information to the state.

Similar to the process described above, another state – after it receives data from the plans – distributes a data book summarizing the plan financial data and encounter data summaries. These summaries are aggregated and weighted by membership but not adjusted by severity of illness. The state then holds two large meetings with all the plans. At the end of the calendar year, the state meets with the plans to discuss the rate-setting process and timeframes. Then in March, the state holds a technical assistance session with the health plans describing the methodology and providing the plans with an overview of the trends and assumptions used in the development of the rates. Attendees of these two meetings include the chief of managed care, the Medicaid Director and/or a designee, the contracting officer from the procurement office, a team from the state's actuarial firm, and the health plans and their actuaries.

This state requests the plans to submit all issues they wish to have considered in rate development, and the state then has individual rate negotiations with each plan where further questions are answered and additional information can be provided. In mid-March, a rate issues chart is distributed by the state, generally containing the issues the plans have raised.

Plans submit cost proposals in early April and then this state holds two individual meetings with each plan. In mid-April, they meet to discuss the submitted cost proposals and outstanding issues, and in May, they conduct negotiations of the rates. This second meeting leads to a verbal agreement of the rates. For these two individual meetings, the plans focus their presentations on issues, trends, and data, with special emphasis on the most recent experience, since the data used by the state is older.

The four meetings between this state and the health plans (two large group and two individual) serve as the main communication medium during the rate-setting process. There is involvement in the process at a variety of levels, including the Medicaid agency,

procurement office, budget director, and legislature. Plans in this state assert that the rate-setting process has improved greatly in recent years and that the state is now providing more information on trends, assumptions, and market factors considered.

However, the plan interviewed for this project in this state indicates that while the process has improved – with a longer timeframe and the ability for the plans to submit information that may affect rates – the data shared are not always fully reflected in the rates that are eventually set by the state. The state sometimes takes the information presented into consideration, particularly if all of the plans say the same thing.

In a third state, the plan interviewed for this project asserted that the relationship between the state and plans is very open compared with some other states and that there is frequent access to the state (several times per month) at a relatively senior level. However, these connections and the openness of the relationships depend upon the personnel in senior roles at the state. In this state, there are no formal meetings on rate setting, so the plans' involvement in the process depends on these open relationships.

While this state indicates that it uses encounter data from the plans to help set the rates, it is not clear how those data are used. In one recent instance, the plan interviewed for this project challenged the actuarial soundness of the proposed rates. After the plan suggested that it would submit a FOIA request, it received the assumptions used to set the rates. The plan then compared the assumptions with actuarial experience, highlighted discrepancies, and asked the state for an explanation. The plan believes that the result of these discussions was a significant increase in the state's rates.

Challenge Areas

The plans interviewed for this project identified several challenge areas in the rate-setting process that may limit the effectiveness of collaboration with the states.

Tight Timeframes and Legislative Approval

A concern among Medicaid managed care plans is that the process for setting Medicaid rates often occurs within tight timeframes and offers little time for review, submission of additional information, or negotiations. Also, in some states the legislature has the ability to affect the rates in its budgeting process, and this can impact timeframes even further.

In one state, the Medicaid rates go into effect on January 1 of each year and the state communicates the rates to the plans in September. In this state, the legislature must approve the budget. It works on this in October and November and has the ability to cut the rates. The state would like the plans to be able to sign contracts by late October, but it is not unusual for the contracts to be signed in late December, just before the rates go into effect. This gives the plans very little time for review or comment prior to the need to sign contracts.

Similarly in another state, the rates must be approved by the legislature. The legislature completes its budget process six months before the Medicaid rate negotiation begins.

The legislature's process does not consider the plans' health care cost trends or expenditures, but the HMO Association in that state does provide comments during the budget process.

Budget Considerations

Medicaid managed care plans are concerned that state budget considerations affect the decisions made by the states around Medicaid rates. Examples of these considerations include changing the rates in an effort to balance the budget or using funds to accomplish other goals in Medicaid without increasing expenditures.

In all three states in which plans were interviewed, budget considerations appear to be a part of the rate-setting discussion at the state level. In one state, this has not seemed to lead to post-actuarial cutting of the rates. However, in another state, where there are explicitly limited dollars available for payments to Medicaid MCOs, capitation rates may be adjusted or benefit packages may be reduced in order to balance the budget, according to the plan interviewed for this project.

According to the plan interviewed in a third state, rate-setting decisions, and increases in particular, appear to be driven somewhat by budget considerations. The involvement of the budget director and legislature likely adds to the impact of budget concerns. In the past year specifically, the budget has been a significant factor in the rate-setting process in this state. The state wanted to expand eligibility for Medicaid but could not afford to pay more, so it did not increase rates. In effect, plans saw a small rate decrease with this expansion in eligibility.

Market Considerations

Medicaid managed care plans must compete in the markets where they are located, and states can be more or less responsive to those market considerations. These market considerations include the size of the plans, special populations covered, and services provided.

The plan interviewed in one state indicates that the state has been responsive to market issues in the past, such as those facing small health plans competing with larger plans (e.g., ability to negotiate with providers, higher MLRs, less ability to spread fixed costs). Plans also have discussed increasing administrative costs with the state related to meeting requirements for accelerated NCQA timeframes, HIPAA, BBA, and others. However, the state appears unwilling to recognize more than 15% in administrative costs, the CMS suggested level of payment for administrative costs[1]. The plan interviewed for this project has added more social workers, utilization management, and care coordination to get and keep patients out of the hospital. While the plan feels strongly that these should be considered medical costs, this state considers them to be administrative costs.

[1] Note that the CMS guidance does not specifically require states to consider differences in underlying population (TANF vs. ABD), services covered, or enrollment size in determining the appropriate administrative cost level that a given state should include in its capitation rates.

Conclusions

Generally, in our interviews with representatives from Medicaid managed care plans in three states, we found that: 1) The level of collaboration between states and Medicaid managed care plans depends on the people involved; 2) Plans are very involved in the process but their input may or may not lead to any changes; and 3) The process in some states has become more collaborative in recent years.

In addition, the project has led to the following specific conclusions:

- **A truly collaborative process between states and plans is important.** Medicaid managed care plans appreciate the opportunity to participate in the rate-setting process but are concerned that, even with regular communication, their access to the data and assumptions used by the states or their actuaries is constrained and that their input does not lead to action.

- **Adequate timeframes are needed.** Medicaid managed care plans are concerned that the Medicaid rate-setting process often occurs within timeframes that are too short for sufficient review of the proposed rates, response, and possible renegotiation.

- **The effect of state budget considerations on Medicaid rates is of great concern to plans.** Medicaid managed care plans believe that budget concerns can and have affected Medicaid rates, and they are concerned that this may inappropriately take precedence over actuarial soundness in some cases.

- **CMS, states and plans need a shared understanding of how plan and program characteristics should be reflected in the administrative cost component of the capitation rates.** Medicaid managed care plans face market considerations such as plan size, populations covered, and services provided, and they are concerned that states are not consistently responsive to those issues.