Rate Setting and Actuarial Soundness in Medicaid Managed Care

Prepared for:

Association for Community Affiliated Plans & Medicaid Health Plans of America

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EXECUTIVE SUMMARY

The Association for Community Affiliated Plans (ACAP) and the Medicaid Health Plans of America (MHPOA) retained The Lewin Group (Lewin) to conduct a study of the ways that states have implemented rules from the Balanced Budget Act of 1997 (BBA) regarding actuarial soundness.

Prior to enactment of the BBA, and the issuance in June 2002 of regulations by the Centers for Medicare & Medicaid Services (CMS) to implement the Medicaid managed care provisions of the BBA, the regulation of premium rates for Medicaid health plans was based on the Upper Payment Limit (UPL) rule. Under this rule, a state could not pay an amount greater than what it would have cost for the state to provide the same benefits to the same population directly (i.e., without going through the health plans). One problem with this rule is that it required a state to be able to determine the fee-for-service (FFS) cost of providing benefits to its Medicaid population. This became difficult as managed care became more prevalent in Medicaid programs and, as a result, it became harder to find recent FFS data that could serve as a credible predictor of program-wide health care costs. Another problem is that while the UPL rule specified a maximum payment level, it did not specify a minimum level. Thus, if a state had sufficient bargaining power over its Medicaid health plans, it could impose rates that were inadequate (i.e., not high enough to cover the plans' cost of providing benefits to their Medicaid enrollees) and still be in compliance with CMS requirements.

The actuarial soundness provision of the BBA addresses the first of these problems by de-coupling managed care payment rates from FFS costs, so that state Medicaid agencies no longer have to show that their managed care costs are less than or equal to what their costs would have been under FFS. The second problem is addressed by the requirement that managed care payment rates be actuarially sound, which traditionally has meant neither excessive nor inadequate.

But the new approach has its own challenges. First, the exact meaning of the phrase "actuarially sound," as it applies to health plans, is still being debated within the actuarial profession—with the likely outcome being that different definitions will be considered appropriate for different situations (e.g., for different types of plans). A wide range of payment rates all could be considered to be actuarially sound for any given health plan and state. The American Academy of Actuaries recently issued a practice note on the actuarial certification of rates for Medicaid managed care programs; however, it does not resolve many of the issues surrounding the definition of actuarial soundness in this context.

The second challenge associated with the BBA's approach to Medicaid managed care rate setting is that, while an actuarially sound premium (in theory) depends on the benefits to be provided and the population to be covered, Medicaid payments (in practice) often are affected by the availability of state funds. As the Academy states in its new practice note, "'[a]ctuarially

sound' rates … are normally independent of budget issues …"[1] However, it appears from the plans' perspective that budget considerations play a role and sometimes override actuarial principles. Health plans, especially Medicaid-only plans, cannot sustain rates that are actuarially unsound over several years. If states set Medicaid premiums at artificially low (and actuarially unsound) levels, then they run the risk of having their Medicaid managed care programs weakened—or even terminated, as happened in Oklahoma in 2003.[2]

In response to these challenges, ACAP and MHPOA asked Lewin to find out how states are implementing the BBA's actuarial soundness requirements, in order to identify both best practices and continuing areas of concern. For this purpose, Lewin developed a survey to gather information from states and health plans on current rate-setting practices. The survey was distributed to ACAP and MHPOA member plans (a total of 37 plans), as well as to Medicaid agencies in the 22 states in which these plans operate. (The states for which Lewin does the rate development and actuarial certification are not among the states that were surveyed.) We received responses from 25 health plans (a response rate of 68 percent) and 14 Medicaid agencies (a response rate of 63 percent). Together, these responses provided us with information on the rate-setting practices of 21 states, whose capitated Medicaid managed care programs cover 12 million enrollees (68 percent of the national total).

Notable results from the survey include:

- **Plans' views of state practices.** 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.

- **Administrative costs and profits.** Just less than one-half of the responding states give plans free rein to decide how to define and classify the component activities that constitute case management and other "combination" services, as well as how to allocate the cost of these activities. The remaining states impose restrictions on how plans can allocate costs between "medical" and "administrative" components. Among the latter group, most have general principles or guidelines that the plans have to follow, but

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[1] Medicaid Rate Certification Work Group, *Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs*, American Academy of Actuaries, August 2005, p. 12.

[2] Because Medicaid programs often have dealt with budget concerns by further lowering (or freezing) unit prices paid to providers, some have argued that no rate is inherently unsound (in that MCOs can negotiate lower provider prices themselves as necessary to remain viable). However, it is not clear that MCOs can successfully negotiate reductions from an already substandard Medicaid FFS baseline, nor that access to services can be ensured if provider payments are reduced below Medicaid FFS.

some of them mandate exactly how specific activities are to be defined and/or how their costs are to be allocated.

- **Actuarial issues.** More than 75 percent of states provide plans with the trend factors used in the rate-setting process, broken out by category of service. Thirty-seven percent of the states provide at least some information on the data and methods used to determine trends, but only five percent provide detailed information on these topics.[3] Average rate increases in fiscal years 2004 and 2005 were 5.6% and 6.1%, respectively. However, a wide range of rate increases were enacted by the various states. In 2004, the lowest rate increase among the responding states was 0.0%, and the highest was 13.7%. In 2005, the lowest rate increase was -1.6% (i.e., a decrease), and the highest rate increase was 14.0%.

- **Data sources and medical cost trends.** The most frequently indicated source of data on base year medical costs is MCO financial statements. Encounter data and fee-for-service claims data were also cited by a majority of respondents.

  States also reported their trend factors by category of service for the last two fiscal years; inpatient care had the lowest average annual trend (4.3 percent), while pharmacy had the highest (12.7 percent). The average trend assumption across all categories was 6.0 percent. A wide range of trends were used by the responding states, both for individual categories and for the overall trend. For example, trends for the professional services category ranged from 2.0% to 28.1%, while the overall trend (i.e., each state's weighted average trend across all categories) ranged from 1.9% to 16.9%. Furthermore, there was very little correlation between (a) the trend assumption in a given state for a given year, and (b) the resulting rate increase in the same state for the same year. Specifically, the correlation coefficient between the overall trends (by state) and the overall rate increases (by state) was 0.0272 in 2004 and 0.0456 in 2005.

  Of the 17 responding states that (a) include some or all of their prescription drug costs in their capitation rates, and (b) provided us with information on how manufacturer rebates are handled, 4 states (24 percent) adjust their rates to reflect the payments that the *states* receive under the federal rebate program (based on their FFS drug spending). The remaining 13 states (76 percent) of these states adjust their rates based on the rebates received by the *plans* under their own agreements with pharmaceutical manufacturers or pharmacy benefit managers.

- **Risk adjustment and risk sharing.** A wide variety of factors is used to define rate cells, with all of the responding states using some combination of age, gender, eligibility category, and/or geographic region for this purpose. Some of the states also reported using other factors to define rate cells, such as institutional, disability, Medicare, and/or

[3] Note that capitation rates are set in two fundamental ways: 1) dictated to MCOs by the state; or 2) determined through negotiations between the MCO and the state or competitive bidding. Typically more information about the trending and other assumptions is provided by the state under the "dictated" rate-setting approach.

maternity status. In eight states, rates can vary by plan based on plan bids or on negotiations between the state and individual plans; while in five other states, rates can vary based on other factors (such as adjustments for new plans). Nine states use risk adjustment by health status (with most of these employing the Chronic Illness and Disability Payment System). Finally, six states (29 percent of the responding states) use risk corridors or other arrangements for sharing risk between the state and the plans; and just less than one-half of the states include quality-related incentives in their MCO contracts.

It is clear that the new actuarial soundness requirements have not severed the link between Medicaid managed care payment rates on the one hand and state budget considerations on the other. If states prioritize short-term budget concerns over actuarial soundness, it could lead to the undermining of their Medicaid managed care programs and of the benefits—such as higher quality health care and greater access to care—that these programs have brought to their Medicaid populations.

I. INTRODUCTION

The Association for Community Affiliated Plans (ACAP) and the Medicaid Health Plans of America (MHPOA) retained The Lewin Group (Lewin) to conduct a study of the ways that states have implemented rules from the Balanced Budget Act of 1997 (BBA) regarding actuarial soundness.

Lewin developed a survey to gather data on the Medicaid rate-setting process from states and health plans. The survey was distributed in early 2005 to all ACAP and MHPOA member plans (37 different health plans in all, as listed on the organizations' web sites) as well as 22 states in which those plans operate. The survey addressed issues related to six major areas:

- What data are used to determine rates, and how often are rates set?
- What was the average rate increase in the past two rate-setting periods, and what were the underlying cost trends on which these rate increases were based?
- If prescription drugs are included in the rates, how are manufacturers' rebates accounted for?
- What risk adjustment methodology is used? Are there other ways in which rates can vary by plan?
- What administration and profit allowance is included in the rates, and what is it based upon?
- How do plans participate in the rate process and what information is shared with them?

The survey contained 32 questions of which 25 were multiple-choice and seven were open-ended. All multiple-choice questions included space for respondents to submit alternate answers or include explanations of their answers. Surveys distributed to health plans included three additional questions (one multiple-choice, two open-ended) regarding the role of budget constraints on rate setting, the fairness of the rate-setting process, and the state's willingness to have an open exchange of information and to incorporate into the rates all factors that could affect the plans' costs in providing heath benefits to Medicaid beneficiaries.

II. BACKGROUND ON BBA ACTUARIAL SOUNDNESS REQUIREMENT

Prior to enactment of the BBA—specifically, before the Centers for Medicare & Medicaid Services (CMS) issued regulations in June 2002 implementing the Medicaid managed care provisions of the BBA—the regulation of premium rates paid to Medicaid health plans consisted of a cap on those rates. Under the Upper Payment Limit (UPL) rule, a state could not pay an amount greater than what it would cost the state and the federal government to provide Medicaid benefits directly to the covered population. There was no floor under the rate paid to a health plan; as long as it was less than the UPL, then it was acceptable to CMS.

One problem with the UPL method is that it required that a state be able to estimate the fee-for-service (FFS) cost of providing Medicaid benefits. While accurate forecasting of future

Medicaid costs (i.e., trending) is challenging in any rate-setting structure, the UPL approach was less challenging when Medicaid managed care programs were first being established. In such cases, there was always recent FFS cost and enrollment data from which the "would-be" FFS cost could be estimated and thus the UPL could be determined. Even for programs that had been in operation for several years, it wasn't too difficult to estimate the UPL as long as the managed care program was relatively small compared to the overall Medicaid program—that is, as long as there were enough FFS Medicaid beneficiaries left to allow the state to gather the enrollment and cost data needed to calculate the UPL. But as the managed care portion of state Medicaid programs became dominant, states found that they had no recent data for the populations and regions covered by Medicaid health plans. Even if there remained some Medicaid beneficiaries not covered by managed care, their experience became less and less reliable as a predictor of health care costs for the growing managed-care-covered majority.

Another drawback of the UPL method is the lack of a *minimum* payment level. Traditionally, insurance regulators have sought to ensure not only that premium rates are not excessive, but also that they are adequate to provide for the benefits covered and the associated administrative costs of the insurer (including the cost of capital, or profit margin). This requirement exists not to protect the insurance company per se but to protect the beneficiaries, to make sure that their insurance company would be able to provide the benefits to which they were entitled. Theoretically a state insurance regulator still could assume this role for the beneficiaries of a Medicaid health plan. But when the purchaser of the health benefits is also the state, there is a danger that the purchaser will be allowed to dictate the premiums to be paid to the plans, even if the premiums are unreasonably low. This is especially true when a participating plan operates only in that state, and even more so if all or most of that plan's revenue comes from the Medicaid program. In such a situation, the plan cannot simply "walk away" from an unfavorable contract—unless it is willing to shut down altogether. Under the UPL model, there were several situations in which Medicaid MCOs either became insolvent or simply ceased doing business with a given state.

The actuarial soundness provision of the BBA provides a potential solution to these problems. As implemented through the CMS Medicaid managed care regulations, this provision requires that a state pay premiums to its participating Medicaid health plans that are actuarially sound: neither too high nor too low; both adequate and not excessive. Note that the concept of actuarial soundness governs not just how high or low the rates should be, but also how they are developed. Specifically, the regulations require that the rates be based on utilization and cost data derived from the Medicaid population (or from a similar population, with appropriate adjustments), that they reflect the benefits covered by the state plan, and that factors such as inflationary trends, regional cost differences, and managed care's cost containment effects be taken into account. The regulations also require an explicit provision for administrative expenses (including profit or contingency margins), instead of, for example, assuming that administrative costs will be covered by savings from utilization controls. Also, just as important as what the regulations say is what they do not say: they do not tie managed care payment rates to the "would-be" cost of providing the same benefits to the same population on a FFS basis. Nor do they tie the payment rates to whatever amount the state has budgeted for its Medicaid managed care program. The cost of the program is to be determined only by the

benefits provided, the population covered, and the costs and savings associated with the manner in which the benefits are administered.

For state Medicaid agencies, the difficulty of switching to the new actuarial soundness requirement is twofold. First, the meaning of the term "actuarial soundness" has not yet been fully articulated even within the actuarial profession. And while the American Academy of Actuaries recently issued a practice note on the actuarial certification of rates for Medicaid managed care programs, this document (like all of the Academy's practice notes) merely provides guidance without imposing any binding rules on actuaries. There is no Actuarial Standard of Practice (which *would* be binding on all actuaries practicing in the U.S.) dealing with the development of payment rates for Medicaid managed care plans.

Second, while the regulations imply that Medicaid managed care payment rates are to be independent of comparable FFS costs and, more importantly, independent of state budgets, the reality is that a state cannot simply write a blank check to a Medicaid health plan and hope that it will be able to afford whatever amount is filled in. Aside from federal subsidies, states can spend only what they are able to raise in taxes, and their ability to do so is limited (especially during economic downturns, when, paradoxically, the need for medical assistance is likely to increase). One way or another, budget constraints are likely to be reflected in the amounts that states pay to their Medicaid health plans.

It was in recognition of these difficulties that ACAP and MHPOA undertook this effort to conduct a study of the ways states are implementing the BBA's actuarial soundness requirement and to identify the best practices that states have established in order to meet these challenges.

III. SUMMARY OF SURVEY DISTRIBUTION AND RESPONSE

Lewin created a list of ACAP and MHPOA plans from the association web sites. This list comprised 37 health plans (if we count subsidiaries operating in different states as separate plans): 19 ACAP members and 22 MHPOA members, including four plans that belong to both associations. Lewin also developed a list of state Medicaid agencies to survey based on where the associations' member plans operate. A total of 22 states were chosen for the survey.

Of the 37 health plans that received the survey, 25 sent their responses back to Lewin. As shown in Table 1, the respondents included 15 of the 19 ACAP member plans and 13 of the 22 MHPOA member plans, with three of the respondents belonging to both organizations. In addition, 14 state Medicaid agencies completed the survey, as shown in Table 2. If a state did not reply, responses from plans in that state were used as a proxy for the state's response. Using this method, data on rate-setting practices were collected from all of the "No Response" states except Illinois, for a total of 21 states.

The states that responded represent 7.4 million capitated enrollees, or approximately 42 percent of the total for capitated Medicaid managed care programs nationwide. When we add in the

states for which we have a proxy response from one or more plans, then the total Medicaid managed care enrollment in the states for which we have responses comes to 12.0 million, or 68 percent of the national total.[4]

Table 1:
Health Plans Responding to Survey

L. A. Care Health Plan (CA)
Colorado Access (CO)
Community Health Network (CT)
Chartered Health Plan (DC)
Health Right (DC)
AlohaCare (HI)
Managed Health Services (IN)
FirstGuard Health Plan (KS)
Neighborhood Health Plan (MA)
Network Health (MA)
Care Source (MI)
FirstGuard Health Plan (MO)
AmeriGroup (NJ)
Horizon Health (NJ)
Affinity Health Plan (NY)
Health Plus (NY)
Hudson Health Plan (NY)
Monroe Plan for Medical Care, Inc. (NY)
Care Source (OH)
CareOregon (OR)
AmeriHealth Mercy Health Plan (PA)
Keystone Mercy Health Plan (PA)
Neighborhood Health Plan (RI)
Select Health Plan (SC)
Community Health Plan (WA)

Table 2:
States Responding to Survey

Arizona
California
Colorado
District of Columbia
Kansas
Kentucky
Maryland
Massachusetts
Missouri
New Jersey
Oregon
Pennsylvania
South Carolina
Washington

[4] *Number of Managed Care Entity Enrollees by State as of June 30, 2004*, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, retrieved September 2005. Available at http://www.cms.hhs.gov/medicaid/managedcare/mctype04.pdf.

IV. SURVEY RESULTS

A. Rate Setting Overview

For the most part, respondents offered similar answers to the basic questions about the rate-setting process. Nearly all respondents indicated that their rate-setting process occurs annually, that the capitation rate schedule is effective for one year, and that the state develops only one rate schedule during each rate-setting cycle. In 14 states (or 67 percent of the responding states, including those states for which plan responses were used as proxies for missing state responses), base costs are recalculated every year, in 4 states (19 percent), re-basing takes place every two or three years.

Respondents next were asked about the overall rate-setting approach in their state. In 67 percent of states, rates are specified by the state and individual plans either agree to those rates or decline to participate in the state's Medicaid managed care program. In 24 percent of the states, the rates are based on bids submitted by the plans, while the remaining nine percent of the states use both approaches. Results are presented in Table 3.

Table 3: Type of Rate-Setting Process

	Which of the following best describes the rate-setting process?			
	Response	**Number of States**	**Percent of States**	
1.	Rates are specified by the State, and individual MCOs either agree to accept these rates, or they decline to participate in the State's Medicaid managed care program	14	**66.7%**	
2.	Rates are based on bids submitted by the MCOs, with the State accepting all bids that fall within the State's independently determined acceptable bid range	3	14.3%	***sum: 23.8%***
3.	Rates are based on bids submitted by the MCOs, with the State accepting only the lowest qualified bid (or otherwise limiting the number of bids accepted)	1	4.8%	
4.	Rates are based on MCO-submitted bids, which may be adjusted based on negotiations with the State	1	4.8%	
5.	Combination of #1 and #4	2	**9.5%**	

B. Medical Costs

Base Year Costs

The survey asked respondents to identify the types of data used to measure or estimate base year medical costs. All of the responding states use some form of data from the participating MCOs for this purpose. Plan financial statements are the most common data source, with 76 percent of the states (16 states) using them, while encounter data is used by 62 percent of the states (13 states), and fee-for-service claims data is used by 57 percent of the states (12 states).

Table 4: Data Sources Used to Estimate Base Costs

Source	Number of States Using Source	Percent of States Using Source
MCO financial statements	16	76.2%
Encounter data	13	61.9%
Fee-for-service claims	12	57.1%
Other data	5	23.8%

The survey asked respondents to tell whether the states compare their data to—and reconcile their data with—the data held by the plans. Forty-three percent of the states (9 states) do not check their data against the plans' data, while 57 percent (11 states) do make these comparisons. Among the latter group, most reconcile some or all of any discrepancies they find during these comparisons.

Trends

Respondents also were asked to identify the data, methods, or sources that are used to develop trends for projecting future costs. From this open-ended question, we found that 88 percent of the responding states use the historical financial results and utilization experience of their Medicaid programs to develop future trends. Thirty-six percent of the states use the encounter data, other experience measures, or financial statements of the participating plans to assess program experience. Another 31 percent of the states use some kind of program experience to develop trends but did not specify what kind they use. Twenty percent of the responding states use only FFS data to assess their program experience for trending purposes, while another 15 percent use their FFS data to supplement their other data sources on program experience.

Besides program experience, 46 percent of the responding states use national or regional trends or indices, industry norms, or other non-proprietary sources to help them estimate future trends, while 45 percent of the states use proprietary models or data sources (either purchased directly by the states or utilized by their actuarial consultants) for this purpose. The last two

figures include the 15 percent of the states that use both proprietary and non-proprietary "outside" sources, while another 24 percent of the states use neither.

The survey asked respondents to report the trends that were used in the two most recent rate-setting cycles. Many respondents provided trends by category of service, as well as providing the overall trends. As shown in Table 5, inpatient care had the lowest average trend among the five main categories of service, while pharmacy services had the highest. While trends for all categories covered wide ranges, the professional services category had the widest range of trends, from a low of 2.0 percent to a high of 28.1 percent.

Table 5:
Most Recent Trends (from FY2004 and FY 2005),
by Category of Service

Category of Service	Lowest Trend	Average Trend	Highest Trend
Inpatient	0.2%	4.3%	9.2%
Outpatient	1.9%	7.8%	23.4%
Professional	2.0%	6.1%	28.1%
Pharmacy	4.5%	12.7%	27.7%
Miscellaneous	2.4%	6.4%	19.0%
Overall	1.9%	6.0%	16.9%

Note that the overall (i.e., weighted average) trend across all categories was 6 percent, with a range of 1.9 percent to 16.9 percent—again, a surprisingly wide range.[5] While this could be a result of different market conditions in different states, it also may indicate the degree of latitude that actuaries generally have in developing "actuarially sound" assumptions. Later in this report (in Section IV.E: Actuarial and Other Issues), we will see how the overall trend assumptions compare to the overall rate increases that were enacted in these two rate cycles.

Excluded Services

Respondents were asked to identify the types of services (if any) that were excluded from the capitated benefits package. The most common exclusion was dental services, which is "carved out" from the capitation rate in 57 percent of the states, followed closely by behavioral health services, which is excluded in 52 percent of the states. Other services that were not covered

[5] Category weights used to calculate overall trends are based on the 2001 data from the tables entitled "Medicaid Payments … by Type of Service: Fiscal Years 1975-2001" (Table 102 for children and Table 103 for adults), from the *Health Care Financing Review Medicare and Medicaid Statistical Supplement, 2003*, published by the Centers for Medicare and Medicaid Services.

included prescription drugs (either for all beneficiaries or for certain subgroups), transplants, and transportation.

Prescription Drug Rebates

All but one of the responding states include some or all of their prescription drug costs in their capitation rates. Of the 17 states that provided information on how manufacturer rebates are handled, 4 of them (24 percent) reported that they adjust their rates to reflect the payments that the *states* receive under the federal rebate program (based on their FFS drug spending). The remaining 13 states (76 percent) adjust their rates based on the rebates received by the *plans* under their own agreements with pharmaceutical manufacturers or pharmacy benefit managers. These results are shown below in Table 6.

Table 6: Adjusting Capitation Payments for Prescription Drug Rebates

Based on rebate that the ***state*** receives:	**CA, CO, CT*, MA**
Based on rebates that the ***plans*** receive	**AZ, DC, HI*, IN*, KS, KY, MI*, MO, NJ, OH*, OR, PA, SC**

*Denotes states with proxy responses.

C. Risk Adjustment and Risk Sharing

In the third set of questions, the survey inquired about risk adjustment factors, which are intended to mitigate differences in risk profiles between plans to limit adverse selection, and risk sharing mechanisms, which are designed to limit gains and losses realized by participating plans. As shown in Table 7, when states were asked what factors are used in defining rate cells, age was the most common factor cited (95 percent of the states). Gender and eligibility category are each used by 86 percent of the states, and location or geographic region is used by 76 percent of the states.

Table 7: Factors Used to Define Rate Cells

Factor	Number of States Using Factor	Percent of States Using Factor
Age	20	95.2%
Gender	18	85.7%
Eligibility category	18	85.7%
Location / region	16	76.2%
Other factor(s)	5	23.8%

In 62 percent of the responding states, capitation rates can vary by plan. Specifically, 38 percent indicated that capitation rates can vary based on the bids submitted by the plans or as a result of negotiations between the states and the individual plans. In another 24 percent of states, capitation rates can vary due to other factors (such as an adjustment for new plans). These results are shown in Table 8.

Table 8: Differences in Capitation Rates Among MCOs

Basis for Differences in Capitation Rates Among MCOs	Number of States	Percent of States
Rates can vary depending on bids submitted by the MCOs or as a result of negotiations between the State and MCOs	8	38.1%
Rates can vary due to other factors	5	23.8%
Rates do not vary by MCO	8	38.1%

The survey then asked respondents about risk adjustment—i.e., the variation of capitation rates according to health status. This practice is followed in 43 percent of the responding states, which generally calculate and apply the risk adjustment factors prospectively. Furthermore, more than three-quarters of this group uses the Chronic Illness and Disability Payment System (CDPS) as their risk adjustment method.

In response to questions about risk sharing, 29 percent of the responding states use risk corridors or some other method to share risk between the state and participating plans. Some examples of specific risk-sharing policies are:

- In Arizona, gains and losses for plans serving individuals covered under the state's waiver program are capped at two percent of premium (with the state receiving or absorbing any excess gains or losses).

- In Hawaii, the state covers aggregate losses above five percent but limits its total exposure to $5 million.

- Massachusetts uses risk pools for special needs populations, and Pennsylvania uses risk pools for certain service carve-outs.

- Rhode Island absorbs 70 percent of losses in excess of 1 percent above the loss threshold of 88 percent and receives 50 percent of gains of more than 2 percent below the loss threshold of 88 percent.

Nearly one-half of the responding states (48 percent) indicated that MCO contracts included financial incentives or penalties tied to quality-of-care standards. For example:

- Indiana, New York, and Ohio use incentive payments and/or withholds that can be up to 1% of the capitation payment.

- Michigan employs a 25% withhold, with a formula to distribute based on quality performance.

- Missouri and New Jersey have withholds and/or penalties tied to the provision of EPSDT services.

D. Administrative Costs and Profits

The next set of questions addressed administrative costs and profits. First, respondents were asked how case management costs were allocated between "medical" and "administrative" components. Just less than one-half of the responding states give plans free rein to decide how to define and classify various case management activities and how to allocate their costs. Of the remaining states, about one-quarter (roughly 10 percent of the total) mandate exactly how specific activities and their associated costs are to be classified. The remaining states impose general guidelines that the plans have to follow, but defer to the judgment of the plans' management on the details of implementing these guidelines. The results for this question are presented in Table 9a.

Table 9a: Classification of Costs for Case Management Programs

Does the State specify how case management costs are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs?		
Response	**Number of States**	**Percent of States**
The State mandates exactly how specific case management activities are to be defined and/or how their costs are to be allocated	2	10.5%
The State defines general principles by which case management activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified or how the costs for activities are to be allocated	7	36.9%
It is left to the MCOs to decide how case management activities are to be defined and how their costs are to be allocated	10	52.6%

As shown below in Table 9b, slightly different answers were obtained when respondents were asked a similar question for other "combination" services, such as disease management, transportation, or translation services.

Table 9b: Classification of Costs for Other Combination Services

Does the State specify how costs for other "combination" services are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs?		
Response	**Number of States**	**Percent of States**
The State mandates exactly how specific activities are to be defined and/or how their costs are to be allocated	4	21.0%
The State defines general principles by which such activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified or how the costs for these activities are to be allocated	6	31.6%
It is left to the MCOs to decide how specific activities are to be defined and how their costs are to be allocated	9	47.4%

Next, the survey asked about the methods by which states derive gross capitation rates from the net benefit costs. Almost all of the states apply a multiplicative factor to the net rates; one state also adds a flat dollar amount (i.e., its administration-and-profit load includes both fixed and variable components). About 14 percent of the responding states use some method other than a multiplicative factor or a fixed dollar amount. In most states, the administration-and-profit factor does not vary by plan or by rate cell. Interestingly, several of the plans asserted that the administration-and-profit load in their state is based on budget considerations or on a specific

savings target as compared to projected FFS costs, even though neither of these factors are among those listed by CMS as forming the basis for actuarially sound rates. The ranges of factors used for the administrative load and for the profit/contingency load, as well the range of combined factors used by the responding states, are shown in Table 10.

Table 10: Administration and Profit/Contingency Factors

Component of Load	Range of Factors
Administration	8% to 15%
Profit / Contingency	0% to 3%
Combined	**8% to 18%**

When respondents were asked which data sources and methods are used to determine administration-and-profit factors, the most often cited source was the financial statements of the participating plans (used by 86 percent of the states). Table 11 shows the full set of responses.

Table 11: Data Sources and Methods Used to Determine Administration-and-Profit Component of Capitation Rates

Data Source or Method	Number of States	Percent of States
A review of past financial statements for participating MCOs	18	85.7%
Discussions with participating MCOs	7	33.3%
A review of past financial statements for other, similar MCOs	6	28.6%
A literature review on appropriate administrative and profit loads	5	23.8%
A literature review on the actual expense-and-profit ratios achieved by MCOs	3	14.3%
A literature review on actual loads used by MCOs in pricing & rate filings	3	14.3%
Other sources and methods	7	33.3%

E. Actuarial and Other Issues

In the vast majority of the responding states, the rate development and supporting analysis is performed by the same firm that does the actuarial certification. Fifty-five percent of the states (11 state respondents) use Mercer as their consulting actuarial firm, while 15 percent (3 state

respondents) report using Milliman. Six states (30 percent) report using other firms, such as Deloitte & Touche and PricewaterhouseCoopers. (Lewin does the rate development and actuarial certification for two states that are not among those that were surveyed.)

Near the end of the survey, respondents were asked a series of open-ended questions. First, the survey inquired about what types of background data are shared by the state with the participating (or proposing) plans during the rate-setting process, and how the plans are otherwise engaged in the process. About 16 percent of the responding states use what is described as a "collaborative" process between the state and the plans to develop the rates. Seventy-two percent of the states provide at least some information on the data and methods used in the rate-setting process, although *detailed* information on both of these topics—as opposed to just a high-level overview—is provided by only 37 percent of the states (or only 9 percent, if we look at just the plan responses). In the remaining 12 percent of the states, plans have, at best, only limited participation in the rate-setting process.

Respondents also were asked about the type of information provided by the state regarding trend factors used in the rate-setting process. Seventy-nine percent of the responding states provide the plans with the trend factors that they use, broken out by category of service. Also, 37 percent of the states provide at least some information on the data and methods used to determine trends, but only one state respondent (five percent) provides detailed information on these topics. In about 11 percent of the states, little or no information regarding the trends used in the rate-setting process is shared with the plans.

Finally, the survey asked respondents to report the overall rate increase from each of the last two rate-setting cycles. As shown in Table 12, the average overall rate increase was 5.6 percent in FY2004 (with a range of 0.0 percent to 13.7 percent) and 6.1 percent in FY2005 (with a range of -1.6 percent to 14.0 percent). Note that the overall rate increases, like the trend assumptions shown in Table 5, occupy a surprisingly wide range. Again, this is indicative of the latitude that actuaries generally have in choosing their methods and assumptions, and the deference to their judgment that regulators and (especially) courts have traditionally granted.

Table 12: Rate Increases from Most Recent Rate-Setting Cycles

Fiscal Year	Lowest Increase	Average Increase	Highest Increase
2004	0.0%	5.6%	13.7%
2005	-1.6%	6.1%	14.0%

In the aggregate, the range and average for the overall rate increases for FY2004 and FY2005 are similar to the range and average for the overall trend assumptions shown in Table 5. However, when we look at overall trends and rate increases on a state-by-state basis, there turns out to be very little correlation between the trend assumption in a given state for a given year and the resulting rate increase in the same state for the same year. Figures 1 and 2 show scatter diagrams that plot each state's rate increase for the indicated year against the overall trend

assumption for the same state and year, along with a regression line for all the states taken together in each year. One can see at a glance that the points in each graph (each of which represents the rate increase versus the overall trend assumption for an individual state) do not even come close to lining up along the regression line. The correlation coefficients (R^2) of 0.0272 for 2004 and 0.0456 for 2005 confirm this; a commonly used interpretation of these numbers is that, on a scale of zero percent to 100 percent, there is only a 2.72 percent correlation between the rate increases and corresponding trend assumptions in 2004 and only a 4.56 percent correlation in 2005.

Figure 1: Rate Increases in Individual States versus Corresponding Overall Trend Assumptions (FY2004)

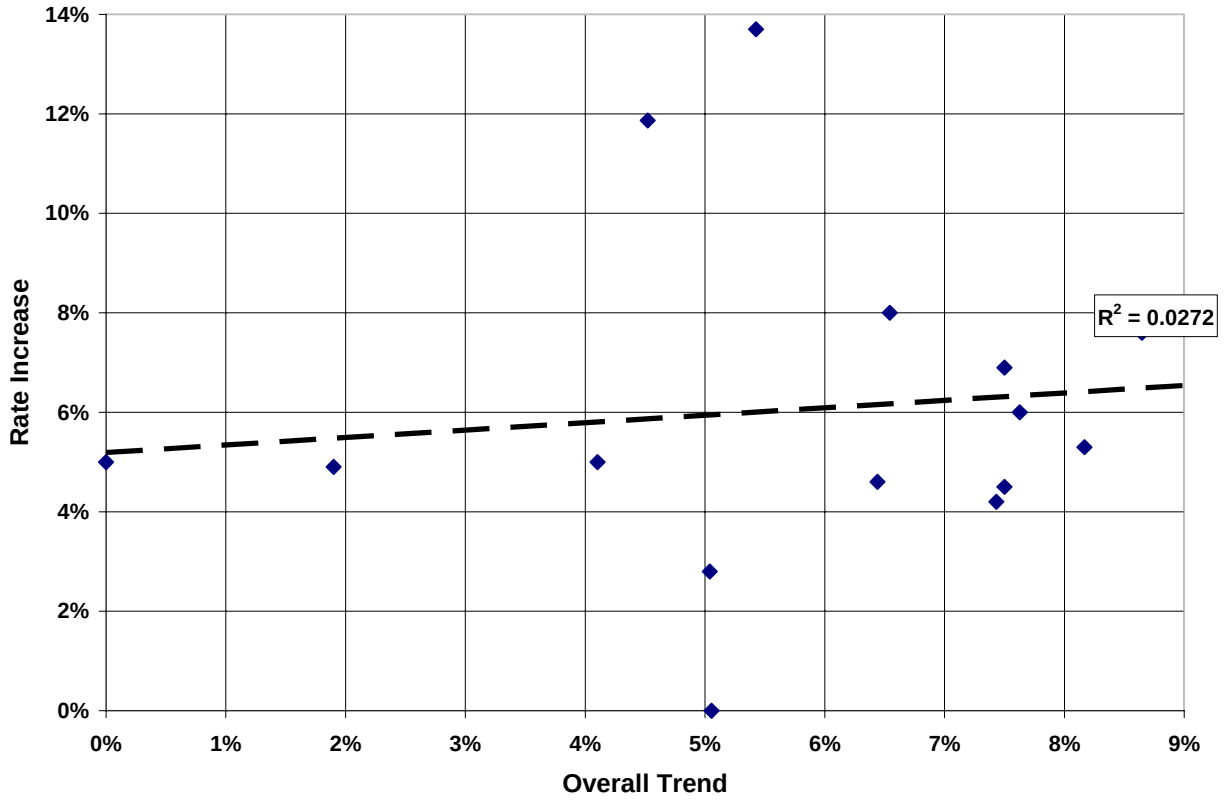
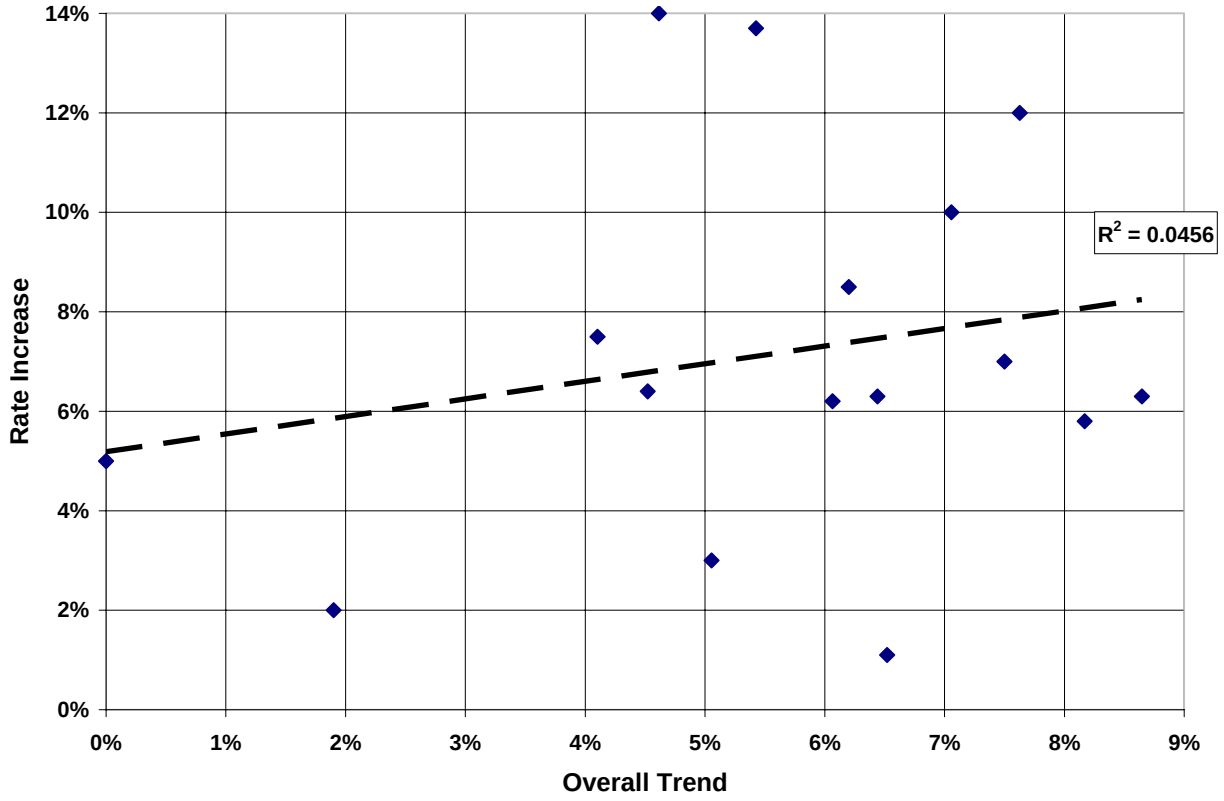


Figure 2: Rate Increases in Individual States versus Corresponding Overall Trend Assumptions (FY2005)



F. Additional Questions for the Plans

Three additional survey questions were asked of the plans but not the states. First, the plans were asked how state budget constraints were reflected in the rates and whether this resulted in explicit limits being placed on rate increases. As we mentioned previously, budget constraints are not among the factors listed by CMS as forming the basis for actuarially sound rates. Nevertheless, 32 percent of the respondents (representing plans operating in 19 percent of the states for which we have plan responses) indicated that payment rates are explicitly budget-driven. Another 21 percent of the plans (in 25 percent of the states) said that budget constraints affect the trends and other assumptions and factors used in the rate development, while five percent of the plans (in six percent of the states) noted that their states tend to choose rates that are at the bottom of the actuarially sound range. Only 26 percent of the plans (in 31 percent of the states) stated categorically that state budget constraints do not affect their states' Medicaid managed care payment rates, while another 16 percent of the plans (in 19 percent of the states) said either that budget constraints are not explicitly mentioned or that they are not sure if budget constraints are a factor in the rate-setting process. These results are summarized in Table 13.

Table 13: Health Plan Perceptions of Relationship Between Rates and Budget Constraints

Plan-Reported Relationship Between Rates and Budget Constraints	Number of States	Percent of States
Rates are explicitly budget-driven	3	18.8%
Budget constraints affect factors used in rate derivation	4	25.0%
State uses bottom of actuarially sound range	1	6.3%
Not explicitly stated / Not sure	3	18.8%
Budget constraints do not affect rates	5	31.3%

Second, MCOs were asked to rate the states where they operate in terms of the openness and fairness of the rate-setting process. Results on this question slightly favored the states, with 38 percent of respondents ranking their state's openness and fairness as "very high" or "moderately high" (mostly the latter), compared with 29 percent of respondents answering "moderately low" or "very low." The remaining one-third (33 percent) ranked their state as "average" in terms of openness and fairness.

Finally, the survey asked the plans whether there is an open exchange of information between their state and its participating plans, and whether the rates that result from the whole process adequately and accurately reflect the plans' costs of providing Medicaid benefits. One-half of the plans (10 plan respondents) reported open exchange of information, while the other half of the plans (10 plan respondents) said that, while there is some exchange of information, the process is not as open and collaborative as it could or should be. On the overall rate-setting process and the resulting rates, 28 percent of the plans (5 plan respondents, in 29 percent of the responding states) said that the process and the rates generally reflect all factors that have a material impact on the plans' cost of providing benefits. However, 39 percent of the plans (7 plan respondents, in 37 percent of the states) said that their state generally is not responsive to their concerns, even if the plans believe that not all relevant information is being taken into account. In other words, even if the state is willing to accept additional data from the plans and allow them to present their questions, concerns, or suggestions about the rate-setting process, it rarely negotiates with them openly or makes any changes to the rates as a result of receiving the additional information. The remaining 33 percent of the plans (6 plan respondents, in 35 percent of the states) are in between, saying that, although they occasionally are able to influence the rate-setting process by providing comments or additional information to the state, in the end the rates still do not necessarily reflect all the factors that influence the plans' costs.

V. CONCLUSIONS

Medicaid agencies are under considerable fiscal pressure due to very low rates of overall state revenue increases, anticipated federal reductions to Medicaid, and Medicaid costs that are growing due both to increases in eligibility and to the forces that drive per capita health care costs upward. The MCO model is widely regarded as a key vehicle for helping states achieve

reductions in the rate of projected cost growth without imposing cuts on eligibility, benefits, or provider payment rates. The actuarial soundness provision of the BBA seeks to enhance or at least stabilize the managed care model's role in the Medicaid arena.

However, this study demonstrates that the actuarial soundness provision to date seems to have had very little bearing on the rates ultimately paid to MCOs. Key actuarial factors such as cost trends do not seem to be at all correlated with actual MCO rate increases, for example. Neither CMS regulations nor existing Actuarial Standards of Practice require states or their actuaries to share information regarding the rate-setting process with participating plans. Furthermore, generally accepted actuarial principles and practices traditionally have given actuaries wide latitude in setting assumptions and choosing and applying the methods by which they derive their results. Because of this, it generally is not possible to specify the expected width for a rate range that would be considered actuarially sound—the concept of actuarial soundness can be stretched to fit almost any rate range. And while it is not clear whether CMS guidance allows a state to select *any* rate within an actuarially sound range (as opposed to having to use the *unique* rate representing the actuary's "best estimate" of per capita health care costs), the guidance does not specifically prohibit a state from selecting the lowest possible rate in a given range in one rate period or over multiple years. Given the regulatory option to pay MCOs at the lowest rate deemed "actuarially sound," states need to consider the long term implications of paying at the low end of the range year on year.

If health plans expected that, when CMS issued its Medicaid managed care regulations, health plan premiums would be decoupled from state budget considerations (including the "would be" cost of the state providing the same benefits under a traditional FFS arrangement), then this expectation has been only partly fulfilled. Plans in one-half of the responding states perceive that rates are explicitly budget-driven, or that budget constraints indirectly affect the rates by influencing the assumptions made (either the cost trends or the administration-and-profit load), or that budget constraints lead states to choose a rate increase that is at or near the bottom of the actuarially sound range. In contrast, plans in less than a third of the states believe that rates are not affected by budget constraints. Regardless of whether or not—or to what extent—payment rates are explicitly budget-driven, the revenues received by Medicaid health plans and their providers are, it appears, inextricably linked to the budget reality in which the states operate.

This means that rate increases may not be closely tied to estimated or actual cost trends, but may be more correlated with observed MCO financial performance in prior year(s) and with overall state budget issues. Additional study is warranted to determine the most appropriate sources of data for trending and rate-setting, along with ground rules for data sharing processes and the most appropriate basis from which to develop an "actuarially sound" rate. Findings of our study suggest that CMS, states, and MCOs need to collaborate to add more detail to the existing actuarial soundness provision. Among other things, specifics could include data sharing and trending methods.

SURVEY OF MCOS:

Rate-Setting for Medicaid Managed Care Plans

(NOTE: Please provide separate answers for each state in which you operate a Medicaid health plan.)

1. OVERVIEW

a. Rate-setting cycle

- How often does the rate–setting process take place (regardless of whether the State is recalculating base year costs or simply trending forward the prior rates)?
  _____ Annually
  _____ Every 2 years
  _____ Every 3 years
  _____ Other (*please specify:* _____)
  (Note: For the remaining questions, the term "rate-setting cycle" will refer to the period of time indicated above.)

- How often are base year costs recalculated?
  _____ Annually
  _____ Every 2 years
  _____ Every 3 years
  _____ Other (*please specify:* _____)

- For what period of time is a given capitation rate schedule effective?
  _____ 6 months
  _____ 1 year
  _____ 2 years
  _____ Other (*please specify:* _____)

- During a single rate-setting cycle, for how many future periods does the State develop rate schedules?
  _____ One
  _____ Two (for example, setting both the Year 1 rate schedule and the Year 2 rate schedule for a two-year contract at the same time, prior to the beginning of the contract period)
  _____ Other (*please specify:* _____)

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b. Type of rate-setting

- Which of the following best describes the rate-setting process? *(Check all that apply [if more than one] and explain in the space below)*

  _____ Rates are specified by the State, and individual MCOs either agree to accept these rates, or they decline to participate in the State's Medicaid managed care program

  _____ Rates are based on bids submitted by the MCOs, with the State accepting all bids that fall within the State's independently determined acceptable bid range

  _____ Rates are based on bids submitted by the MCOs, with the State accepting only the lowest qualified bid (or otherwise limiting the number of MCOs with which it will contract – *please provide details below*)

  _____ Rates are based on MCO-submitted bids, which may be adjusted based on negotiations with the State

  _____ Other (*please describe below*)

  _____

  _____

  _____

  _____

2. MEDICAL COSTS

a. Overall data, methods, and trends

- What data are used to measure or estimate the base year medical costs that form the basis of the capitation rates? (*Please check all that apply*)

  _____ Fee-for-service (FFS) claims

  _____ Encounter data

  _____ MCO financial statements

  _____ Other (*please specify:* _____
  or describe below)

  _____

  _____

- What data, methods, or sources does the State utilize to determine the trends that are used to project the base year costs forward to the contract year(s)? (*Please provide details below*)

  _____

  _____

  _____

  _____

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- To what extent does the State check or reconcile its data (for both base costs and trends) against the data held by the MCOs?
  _____ The State does not check its data against the MCOs' data
  _____ The State checks its data against the MCOs' data, but does not attempt to reconcile any differences (*please provide details below*)
  _____ The State reconciles some or all of the discrepancies it finds between its data and the MCOs' data (*please provide details below*)

_____
_____
_____
_____

- What trend factors were used in the last two rate-setting cycles? (*Please provide separate percentages or factors by type of trend [e.g., price vs. utilization] and by type of service [e.g., hospital, physician, drug, behavioral health, dental, and "other"], to the extent that the State's rate-setting process reflects such distinctions*)

_____
_____
_____
_____
_____
_____
_____
_____

b. Excluded Services

- What categories of service, if any, are excluded from the capitation rates (i.e., the MCO is not responsible for providing)? (*Please check all that apply*)
  _____ Prescription drugs
  _____ Behavioral health services
  _____ Dental services
  _____ Other *(please describe below)*
  (Also, if for one or more of the categories listed above, the State excludes some but not all services from the capitation rates, please provide details below)

_____
_____
_____
_____
_____

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- If prescription drugs are included in the capitation rates, how are drug manufacturers' rebates reflected in the rate-setting process?
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of base-year FFS drug spending that was offset by payments received by the State under the federal rebate program
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of contract-year (i.e., future) FFS drug spending that is expected to be offset by payments received by the State under the federal rebate program
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of base-year managed-care drug spending that was offset by payments received by the MCOs under their own agreements with pharmaceutical manufacturers (or with their pharmacy benefit managers)
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of contract-year (i.e., future) managed-care drug spending that is expected to be offset by payments received by the MCOs under their own agreements with pharmaceutical manufacturers (or with their pharmacy benefit managers)
  _____ Other (*please describe below*)
  _____
  _____
  _____
  _____
  _____

3. RISK SEGMENTATION, ADJUSTMENT, AND MANAGEMENT

a. Variation by rate cell and by MCO

- What factors are used in defining rate cells? (*Please check all that apply*)
  _____ Age
  _____ Gender
  _____ Eligibility category
  _____ Location (geographic region)
  _____ Other (*please specify:* _____)

- Do capitation rates vary by MCO?
  _____ No, the same capitation rate schedule is used for all MCOs, except to the extent that different MCOs are covering different subsets of the eligible population, such as TANF vs. SSI (*skip to Section 3b*)
  _____ Yes, capitation rates may vary by MCO

- On what basis can the capitation rates vary by MCO? *(Check all that apply [if more than one] and explain in the space below)*
  _____ Capitation rates can vary depending on the bids submitted by the MCOs
  _____ Capitation rates can vary as a result of negotiation between the State & MCOs
  _____ A formula-based rate differential is determined by the State (*please describe)*
  _____ Other (*please describe below*)

  _____

  _____

b. Variation by health status

- Are the capitation rates risk-adjusted by health status?
  _____ No (*skip to Section 3c*)
  _____ Yes

- Is the risk-adjustment method applied prospectively or retrospectively?
  _____ Prospectively: Prior to the beginning of the contract year, risk scores for an MCO's enrollees, based on past (i.e., base year) claims data for those individuals, are used to calculate the adjustment factors that will be applied to the capitation rate schedule to determine the actual monthly payments that the MCO will receive
  _____ Retrospectively (a.k.a. Concurrently): After the end of the contract year (or after the month for which an adjustment is being calculated), risk scores for an MCO's enrollees, based on the individuals' claims during the contract year (or during the month for which an adjustment is being calculated), are used to calculate an adjustment or reconciliation amount that will be paid either by the State to the MCO (if the MCO's average risk level is above the baseline risk level incorporated in the capitation rate schedule) or by the MCO to the State (if the MCO's risk level is below the baseline risk level)
  _____ Other (*please describe below*)

  _____

  _____

  _____

- What risk-adjustment method is used?
  _____ Adjusted Clinical Groups (ACGs)
  _____ Chronic Illness and Disability Payment System (CDPS)
  _____ Diagnostic Cost Groups (DCGs – including the Principal In-Patient [PIP] and Hierarchical Condition Category [HCC] variants)
  _____ Other (*please specify or describe below:* _____

  _____

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c. Risk sharing

- Is a risk corridor or other arrangement for sharing risk between the State and the MCOs used? (An example of a risk corridor arrangement would be the sharing of the portion of a loss [actual minus expected claims] in excess of 5% of expected claims on a 50%-50% basis between the State and the MCO)
  _____ No
  _____ Yes (*please provide details below*)
  _____
  _____
  _____

- Does the managed care contract provide for an incentive payment, penalty, or withhold that is tied to the MCO's performance with regard to quality-of-care standards?
  _____ No
  _____ Yes (*please provide details below*)
  _____
  _____

4. ADMINISTRATIVE COSTS AND PROFITS

- Does the State specify how case management costs are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs? *(Check all that apply [if more than one] and explain in the space below)*
  _____ The State mandates exactly how specific case management activities are to be defined and/or how their costs are to be allocated
  _____ The State defines general principles by which case management activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified, or how the costs for these activities are to be allocated
  _____ It's left to the MCOs to decide how case management activities are to be defined and how their costs are to be allocated
  _____ Other (*please describe below*)
  _____
  _____
  _____

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- Does the State specify how costs for other "combination" services – such as disease management, transportation, or translation services – are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs? *(Check all that apply [if more than one] and explain in the space below)*
  _____ The State mandates exactly how specific activities are to be defined and/or how their costs are to be allocated
  _____ The State defines general principles by which such activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified, or how the costs for these activities are to be allocated
  _____ It's left to the MCOs to decide how specific activities are to be defined and how their costs are to be allocated
  _____ Other (*please describe below*)
  _____
  _____
  _____

- How does the State derive the gross capitation rates (i.e., including the administrative cost and profit component) from the net (i.e., "medical-only" or "benefit-only") capitation rates?
  _____ The State applies a multiplicative factor (e.g., based on a target percentage of medical costs, or of total costs) to the net capitation rates to derive gross rates
  _____ The State adds a flat dollar amount (e.g., "$X.yz per member per month") to the net capitation rates to derive the gross rates
  _____ Some other method or combination of methods is used (*please describe below*)
  _____
  _____

- Does the administration-and-profit factor or amount vary by rate cell?
  _____ No
  _____ Yes (*please explain below*)
  _____
  _____

- Does the administration-and-profit factor or amount vary by MCO?
  _____ No
  _____ Yes (*please explain below*)
  _____
  _____

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- What data sources and methods are used to determine the administrative cost and profit component of the capitation rates? *(Check all that apply, and explain below)*
  _____ A literature review on appropriate administrative and profit loads
  _____ A literature review on the actual loads used by MCOs in their pricing practices and/or rate filings
  _____ A literature review on the actual expense-and-profit ratios (= 1 – medical loss ratio) achieved by MCOs
  _____ A review of past financial statements for participating MCOs
  _____ A review of past financial statements for other, similar MCOs
  _____ Discussions with participating MCOs
  _____ Other (*please describe below*)

  _____
  _____
  _____
  _____

- What administration and profit factors or dollar amounts were used in the last two rate-setting cycles?

  _____
  _____
  _____
  _____

5. ACTUARIAL ANALYSIS AND CERTIFICATION

- Who is the State's actuary? (*Along with the name of the individual who provides the actuarial certification, please provide the name of the firm [if applicable]*)

  _____
  _____
  _____

- Is the rate development or supporting analysis performed by the same firm (or independent actuary) that provides the actuarial certification?
  _____ Yes
  _____ No (*in the space below, please provide the name of the firm[s] that performs the rate development or supporting analysis*)

  _____
  _____
  _____

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- How often does the State obtain an actuarial certification of its Medicaid capitation rates?
  _____ Every time the rates are set (i.e., every rate-setting cycle)
  _____ Only when base year costs are recalculated
  _____ Other (*please specify or describe below):* _____
  _____
  _____

6. OTHER RATE-SETTING ISSUES

- What background data or other information (e.g., regarding methods, assumptions, sources, or State goals and priorities) does the State share with participating MCOs during the rate-setting process? What input does the State seek from participating MCOs regarding these or other aspects of the rate-setting process? In what other ways do the MCOs participate in the process?
  _____
  _____
  _____
  _____

- What information has the State provided regarding trend factors used in the rate-setting process? Has it provided separate factors by type of service (or other rate component)?
  _____
  _____
  _____
  _____

- What was the total rate increase in each of the last two rate-setting cycles? (If the rate-setting cycle was not one year in length, please also give the average annual rate increase.)
  _____
  _____
  _____
  _____

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ADDITIONAL QUESTIONS FOR THE MCOs

The above-listed questions have been sent to the state Medicaid agencies as a separate survey. The following questions are included only in the MCO survey:

- How are State budget constraints reflected in the rates? Are reduction factors applied to the rates to reflect budget cuts or limitations? Are explicit limits placed on rate increases?

  _____
  _____
  _____
  _____
  _____
  _____

- How would you rate this State in terms of the openness and fairness of its Medicaid managed care rate-setting process?

  _____ Very high (i.e., very open and fair)
  _____ Moderately high
  _____ Average
  _____ Moderately low
  _____ Very low

- In general, does the State provide useful information to participating MCOs in connection with the rate-setting process? Do the MCOs have the opportunity to submit to the State (or to discuss with State officials) all the information they have that might affect the rates? Does the rate-setting process (and the resulting set of capitation rates) adequately and accurately reflect all the factors that could affect an MCO's costs in providing Medicaid benefits or – more broadly – that could affect the profitability of an MCO's Medicaid line of business?

  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

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1. OVERVIEW

a. Rate-setting cycle

- How often does the rate–setting process take place (regardless of whether the State is recalculating base year costs or simply trending forward the prior rates)?
  _____ Annually
  _____ Every 2 years
  _____ Every 3 years
  _____ Other (*please specify:* _____)
  (Note: For the remaining questions, the term "rate-setting cycle" will refer to the period of time indicated above.)

- How often are base year costs recalculated?
  _____ Annually
  _____ Every 2 years
  _____ Every 3 years
  _____ Other (*please specify:* _____)

- For what period of time is a given capitation rate schedule effective?
  _____ 6 months
  _____ 1 year
  _____ 2 years
  _____ Other (*please specify:* _____)

- During a single rate-setting cycle, for how many future periods does the State develop rate schedules?
  _____ One
  _____ Two (for example, setting both the Year 1 rate schedule and the Year 2 rate schedule for a two-year contract at the same time, prior to the beginning of the contract period)
  _____ Other (*please specify:* _____)

b. Type of rate-setting

- Which of the following best describes the rate-setting process? *(Check all that apply [if more than one] and explain in the space below)*

  _____ Rates are specified by the State, and individual MCOs either agree to accept these rates, or they decline to participate in the State's Medicaid managed care program

  _____ Rates are based on bids submitted by the MCOs, with the State accepting all bids that fall within the State's independently determined acceptable bid range

  _____ Rates are based on bids submitted by the MCOs, with the State accepting only the lowest qualified bid (or otherwise limiting the number of MCOs with which it will contract – *please provide details below*)

  _____ Rates are based on MCO-submitted bids, which may be adjusted based on negotiations with the State

  _____ Other (*please describe below*)

  _____

  _____

  _____

2. MEDICAL COSTS

c. Overall data, methods, and trends

- What data are used to measure or estimate the base year medical costs that form the basis of the capitation rates? (*Please check all that apply*)

  _____ Fee-for-service (FFS) claims

  _____ Encounter data

  _____ MCO financial statements

  _____ Other (*please specify:* _____
  or describe below)

  _____

- What data, methods, or sources does the State utilize to determine the trends that are used to project the base year costs forward to the contract year(s)? (*Please provide details below*)

  _____

  _____

  _____

  _____

  _____

  _____

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- To what extent does the State check or reconcile its data (for both base costs and trends) against the data held by the MCOs?
  _____ The State does not check its data against the MCOs' data
  _____ The State checks its data against the MCOs' data, but does not attempt to reconcile any differences (*please provide details below*)
  _____ The State reconciles some or all of the discrepancies it finds between its data and the MCOs' data (*please provide details below*)

_____
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_____

- What trend factors were used in the last two rate-setting cycles? (*Please provide separate percentages or factors by type of trend [e.g., price vs. utilization] and by type of service [e.g., hospital, physician, drug, behavioral health, dental, and "other"], to the extent that the State's rate-setting process reflects such distinctions*)

_____
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d. Excluded Services

- What categories of service, if any, are excluded from the capitation rates (i.e., the MCO is not responsible for providing)? (*Please check all that apply*)
  _____ Prescription drugs
  _____ Behavioral health services
  _____ Dental services
  _____ Other *(please describe below)*
  (Also, if for one or more of the categories listed above, the State excludes some but not all services from the capitation rates, please provide details below)

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- If prescription drugs are included in the capitation rates, how are drug manufacturers' rebates reflected in the rate-setting process?
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of base-year FFS drug spending that was offset by payments received by the State under the federal rebate program
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of contract-year (i.e., future) FFS drug spending that is expected to be offset by payments received by the State under the federal rebate program
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of base-year managed-care drug spending that was offset by payments received by the MCOs under their own agreements with pharmaceutical manufacturers (or with their pharmacy benefit managers)
  _____ The State adjusts the drug component of the capitation rates to reflect the portion of contract-year (i.e., future) managed-care drug spending that is expected to be offset by payments received by the MCOs under their own agreements with pharmaceutical manufacturers (or with their pharmacy benefit managers)
  _____ Other (*please describe below*)
  _____
  _____
  _____
  _____

3. RISK SEGMENTATION, ADJUSTMENT, AND MANAGEMENT

e. Variation by rate cell and by MCO

- What factors are used in defining rate cells? (*Please check all that apply*)
  _____ Age
  _____ Gender
  _____ Eligibility category
  _____ Location (geographic region)
  _____ Other (*please specify:* _____)

- Do capitation rates vary by MCO?
  _____ No, the same capitation rate schedule is used for all MCOs, except to the extent that different MCOs are covering different subsets of the eligible population, such as TANF vs. SSI (*skip to Section 3b*)
  _____ Yes, capitation rates may vary by MCO

- On what basis can the capitation rates vary by MCO? *(Check all that apply [if more than one] and explain in the space below)*
  _____ Capitation rates can vary depending on the bids submitted by the MCOs
  _____ Capitation rates can vary as a result of negotiations between the State and the MCOs
  _____ A formula-based rate differential is determined by the State (*please describe below*)
  _____ Other (*please describe below*)

_____
_____
_____
_____
_____

f. Variation by health status

- Are the capitation rates risk-adjusted by health status?
  _____ No (*skip to Section 3c*)
  _____ Yes

- Is the risk-adjustment method applied prospectively or retrospectively?
  _____ Prospectively: Prior to the beginning of the contract year, risk scores for an MCO's enrollees, based on past (i.e., base year) claims data for those individuals, are used to calculate the adjustment factors that will be applied to the capitation rate schedule to determine the actual monthly payments that the MCO will receive
  _____ Retrospectively (a.k.a. Concurrently): After the end of the contract year (or after the month for which an adjustment is being calculated), risk scores for an MCO's enrollees, based on the individuals' claims during the contract year (or during the month for which an adjustment is being calculated), are used to calculate an adjustment or reconciliation amount that will be paid either by the State to the MCO (if the MCO's average risk level is above the baseline risk level incorporated in the capitation rate schedule) or by the MCO to the State (if the MCO's risk level is below the baseline risk level)
  _____ Other (*please describe below*)

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- What risk-adjustment method is used?
  _____ Adjusted Clinical Groups (ACGs)
  _____ Chronic Illness and Disability Payment System (CDPS)
  _____ Diagnostic Cost Groups (DCGs – including the Principal In-Patient [PIP] and Hierarchical Condition Category [HCC] variants)
  _____ Other (*please specify:* _____
  or describe below)

  _____
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  _____

g. Risk sharing

- Is a risk corridor or other arrangement for sharing risk between the State and the MCOs used? (An example of a risk corridor arrangement would be the sharing of the portion of a loss [actual minus expected claims] in excess of 5% of expected claims on a 50%-50% basis between the State and the MCO)
  _____ No
  _____ Yes (*please provide details below*)
  _____
  _____

- Does the managed care contract provide for an incentive payment, penalty, or withhold that is tied to the MCO's performance with regard to quality-of-care standards?
  _____ No
  _____ Yes (*please provide details below*)
  _____
  _____

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3. ADMINISTRATIVE COSTS AND PROFITS

- Does the State specify how case management costs are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs? *(Check all that apply [if more than one] and explain in the space below)*
  - _____ The State mandates exactly how specific case management activities are to be defined and/or how their costs are to be allocated
  - _____ The State defines general principles by which case management activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified, or how the costs for activities are to be allocated
  - _____ It's left to the MCOs to decide how case management activities are to be defined and how their costs are to be allocated
  - _____ Other (*please describe below*)

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- Does the State specify how costs for other "combination" services – such as disease management, transportation, or translation services – are to be allocated between "medical" and "administrative" components? Or is this left to the discretion of the MCOs? *(Check all that apply [if more than one] and explain in the space below)*
  - _____ The State mandates exactly how specific activities are to be defined and/or how their costs are to be allocated
  - _____ The State defines general principles by which such activities are to be classified as "medical" or "administrative" (or how their costs are to be allocated between the two categories), but it does not mandate how specific activities are to be classified, or how the costs for these activities are to be allocated
  - _____ It's left to the MCOs to decide how specific activities are to be defined and how their costs are to be allocated
  - _____ Other (*please describe below*)

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- How does the State derive the gross capitation rates (i.e., including the administrative cost and profit component) from the net (i.e., "medical-only" or "benefit-only") capitation rates?
  _____ The State applies a multiplicative factor (e.g., based on a target percentage of medical costs, or of total costs) to the net capitation rates to derive the gross rates
  _____ The State adds a flat dollar amount (e.g., "$X.yz per member per month") to the net capitation rates to derive the gross rates
  _____ Some other method or combination of methods is used (*please describe below*)
  _____
  _____

- Does the administration-and-profit factor or amount vary by rate cell?
  _____ No
  _____ Yes (*please explain below*)
  _____
  _____

- Does the administration-and-profit factor or amount vary by MCO?
  _____ No
  _____ Yes (*please explain below*)
  _____
  _____

- What data sources and methods are used to determine the administrative cost and profit component of the capitation rates? *(Check all that apply, and explain below)*
  _____ A literature review on appropriate administrative and profit loads
  _____ A literature review on the actual loads used by MCOs in their pricing practices and/or rate filings
  _____ A literature review on the actual expense-and-profit ratios (= 1 – medical loss ratio) achieved by MCOs
  _____ A review of past financial statements for participating MCOs
  _____ A review of past financial statements for other, similar MCOs
  _____ Discussions with participating MCOs
  _____ Other (*please describe below*)
  _____
  _____
  _____
  _____

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- What administration and profit factors or dollar amounts were used in the last two rate-setting cycles?

_____
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_____
_____

4. ACTUARIAL ANALYSIS AND CERTIFICATION

- Who is the State's actuary? (*Along with the name of the individual who provides the actuarial certification, please provide the name of the firm [if applicable]*)

_____
_____
_____

- Is the rate development or supporting analysis performed by the same firm (or independent actuary) that provides the actuarial certification?
  _____ Yes
  _____ No (*in the space below, please provide the name of the firm[s] that performs the rate development or supporting analysis*)

_____
_____
_____

- How often does the State obtain an actuarial certification of its Medicaid capitation rates?
  _____ Every time the rates are set (i.e., every rate-setting cycle)
  _____ Only when base year costs are recalculated
  _____ Other (*please specify:* _____
  or describe below)

_____
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5. OTHER RATE-SETTING ISSUES

- What background data or other information (e.g., regarding methods, assumptions, sources, or State goals and priorities) does the State share with participating MCOs during the rate-setting process? What input does the State seek from participating MCOs regarding these or other aspects of the rate-setting process? In what other ways do the MCOs participate in the process?

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- What information has the State provided regarding trend factors used in the rate-setting process? Has it provided separate factors by type of service (or other rate component)?

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- What was the total rate increase in each of the last two rate-setting cycles? (If the rate-setting cycle was not one year in length, please also give the average annual rate increase.)

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