MACPAC

Managed Care Rate Setting and Actuarial Soundness

Federal Oversight and Implications for Efficiency, Access, and Value in Medicaid

Medicaid and CHIP Payment and Access Commission

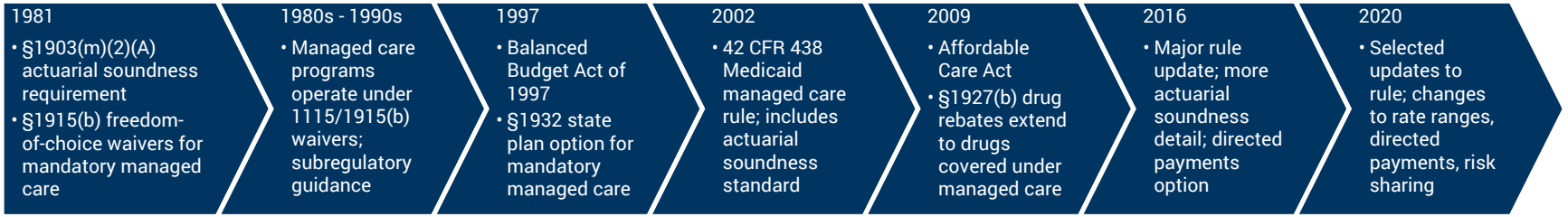
Moira Forbes and Chris Park

Agenda

- Context
- Rate setting and the actuarial soundness standard
- Findings from MACPAC study
  - Reviewed federal statutes, rules, and guidance
  - Examined recent capitation rate certifications from seven states
  - Conducted interviews with state Medicaid officials, MCO managers, actuaries, and staff from the Centers for Medicare & Medicaid Services (CMS)
- Opportunities to improve managed care rate setting

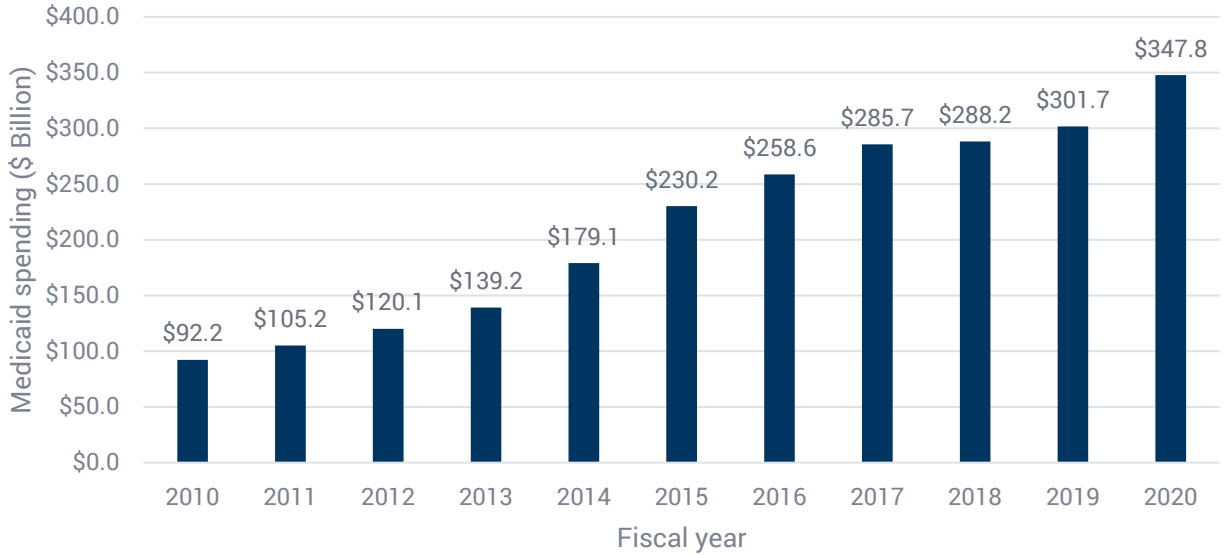
Context

States and CMS Have Operated under Current Actuarial Soundness Approach since 2002



Managed Care Spending is Growing in Absolute Terms

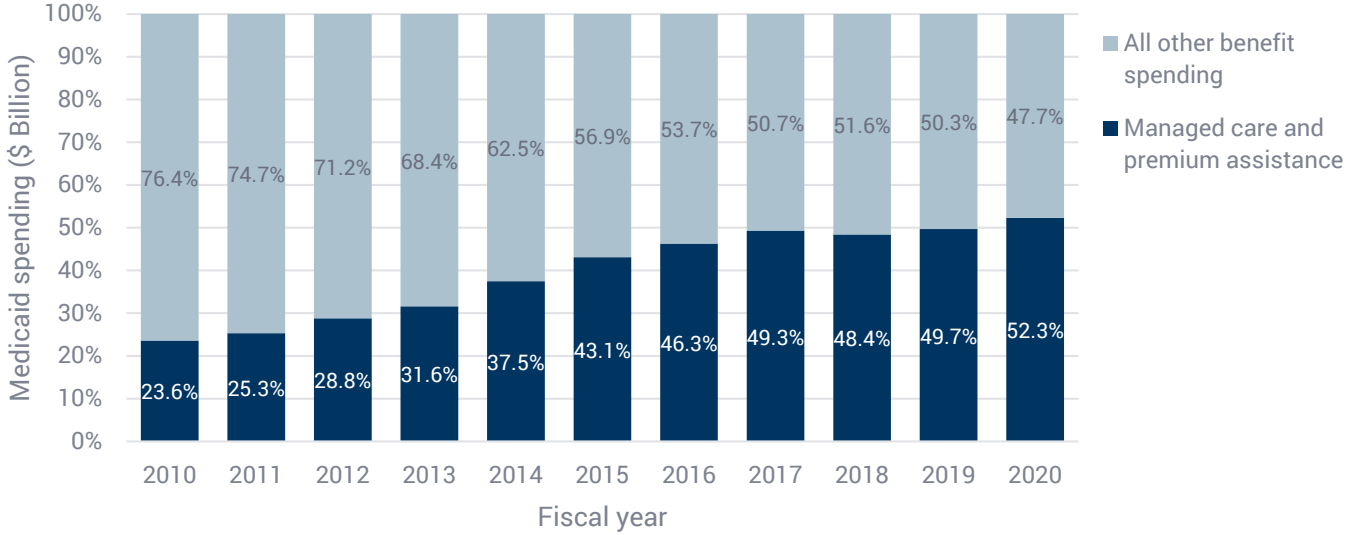
Medicaid Spending on Managed Care and Premium Assistance ($ in billions), FYs 2010–2019



Notes and sources: see slide 23

Managed Care Spending is Growing as a Proportion of Overall Spending

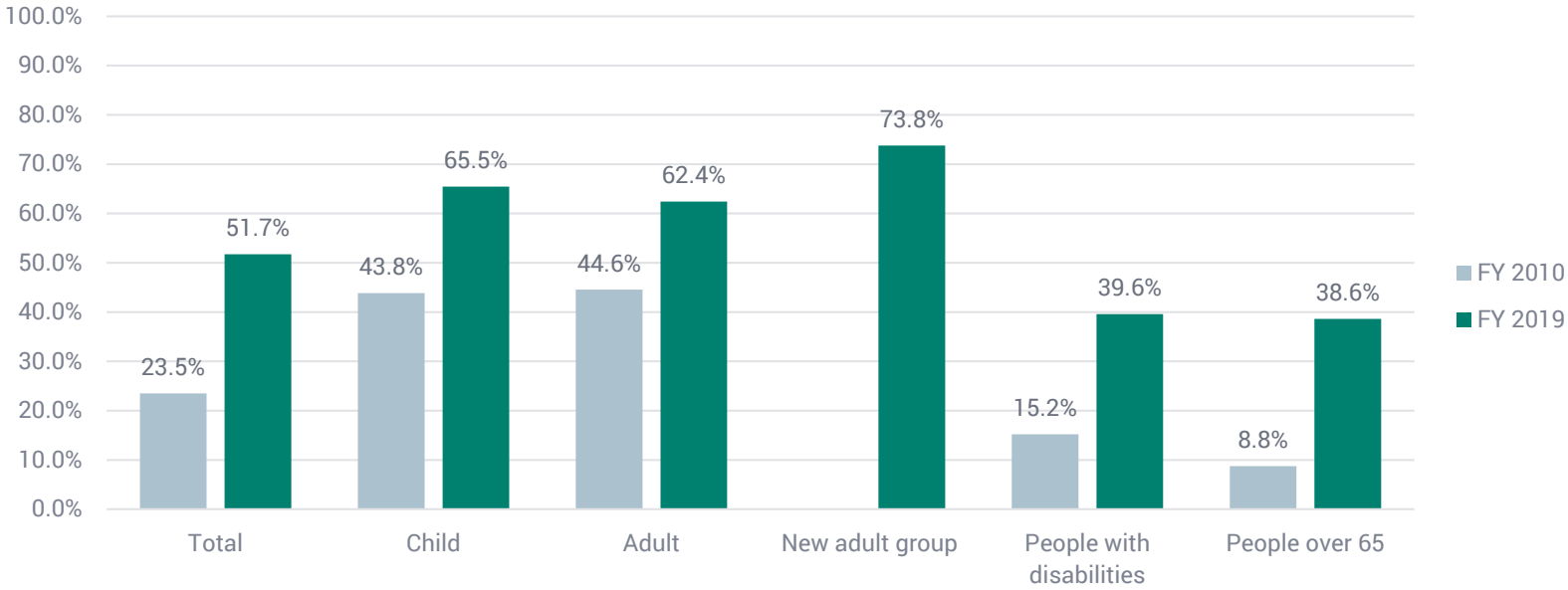
Medicaid Spending on Managed Care and Premium Assistance as a Percentage of Overall Benefit Spending, FYs 2010–2020



Notes and sources: see slide 23

Proportion of Medicaid Spending on Managed Care Is Increasing for Every Eligibility Group

Medicaid Spending on Managed Care and Premium Assistance as a Percentage of Overall Benefit Spending by Eligibility Group, FYs 2010 and 2019



Notes and sources: see slide 24

Managed Care Rate Setting and the Actuarial Soundness Standard

Focus of Work

- Capitation payment rates influence many factors that are critical to operating successful managed care programs
  - MCO willingness to contract with states
  - Solvency of participating MCOs
  - MCO ability to pay providers sufficiently
  - Access to care and quality
- Degree to which federal rate setting standards support meaningful development and review of capitation rates is an important question for federal oversight

Capitation Payments are the Basis of Payment in Medicaid Managed Care

- State Medicaid programs pay MCOs to cover a defined benefits package for an enrolled population through fixed periodic payments, also referred to as capitation payments
- Capitation payment rates are typically established prospectively and remain in effect for the duration of the 12-month rating period, regardless of changes in health care costs or service use
- Capitation rates must be actuarially sound and a certified actuary must attest that the rates submitted to CMS meet this standard

Actuarial Soundness is the Payment Standard for Managed Care

- Standard is unique to Medicaid; defined in regulation since 2002
- Rates must be:
  - developed in accordance with generally accepted actuarial principles and practices
  - appropriate for the covered population and services
    - Updated in 2016 to add: projected to provide for all reasonable, appropriate, and attainable costs required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract
  - certified by a qualified actuary
- Must also be developed and documented in accordance with additional federal rules and guidance

Capitation Rate Development Process is Managed by States

- States and their actuaries apply generally accepted actuarial methods and follow a process to develop and document rates in compliance with federal rules
  - Establish baseline costs, define rate cells, project future costs and make appropriate adjustments, estimate non-benefit costs, and address special contract provisions
- States make choices and apply actuarial judgment to advance policy goals of efficiency, access, quality, and value
  - Which risk mitigation tools to use, how much risk to shift to MCOs
  - Underwriting gain assumptions, limits on profit
  - Use of performance incentives, withholds, directed payments

Federal Review Focuses on Compliance with Actuarial Soundness Requirements

- CMS establishes rate development standards in regulation and provides details in the annual rate development guide
- Federal actuaries review state certification of actuarial soundness, underlying assumptions, and rate development documentation
  - Assess whether rates are reasonable and appropriate for the covered benefits and populations, rate development is well documented
  - Question states about areas of ambiguity or inconsistency with federal rules
- Capitation rates are reviewed as part of annual contract review
  - Check for consistency among contract, rate certification, directed payments
  - Will not approve contract or rates until both are finalized by the state
  - Approval is necessary before states can claim federal match for MCO payments

Findings

Relationship between Managed Care Payment Standards and Program Objectives

- Capitation payments are the majority of Medicaid expenditures and influence program success (e.g., MCO solvency, provider payments, enrollee access to care)
- CMS delegated to states responsibility for demonstrating that capitation rates are sufficient and retained oversight of the state rate setting process
- We conducted an extensive study to examine how federal oversight of managed care payments relates to Medicaid program objectives
  - How do federal rate setting standards and processes support the meaningful development and review of capitation rates?
  - How have states and their actuaries interpreted and applied the federal regulatory framework and guidance to achieve Medicaid managed care policy goals related to increasing efficiency, access and quality of care?

Key Findings

- Federal guidance and oversight procedures:
  - provide states with substantial flexibility to use a variety of rate setting tools to align state spending and MCO outcomes
  - focus on compliance and whether rates provide for all reasonable, appropriate, and attainable costs
  - require substantial deference to state actuaries in the absence of clear federal standards
  - do not explicitly examine whether rates represent the most efficient use of Medicaid funds, provide for adequate quality of care for enrollees, or assure that MCOs meet network adequacy and access to care standards
- Federal rules neither encourage nor prevent states from using managed care payment approaches to advance program goals

Specific Findings Relating to the Federal Oversight Process

- Current rules provide consistency and guidance in many areas of rate setting although recent changes created new questions
- There is little guidance to support review of actuarial soundness in some areas, particularly regarding access
- When CMS identifies concerns with actuarial soundness, it has limited ability to require states to make changes
- Process considerations limit the effectiveness of the rate certification documentation and review process
- MCOs have a limited role in the development, certification, and review of rates but continue to ask for more transparency

Specific Findings Relating to State Efforts to Promote Efficiency, Access, and Value

- Federal actuarial soundness rules provide substantial flexibility and opportunity for interpretation by states and their actuaries
- States manage program costs through rate setting and use various strategies to address program efficiency and plan profits
- It is unclear how far states can apply managed care flexibility under the actuarial soundness rule

Opportunities to Improve Managed Care Rate Setting

Several Potential Areas for Policy Changes

- Additional subregulatory guidance
  - Account for emerging rate setting issues (e.g., social determinants of health, promoting health equity)
  - Align goals of state directed payments with actuarial soundness requirements
- Rate review process changes
  - Develop schedule for changes to annual rate guide and shorten timeline for rate reviews
  - Clarify roles of state and federal actuaries in reviewing state directed payments
- Federal statutory and rule changes
  - Add transparency requirements to the rate development process
  - Give CMS authority to defer non-compliant components of a rate certification

Next Steps

- Commissioner feedback on opportunities for potential recommendations
- Staff will combine with feedback from next session (as appropriate) and present options at a future meeting

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March 3, 2022

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Data Notes and Sources

- Managed care spending is growing in absolute terms
  - Notes: Includes federal and state spending. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management, employer-sponsored premium assistance programs, and Programs of All-Inclusive Care for the Elderly. Comprehensive plans account for over 90 percent of spending in this category. Also includes rebates for drugs provided by managed care plans.
  - Source: MACPAC, 2022, analysis of FYs 2010–2020 CMS-64 net expenditure financial management reports
- Managed care spending is growing as a proportion of overall spending
  - Notes: Includes federal and state spending. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management, employer-sponsored premium assistance programs, and Programs of All-Inclusive Care for the Elderly. Comprehensive plans account for over 90 percent of spending in this category. Also includes rebates for drugs provided by managed care plans.
  - Source: MACPAC, 2022, analysis of FYs 2010–2020 CMS-64 net expenditure financial management reports

Data Notes and Sources, Continued

- Proportion of spending on managed care is increasing in every eligibility group
  - Notes: Includes federal and state spending. Excludes spending for administration, the territories, and Medicaid-expansion CHIP enrollees. Children and adults under age 65 who qualify for Medicaid on the basis of disability are included in the disabled category. Individuals age 65 and older eligible through an aged, blind, or disabled pathway are included in the aged category. Amounts are fee for service unless otherwise noted. Benefit spending from Transformed Medicaid Statistical Information System (T-MSIS) data has been adjusted to reflect CMS-64 totals.
  - Source: For FY 2019: MACPAC, 2021, Exhibit 18 in *MACStats: Medicaid and CHIP databook*, December 2021. For FY 2010: MACPAC, 2013, Figure 3 in *MACStats: Medicaid and CHIP Program Statistics*, June 2013.