DEPARTMENT OF HEALTH & HUMAN SERVICES
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2015 Managed Care Rate Setting Consultation Guide

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Introduction

In September 2013, the Centers for Medicare & Medicaid Services (CMS) released the *2014 Managed Care Rate Setting Consultation Guide (2014 Consultation Guide)* to states. The *2014 Consultation Guide* contained questions about critical elements for setting actuarially sound rates with respect to coverage of the new adult population in Medicaid managed care plans. The actuarial review of the rates and the use of the *2014 Consultation Guide* have increased the transparency of the rate development process and have led to a better understanding of expectations between states and CMS on Medicaid managed care rate setting and CMS' oversight of the process. In order to be transparent regarding expectations for 2015 rate setting and to prepare the way for an efficient and effective review process, CMS is releasing a *2015 Managed Care Rate Setting Consultation Guide* to all states to use when setting rates for rating periods starting in calendar year 2015 with any managed care program subject to the actuarial soundness requirements in 42 CFR §438.6. This guide, which is based on the experience from 2014, describes information that CMS expects states to provide when developing the actuarial rate certifications. This information will be the focus of CMS' review of capitation rates in 2015, and may also be helpful to states in their conversations with actuaries and managed care organizations.

This required information will help CMS and states ensure that Medicaid managed care rates meet three sets of standards:

- Medicaid managed care capitation rates and the rate development process comply with all applicable laws, regulation, and other guidance for Medicaid managed care, including that the rates have been developed in accordance with generally accepted actuarial principles and practices.
- The rate development reflects, as appropriate, program compliance with all applicable laws, regulation, and other guidance for the Medicaid program, including but not limited to eligibility, benefits, financing, any applicable waiver or demonstration requirements, and program integrity.
- The final capitation rates must be reasonable, and the documentation must be sufficient to demonstrate that the rates comply with applicable law.

CMS has developed two sections for this consultation guide. The first section applies to all Medicaid managed care capitation rates, while the second section focuses on issues specific to capitation rates for the new adult population in light of the more limited experience covering this population. This guidance builds upon the *2014 Consultation Guide*.

CMS anticipates that the information discussed in this guide is already part of the actuarial work and program management work ongoing in states. However, delineating the specific elements below provides a way to ensure that states are fully informed in advance of the information needed for federal review and state consultation and that such information is consistently addressed. CMS does not prescribe a specific format for supplying this information. Instead, CMS expects to see a discussion of the below elements in the actuarial certification, and, to expedite the review, CMS asks the state to supply page numbers where relevant information is located.

Section I. 2015 Medicaid Managed Care Rates

This section of the guidance is directed to all states setting Medicaid managed care rates subject to the actuarial soundness requirements in 42 CFR §438.6. CMS expects states and their actuaries to document all the elements described below within their actuarial certification with enough detail so that CMS is able to determine the reasonableness of the information contained in the certification for the purposes of rate development. CMS believes the documentation standards outlined below are consistent with requirements in 42 CFR §438.6 and relevant Actuarial Standards of Practice.

1. **General information**
   States should provide the following items and information in the rate certification submission:
   - A letter from the certifying actuary, who meets the qualification standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board, that certifies that the final capitation rates or rate ranges meet the standards in 42 CFR §438.6(c).
   - The final and certified capitation rates or the final and certified rate ranges for all rate cells and regions, as applicable.
   - Brief descriptions of:
     - The specific state Medicaid managed care programs covered by the certification.
     - The rating periods covered by the certification.
     - The Medicaid populations covered through the managed care programs for which the certification applies.
     - The services that are required to be provided by the managed care plans.

2. **Data**

The actuarial certification should adequately describe the data used to develop the capitation rates. States should provide the following information and identify its location in the rate certification submission:

- A description of the data used to develop capitation rates. This description should include:
    - The types of data used, which may include (but is not limited to) claims data, encounter data, plan financial data, or other Medicaid program data.
    - The age of all data used.
    - The sources of all data used.
    - To the extent that a significant portion of benefits are provided through subcapitated arrangements, a description of the data received from the subcapitated plans or providers.
    - To the extent that claims or encounter data are not used or are not available, an explanation of why that data was not used or was not available.
- Information related to the availability and the quality of the data used:
    - The steps taken by the actuary or by others (which may include but is not limited to the state Medicaid program or the managed care organizations) to validate or improve the quality and accuracy of the data.
    - Any concerns that the actuary has over the availability or quality of the data.
- Any information related to changes in data used when compared to the most recent rating period:
    - Any new data sources used by the actuary since the last certification and any data sources that the actuary has not continued to use since the last certification.
    - How the data sources used have changed since the last certification.
- Any plans or efforts to improve the data sources used for future certifications and any new data sources that are expected to be available and potentially used for future certifications.
- Any adjustments that are made to the data.

3. **Projected benefit costs**

The actuarial certification should describe the development of the projected benefit costs of the capitation rates, which should include a description of the data, assumptions, and methodologies used to develop the projected benefit costs. In general, the detail in the description for each applicable item or step should be commensurate with the importance, the magnitude, and the complexity of that item or step in the rate development process (that is, the items or steps that are most critical, have the largest impact, or are the most complex should be described in greater detail than the items or steps that are less critical, have smaller impacts, or are more simple). In addition, any material changes to the data,

assumptions, and methodologies used to develop projected benefit costs since the last certification should be described.

States should describe and identify the location of the following information in the rate certification submission:

a. Covered services and benefits

- Any changes related to the benefits covered by the Medicaid managed care organizations since the last certification, including but not limited to:
    - More or fewer state plan benefits covered by the Medicaid managed care organization.
    - Requirements deemed necessary by the state to ensure access or proper delivery of covered services, for minimum or maximum levels of payment from managed care organizations to any providers or class of providers.
    - Requirements or conditions of any applicable waivers.
- For each change related to benefits covered, the estimated impact of the change on the amount of projected benefit costs and a description of the data, assumptions, and methodologies used to develop the adjustment.

b. Projected benefit cost trends

- The projected change in benefit costs from the historical period to the rating period, or trend, including but not limited to:
    - The methodologies used to develop projected benefit cost trends.
    - Any data used or assumptions made in developing projected benefit cost trends.
    - Any applicable comparisons to historical benefit cost trends or other program benefit cost trends.
    - The different components of projected benefit cost trends, including but not limited to changes in price (such as provider reimbursement rates) and changes in utilization (such as the volume of services provided).
    - Any other material adjustments to projected benefit cost trends, and a description of the data, assumptions, and methodologies used to determine those adjustments.
    - To the extent there are any differences, projected benefit cost trends by:
        - Service or category of service.
        - Rate cell or Medicaid population.

c. Other adjustments to projected benefit costs

- Any other adjustments made to projected benefit costs excluding those described above, including but not limited to:
    - The impact of managed care on the utilization and the unit costs of health care services.
    - Changes to projected benefit costs in the rating period outside of regular changes in utilization or unit cost of services.

d. Final projected benefit costs by relevant level of detail (for example, by Medicaid population or by rate cell).

4. Projected non-benefit costs

The actuarial certification should describe the development of the projected non-benefit costs of the capitation rates, including a description of the data, assumptions, and methodologies used to develop the projected non-benefit costs. The detail in the description for each applicable item or step should be commensurate with the importance, the magnitude, and the complexity of that item or step in the rate development process (that is, the items or steps that are most critical, have the largest impact, or are the most complex should be described in greater detail than the items or steps that are less critical, have smaller impacts, or are more simple). In addition, any material changes to the data, assumptions, and methodologies used to develop projected non-benefit costs since the last certification should be described.

States should provide a description and identify the location of the following information in its rate certification submission:

- Non-benefit costs including but not limited to:
    - Administrative costs.
    - Care management or coordination costs.
    - Provisions for:
        - Cost of capital.
        - Risk margin.
        - Contingency margin.
        - Underwriting gain.
        - Profit margin.
    - Taxes, fees, and assessments.
    - Any other material non-benefit costs.

5. Rate range development

In cases when the actuary develops and certifies rate ranges on behalf of a state, the rate certification should describe how the rate ranges were developed. States should provide a description of and identify the location of the following information in its rate certification submission:

- Any assumptions for which values vary in order to develop rate ranges.
- The values of each of the assumptions used to develop the minimum, the mid-point (as applicable), and the maximum of the rate ranges.
- A description of the data, assumptions, and methodologies that were used to develop the values of the assumptions for the minimum, the mid-point (as applicable), and maximum of the rate ranges.

This information may be included in the relevant sections of the rate certification or in a separate section related to rate range development. For example, a description of how certain assumptions related to projected benefits vary to develop the rate ranges may be included with the description of other information related to projected benefits, or may be included in a section that describes all of the assumptions that were varied to develop the rates.

6. Risk and contractual provisions

States should describe and explain, including identification of the location in the actuarial certification submission any risk or contractual provisions that may affect the rate or rate ranges or the final net payments to the managed care organizations. Such provisions include:

- Risk adjustment processes.
- Risk sharing arrangements, such as a risk corridor or a large claims pool.
- Medical loss ratio requirements, such as a minimum medical loss ratio requirement.
- Reinsurance requirements.
- Incentives or withhold amounts.

7. Other rate development considerations

States should address in their rate certification submission, as appropriate, several other considerations:

- All adjustments to the capitation rates, or to any portion of the capitation rates, should reflect reasonable, appropriate, and attainable costs in the actuary's opinion and must be included in the rate certification. CMS notes that adjustments that are performed at the end of the rate setting process without adequate justification might not be considered actuarially sound.

- The final contracted rates should either match the capitation rates or be within the rate ranges in the actuarial certification. This is required in total and by each rate cell.

Section II. New Adult Population Capitation Rates

This section of the guidance is focused on rate setting for new adult eligibility groups. It is consistent with and builds upon the *2014 Consultation Guide*. For both states that have previously covered the new adult eligibility groups in 2014 and states expanding eligibility in 2015, this section of the consultation guide describes the additional information expected from states related to the new adult eligibility groups. For states that previously covered the new adult eligibility groups through managed care, this section of the consultation guide further describes the information expected from states related to how the capitation rates or the rate development process has changed since the most recent certification. The same principles and standards of actuarial soundness that apply to capitation rates traditionally set for managed care organizations as detailed in Section I apply to rates for the new adult eligibility groups. Consistent with these principles and standards, capitation rates for the new adult eligibility groups may appropriately vary for a number of reasons, but those reasons must be documented and justified in the certification. The capitation rates may not vary only due to differences in the applicable federal medical assistance percentages (FMAPs). This section outlines elements specific to the new adult population, as CMS understands variations in available data, utilization, benefit packages or provider networks may need to be taken into account when developing these capitation rates.

1. **Data**
   In addition to the expectations for all Medicaid managed care rate certifications, the rate certification should describe any data used to develop rates for the new adult eligibility groups. For states that have already covered adults in Medicaid managed care plans, CMS expects the rate certification submission to describe any new data that was available and how the state and the actuary followed through on any plans to monitor costs and experience for the new adult eligibility groups as described in the *2014 Consultation Guide*.

2. **Projected Benefit Costs**
   The rate certification should contain adequate documentation to support the data, assumptions, and methodologies used to project the benefit costs for enrollees covered under the Alternative Benefit Plan (ABP). In addition to the expectations for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission a description of the following issues related to capitation rates for the new adult eligibility groups:

   - For states that covered new adult eligibility group in 2014:

    - Any data and experience specific to new adult eligibility groups covered in 2014 that was used to develop projected benefits costs for capitation rates.
    - Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.
- Information on key assumptions related to the new adult eligibility population (and for states that covered the new adult eligibility groups in Medicaid managed care plans in 2014, how those assumptions changed from the last certification), including but not limited to:
    - Acuity or health status adjustments (in most cases comparing new adult group enrollees to other Medicaid adult enrollees who are not disabled or pregnant).
    - Adjustments for pent-up demand.
    - Adjustments for adverse selection.
    - Adjustments for the demographics of the new adult population.
    - Differences in provider reimbursement rates or provider networks, including any documented differences between provider reimbursement rates or provider networks for the rates pertaining to the new adult eligibility groups and for other Medicaid populations.
    - Other material adjustments to the projected benefit costs of the new adult eligibility groups.
- Any changes to the benefit plan offered to the new adult eligibility groups.
- Any other material changes or adjustments to projected benefit costs.

3. Projected Non-Benefit Costs

In addition to the expectations for all Medicaid managed care rate certifications described in Section I, states should describe in their rate certification submission the following information related to the capitation rates for the new adult eligibility groups. While CMS expects that projected non-benefit costs would generally be calculated using the same assumptions as for other managed care arrangements, CMS recognizes that there may be differences for various reasons. Different assumptions or methodologies applied solely to capitation rates for the new adult eligibility groups will be considered by CMS only when supported by sufficient justification. States should include in the rate certification submission a description of the following issues related to capitation rates for the new adult eligibility groups:

- For states that covered the new adult eligibility groups in Medicaid managed care plans in 2014, any changes in data sources, assumptions, or methodologies used to develop projected non-benefit costs capitation rates since the last certification.

- Information on key assumptions related to the new adult eligibility groups (and for states that covered the new adult eligibility groups in Medicaid managed care plans in 2014, how those assumptions changed from the last certification) and any differences between these assumptions and those used to develop other Medicaid population rates, including but not limited to:
    - Administrative costs.
    - Care management or coordination costs.
    - Provisions for:
        - Cost of capital.
        - Risk margin.
        - Contingency margin.
        - Underwriting gain.
        - Profit margin.
    - Taxes, fees, and assessments.
    - Any other material non-benefit costs.

4. Final Certified Rates or Rate Ranges

In addition to the expectations for all Medicaid managed care rate certifications described in Section I, states that covered the new adult eligibility groups in Medicaid managed care plans in 2014 should provide a comparison to the final certified rates or rate ranges in the previous certification and descriptions of any other material changes to the capitation rates or the rate development process not otherwise addressed in the other sections of this guidance.

5. Risk Mitigation Strategies

States should describe the risk mitigation strategy for rates for the new adult eligibility group, including but not limited to:

- The risk mitigation strategy that will be used during the rating period.
- For states that covered the new adult eligibility groups in Medicaid managed care plans in 2014:
    - Any changes in the risk mitigation strategy from those used during 2014.
    - Any relevant experience, results, or preliminary information available related to the risk mitigation strategy used during 2014.