

Department of Health Care Services  
*Medi-Cal Managed Care  
Rate-Setting Overview  
(Rate-Setting 101)*

November 8, 2017



# **Managed Care Rate Development**

# Managed Care Rate-Setting 101: Presentation Topics

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# Overview

- \* DHCS' goals in the rate development process is to ensure rates are reasonable, appropriate, and attainable and encourage quality and efficiency in our Medi-Cal health plans, and match payment to risk.
- \* In general, DHCS uses actual health plan experience for the specified population in setting rates for the managed care populations and uses a combination of plan-specific and risk-adjusted county average experience for each plan's rates.
  - \* When populations are new to managed care and/or new to Medi-Cal other data sources may be utilized for rate development.

# Overview

- \* Rates are developed in four primary managed care models:
  - Two-Plan
  - Geographic Managed Care (GMC)
  - County Organized Health System (COHS)
  - Regional Model (includes San Benito and Imperial)
- \* Rates within each model are developed at a county specific or regional level.
  - \* Counties with small populations are grouped into regions for rate setting purposes.
- \* Actuaries certify to a rate range (Lower Bound, Midpoint and Upper Bound) that considers natural statistical variation in rate setting.



# **Actuarial Soundness & Federal and State Rate Setting Requirements**

# Actuarial Soundness

- \* Per the Managed Care Final Rule issued by the Centers for Medicare and Medicaid Services (CMS) on May 6, 2016, managed care capitation rates are “actuarially sound” if:
  - \* Projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs under the terms of the contract;
  - \* Have been developed in accordance with CMS standards and generally accepted actuarial principles and practices; and
  - \* Are appropriate for the populations to be covered.
- \* In addition to federal requirements, actuaries adhere to standards of practice published by the Actuarial Standards Board.

# CMS Review and Approval

- \* CMS Office of the Actuary (OAC) reviews Medicaid capitation rates for compliance with actuarial standards and federal requirements.
- \* Capitation rates are developed and must be submitted to CMS for a defined period of time, known as a “rating period”.
- \* For each rating period, OAC reviews the following components:
  - \* Actuarial rate methodology and rates
  - \* Actuarial certification
  - \* Projection of expenditures for the rating period
  - \* Base data (utilization and cost), base data adjustments, programmatic changes, trend, etc.

# State Statutory Requirements

Rate setting process must follow CA Welfare and Institutions Code Section 14301.1 (a) through (n):

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



# Data Used for Rate Development

# Base Data Used for Rate Development

Data specific to the Medicaid population must be used to develop rates. If data is not available, other types of data may be used and then adjusted to fit the Medicaid population. Data elements used in rate setting include:

- \* Plan-specific utilization and cost data
- \* Plan-specific encounter and claims data
- \* Fee-for-Service (FFS) data and other ad hoc data as needed

Financial statements specific to Medi-Cal operations are also reviewed.

Rates are plan-specific and developed by county/region and category of aid (COA) group.

# Category of Aid

Rates are plan-specific and developed by county/region and the following category of aid (COA) groups:

- \* **Adult**
- \* **Child**
- \* Seniors and Persons with Disabilities (**SPD**) Medi-Cal Only
- \* **SPD Dual** Eligible
- \* Optional Expansion (**OE**)
- \* Breast and Cervical Cancer Treatment and Prevention (**BCCTP**)
- \* **OBRA** (only in COHS – Napa/Solano/Yolo Counties)
- \* Long Term Care (**LTC**) Medi-Cal Only (COHS/CCI Counties Only)
- \* **LTC Dual** Eligible (COHS/CCI counties Only)

# Category of Service

Each COA is subdivided into 18 categories of service (COS):

- \* Inpatient Hospital Services
- \* Outpatient Facility Services
- \* Emergency Room Facility Services
- \* LTC Facility Services
- \* Physician Primary Care Services
- \* Physician Specialty Services
- \* Federally Qualified Health Centers
- \* Other Medical Professional Services
- \* Mental Health - Outpatient
- \* Pharmacy
- \* Laboratory and Radiology
- \* Transportation
- \* Community Based Adult Services
- \* Hospice
- \* Multipurpose Senior Services Program (CCI counties only)
- \* In-Home Supportive Services (CCI counties only)
- \* Home and Community Based Services (HCBS) Other
- \* All Other

# Base Data Sources (for SFY 2017-18 Rates)

- \* Detailed Supplemental Health Plan Data Request
  - \* Rate Development Template (RDT) - CY 2015
- \* Encounter data - Calendar Year (CY) 2015
- \* FFS data – CY 2015
- \* Examples of additional Health Plan Data Requests (to help inform rate development and /or adjustments):
  - \* Mental Health Carve-In
  - \* Behavioral Health Treatment
  - \* Hepatitis C

# Base Data Selection

- \* Actuaries analyze health plan-specific base data at the COA group, County/Region and COS levels. The data includes:
  - \* Unit Cost
  - \* Utilization
  - \* Per Member Per Month (PMPM) Cost
- \* Data is further analyzed for “credibility”, which is a measure of statistical reliability based on the size of the population.
- \* Actuaries determine if the base data includes excessive variation due to small membership or data outliers.
  - \* The identified variation and/or outliers are re-bucketed between COA and COS in a budget-neutral fashion.
  - \* A common cause of this type of variation is misreporting of health plan costs.
- \* The adjusted base data serves as the starting point for the rate development.



# Base Data Adjustments

# Base Data Adjustments

Further, adjustments are made for changes in utilization, medical cost inflation (trend), program changes or other items that are expected to change in the rating period.

- \* **Trend** – An estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period.
- \* **Program changes** – Adjustments that recognize the impact of benefit, rate or eligibility changes that took place during or after the base data period.

# Program Change Examples

- \* Annual LTC rate adjustments
- \* Hepatitis C Drug Carve-Out
- \* Mild to Moderate Mental Health Services incorporation into managed care
- \* Acupuncture (as of July 1, 2016)
- \* Non-Medical Transportation (as of July 1, 2017 and October 1, 2017)



# Efficiency Adjustments

# Efficiency Adjustments

- \* DHCS currently incorporates 3 efficiency adjustments into managed care rate-setting:
  - \* Potentially Preventable Hospital Admissions (PPA)
  - \* Maximum Allowable Cost (MAC) Pricing Adjustment
  - \* Medicare Part B/D

# Efficiency Adjustments

## Potentially Preventable Admissions

- \* Actuaries apply PPA adjustments to the managed care inpatient base data to account for levels of inefficiency and/or potentially avoidable expenses present in the health plan encounter data.
- \* PPAs are identified through the encounter data using criteria from the Agency for Healthcare Research and Quality Guide to Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI).
- \* Additional exclusions for enrollment duration and risk are part of the analysis.

# Efficiency Adjustments

## Maximum Allowable Cost

- \* Actuaries analyze the effectiveness of each health plan's pharmacy cost management.
  - \* To identify potentially avoidable costs due to reimbursement inefficiencies, actuaries utilize prior period pharmacy data and review the reimbursement contracting for generic products.
  - \* Each pharmacy claim is compared against a benchmark Medicaid MAC list for the same timeframe to create a potential cost savings amount for each claim.

# Efficiency Adjustments Medicare Part B/D

- \* Actuaries identify pharmacy claims paid for recipients who had Medicare coverage under either Part B or Part D for the base data period.
- \* These costs are removed from the base data in order to ensure projected future costs are appropriate for Medicaid.



# **Risk Adjustment**

# Risk Adjustment

- \* As of 2009/10, risk adjustment was implemented in the rate development process for all counties/regions with at least 2 health plans.
  - \* COHS counties only have a single plan in the county, therefore risk adjustment does not occur.
- \* Risk adjustment helps to capture adverse or positive selection by distributing capitation payments across plans based on the health risk of the members enrolled in each plan.
- \* It addresses the real and imagined perceptions of fairness by reducing the incentive to “cherry pick” low risk individuals and increasing the incentive to attract higher risk individuals.

# Risk Adjustment (cont.)

- \* Better matches payment to risk.
- \* Nearly half of states across the nation (and Medicare) are currently using, or are in process of implementing risk adjustment for payment purposes.
- \* County/regional-average rates are currently risk adjusted using the Medicaid Rx Model developed by University of California, San Diego.
- \* The Medicaid Rx Model uses National Drug Codes to classify individuals into various disease categories.

# County Averaging

- \* Following risk adjustments, for SFY 2017/18, final rates are blended at the following 70/30 ratio:
  - \* 70% of the rate is developed using the county/regional average.
  - \* 30% of the rate is developed using the plan-specific county/regional data.
- \* Please note, this does not currently apply to COHS (only 1 plan per county/region).

# Administrative Load & Underwriting Gain

- \* An administrative load is added to all rates to account for a health plan's operational costs.
- \* Underwriting Gain:
  - \* The low end of the rate range utilizes a 2 percent assumed load. The high end of the rate range utilizes a 4 percent assumed load.
  - \* Assumptions surrounding the Underwriting Gain load, along with Investment Income generated, are sufficient to cover at least minimum cost of capital needs for a typical health plan.

# Rate Range

- \* Actuaries certify to a rate range.
- \* The base data is built up and various adjustments (as previously described) are applied to develop a midpoint rate.
- \* Separate upper bound and lower bound trend, administration, and underwriting gain loads are utilized to develop the upper and lower bound rates.
- \* Results consider the natural statistical variation associated with components of reasonable, appropriate, and attainable rates.

# Supplemental Payments

## SFY 2017-18

A supplemental capitation payment may be developed for certain benefits and/or services with uncertain utilization and/or cost patterns.

Currently DHCS utilizes the following supplemental payments:

- \* Behavioral Health Treatment
- \* Hepatitis C
- \* Maternity – excluding COHS
- \* HCBS (CCI counties only)

# Managed Care FFS Carve-Outs

As of SFY 2017-18 a subset of managed care beneficiaries' services are provided through the FFS delivery system. These include but are not limited to:

- \* Blood Factor Drugs
- \* AIDS Drugs
- \* Major Organ Transplant - except Kidney
- \* All Waiver Services
- \* California Children Services (CCS) - except in San Mateo, Santa Barbara, Solano, Napa, Yolo, and Marin counties<sup>1</sup>
- \* Extended LTC – except in COHS and CCI counties.
- \* Psychotropic Drugs
- \* Multipurpose Senior Support Program (MSSP) – except in CCI counties

<sup>1</sup>Note the Department is working on a Pilot, Whole Child Model which will carve-in all COHS CCS benefits/services (except Ventura County) into managed care beginning July 1, 2018.



**Questions?**