



Medicaid and CHIP Managed Care Final Rule (CMS-2390-F)

**Rate Setting, Medical Loss Ratio
and Delivery System Reform**

Center for Medicaid and CHIP Services



Background

This final rule is the first update to Medicaid and CHIP managed care regulations in over a decade. The health care delivery landscape has changed and grown substantially since 2002.

- Today, the predominant form of service delivery in Medicaid is managed care, which are risk-based arrangements for the delivery of covered services
- The Children's Health Insurance Program Reauthorization Act of 2009 adopted key Medicaid managed care provisions for CHIP
- Many States have expanded managed care in Medicaid to enroll new populations, including seniors and persons with disabilities who need long-term services and supports, and individuals in the new adult eligibility group
- In 1998, 12.6 million (41%) of Medicaid beneficiaries received Medicaid through capitation managed care plans
- In 2013, 45.9 million (73.5%) of Medicaid beneficiaries received Medicaid through managed care (MCOs, PIHPs, PAHPs, PCCMs)
- As of December 2015, there are 25 states with approximately 2.7 million (73%) children enrolled in managed care in separate CHIP programs

Goals of the Final Rule

This final rule advances the agency's mission of *better care, smarter spending, and healthier people*

Key Goals

- To support State efforts to advance **delivery system reform** and **improve the quality of care**
- To strengthen the **beneficiary experience of care** and key beneficiary protections
- To strengthen program integrity by **improving accountability and transparency**
- To **align** key Medicaid and CHIP managed care requirements with other health coverage programs

Key Dates

- Publication of Final Rule
 - On display at the **Federal Register** on April 25th
 - Published in the **Federal Register** on May 6th (81 FR 27498)
- Important Dates
 - Effective Date was July 5th
 - Provisions with implementation date as of July 5th
 - Phased implementation of new provisions primarily over 3 years, starting with rating period for contracts starting on or after July 1, 2017
 - Compliance with CHIP provisions beginning with the state fiscal year starting on or after July 1, 2018
 - Applicability dates/Relevance of some 2002 provisions

Rating Period Examples

Provisions with implementation date of the rating period for contracts starting on or after July 1, 2017

Calendar Year contract and rating period cycle	Implementation of provisions for the rating period for contracts starting January 1, 2018
State Fiscal Year contract and rating period cycle (assuming July-June cycle)	Implementation of provisions for the rating period for contracts starting July 1, 2017
Federal Fiscal Year contract and rating period cycle (or State Fiscal Year that runs on FFY cycle)	Implementation of provisions for the rating period for contracts starting October 1, 2017
Any other contract and rating period cycle	The contract and rating period that starts after July 1, 2017

Resources

- Medicaid.gov – Home and Managed Care Pages
 - Link to the Final Rule
 - 8 fact sheets
 - Implementation timeframe table
 - 2002 Regulation
 - Slides from past webinars
 - Link to the CMS Administrator’s “Medicaid Moving Forward” blog
- ManagedCareRule@cms.hhs.gov

Topics for Today's Presentation

- Actuarial Soundness Requirements
- Rate Development Standards and Rate Certification Requirements
- Medical Loss Ratio
- Delivery System Reform
 - In-Lieu-of-Services
 - Capitation Payments for Enrollees with a Short-Term Stay in an Institution for Mental Disease
 - Incentive Arrangements
 - Withhold Arrangements
 - Delivery System Reform and Provider Payment Initiatives

Actuarial Soundness

- **1903(m)** of the Social Security Act requires that capitation rates paid to managed care organization be actuarially sound in order for a State to receive FFP on the capitation payment
- **438.4(a)**: Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract

Actuarial Soundness – July 5, 2016

- **438.4(b)(1):** Capitation rates have been developed in accordance with standards specified in §438.5 (rate development standards) and generally accepted actuarial principles and practices
- **438.4(b)(1):** Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of FFP associated with the covered populations
- **438.4(b)(2):** Capitation rates are appropriate for the populations to be covered and the services to be furnished under the contract

Actuarial Soundness – July 5, 2016

- **438.4(b)(5):** Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell
- **438.4(b)(6):** Be certified by an actuary as meeting the applicable requirements of 42 CFR 438, including that the rates have been developed in accordance with the requirements specified in §438.3(c)(1)(ii) and (e)
 - 438.3(c)(1)(ii): State plan services and additional services for compliance with mental health parity standards
 - 438.3(e): Does *not* include value-added services and includes in lieu of services if such services are authorized under the contract

Actuarial Soundness

Rating Periods on/after July 1, 2017

- **438.4(b)(7):** Capitation rates meet any applicable special contract provisions as specified in §438.6.
 - Incentive arrangements
 - Withhold requirements
 - State directed payments
- **438.4(b)(8):** Capitation rates are provided to CMS in a format and within a timeframe that meets requirements for a rate certification in §438.7

Actuarial Soundness

Rating Periods on/after July 1, 2018

- **438.4(b)(3)**: Capitation rates are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§438.206, 438.207, and 438.208.
 - Availability of services
 - Assurance of adequate capacity and services
 - Coordination and continuity of care
- **438.4(b)(4)**: Capitation rates are specific to payments for each rate cell under the contract
 - States must develop and certify a specific rate for each rate cell rather than certifying a rate range
 - **438.7(c)(3)**: States may increase or decrease the capitation rate per rate cell, as required in up to 1.5 percent without submitting a revised rate certification

Actuarial Soundness

Rating Periods on/after July 1, 2019

- **438.4(b)(9)**: Capitation rates are developed in such a way that the managed care plan would reasonably achieve a medical loss ratio standard, as calculated under §438.8, of at least 85 percent for the rate year.
- The capitation rates may be developed in such a way that the managed care plan would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under §438.8, as long as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

Rate Development Standards

438.5(b) provides that the State must follow the steps below, in an appropriate order, when developing capitation rates or explain why they are not applicable:

- Identify and develop the **base utilization and price data**;
- Develop and apply **trend factors** to base data developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles;
- Develop the **non-benefit component** of the rate;
- Make appropriate and reasonable **adjustments**;
- Take into account managed care plans' past **MLR experience**;
- If **risk adjustment** is applied, select appropriate model and apply it in a budget neutral manner

Base Data

- **438.5(c)(1):** States must provide all validated encounter data, FFS data (as appropriate), and audited financial reports that demonstrate experience for the populations under the contract to the actuary for the **3 most recent and complete years prior to the rating period**
- **438.5(c)(2):** States and their actuaries must use the most appropriate data from the data sets provided in paragraph (c)(1)
 - Base data must be derived from the Medicaid population, or if data on the Medicaid population is not available, be derived from a similar population and adjusted appropriately

Applies to rating period for contracts starting on or after July 1, 2017

Base Data

- **438.5(c)(3):** Sets forth an exception process for States that cannot base rates in accordance with the required data sets from the 3 most recent and complete years prior to the rating period
 - Request must be approved by CMS, describe why an exception is necessary, and set forth a corrective action plan to come into compliance with the base data standards no later than 2 years from the rating period for which the deficiency was identified
- **438.7(b)(1):** Rate certification must describe the base data used
 - Base data requested by the actuary;
 - Base data provided by the State;
 - Explanation of why any base data requested was not provided;
 - How actuary determined which base data set was appropriate

Trend

- **438.5(d):** Each trend must be reasonable and developed in accordance with generally accepted actuarial principles and practices
 - Must be developed primarily from actual experience on the Medicaid population or a similar population
 - Trend is a projection of future costs for the covered population and services; it should be based on what the actuary expects for that covered population and historical experience is an important consideration
 - This requirement does not prohibit the actuary from using national projections for other payer trends in addition to sources derived from the Medicaid population or similar populations

Applies to rating period for contracts starting on or after July 1, 2017

Trend

- **438.7(b)(2):** Each trend factor, including trend factors for changes in the utilization and price of services, applied to develop the capitation rates must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:
 - The calculation of each trend used for the rating period and the reasonableness of the trend for the enrolled population
 - Any meaningful difference in how a trend differs between the rate cells, service categories, or eligibility categories

Non-Benefit Component

- **438.5(e):** Non-benefit component must include reasonable, appropriate, and attainable expenses related to the following:
 - Managed care plan administration
 - Taxes
 - Licensing and regulatory fees
 - Contribution to reserves
 - Risk margin
 - Cost of capital
 - Other operations costs association with provision of services under the State plan (and for compliance with mental health parity standards) for populations covered under the contract
- Non-benefit component may be developed at the aggregate level and incorporated at the rate cell level

Non-Benefit Component

- **438.7(b)(3):** Non-benefit component must be adequately described with enough detail so CMS or an actuary applying generally accepted actuarial principles and practices can identify:
 - Each type of non-benefit expense that is included in the capitation rate (as listed on previous slide); and
 - Evaluate the reasonableness of the cost assumptions underlying each expense
- Actuary may document the non-benefit costs according to the types of costs in 438.5(e) (as listed on previous slide)

Applies to rating period for contracts starting on or after July 1, 2017

Adjustments

- **438.5(f):** Each adjustment used in the rate development process must:
 - Reasonably support the development of an accurate base data set
 - Address appropriate programmatic changes
 - Reflect the health status of the enrolled population
 - Reflect non-benefit costs
 - Be developed in accordance with generally accepted actuarial principles and practices

Applies to rating period for contracts starting on or after July 1, 2017

Adjustments

- **438.7(b)(4):** All adjustments must be adequately described with enough detail so that CMS or an actuary applying actuarial principles and practices and understand and evaluate all of the following:
 - How each material adjustment was developed and the reasonableness of the material adjustment for the enrolled population;
 - Cost impact of each material adjustment;
 - Aggregate cost impact of non-material adjustments;
 - Where in the rate setting process the adjustment was applied; and
 - A list of all non-material adjustments used in the rate development process
- **Material adjustment** is defined in 438.2 as an adjustment that has a significant impact of the development of the capitation payment such that its omission or misstatement could impact whether the rate development is consistent with generally accepted actuarial principles and practices

Risk Adjustment

- **438.5(a): Risk adjustment** is a methodology to account for the health status of enrollees via relative risk factors
- Two types of risk adjustment
 - *Prospective*: methodology derived from *historical experience* of the contracted managed care plans and applied to the capitation rates for the rating period for which the certification is submitted
 - *Retrospective*: methodology derived from *experience concurrent* with the rating period and is calculated at the expiration of the rating period
- **438.5(g):** Either approach to risk adjustment must be **budget neutral**, meaning that application of the methodology does not create a net aggregate gain or loss across all payments under that managed care program

Budget neutral requirement applies July 5, 2016

Risk Adjustment

- Documentation requirements for prospective and retrospective risk adjustment are specified at 438.7(b)(5)(i) and 438.7(b)(5)(ii), respectively
- Application of an approved risk adjustment methodology to capitation rates does not require a revised rate certification
 - However, the revised capitation rate must be updated as a payment term under the contract, per 438.3(c)

Documentation requirements apply to rating period for contracts starting on or after July 1, 2017

Medical Loss Ratio

- Managed care plans are required to calculate and report their MLR experience for each contract year (i.e., MLR reporting year) in accordance with the calculation standards in 438.8
 - *Applies to rating periods for contracts starting on or after July 1, 2017*
- Actuarially sound rates are set to achieve a MLR of at least 85%
 - *Applies to rating periods for contracts starting on or after July 1, 2019*
- States have the flexibility to set a MLR higher than 85% and/or impose a remittance requirement

Medical Loss Ratio

438.8: calculation standards for components of the MLR

- **Numerator** is sum of:
 - Incurred claims (438.8(e)(2));
 - Activities that improve health care quality as provided in the private market rules at 45 CFR 158.150 (438.8(e)(3));
 - Fraud prevention activities (438.8(e)(4)) *if private market rules adopt such a standard*
 - Note that fraud reduction efforts are part of incurred claims at 438.8(e)(2)(iii)(B)
- **Denominator** = adjusted premium revenue, which is:
 - Premium revenue (438.8(f)(2)) MINUS
 - Federal, state, and local taxes/fees (438.8(f)(3))

Delivery System Reform

In Lieu of Services

438.3(e)(2) addresses “In-lieu-of-services” (ILOS)

- Medically appropriate and cost effective alternatives to State plan services or settings
- Establishes contractual requirements for ILOS
 - State determines in general that ILOS is medically appropriate and cost effective substitute
 - Enrollee is not required by managed care plan to use the ILOS
 - Approved ILOS are authorized and identified in the managed care plan contract and managed care plan has the option to offer the ILOS to enrollees
- Establishes rate setting requirements for ILOS
 - Utilization and actual cost of ILOS are taken into account in developing the relevant service component of the capitation rate

These provisions apply as of the effective date of the final rule

Delivery System Reform

Capitation Payment for Enrollee in an IMD

438.6(e) provides that a State may make a capitation payment to a MCO or PIHP for an enrollee with a short term stay in an IMD

- **NOTE:** This is at the option of the State and the “authorization” of use of the IMD as an ILOS must be in the contract
- **PURPOSE:** To address access issues for short term acute psychiatric and substance use disorder needs
- **AUTHORITY:** The IMD is an alternative (or in lieu of) setting to the hospital setting for covered services under the State plan
- **SERVICES/SETTING:** Facility is hospital providing psychiatric or SUD inpatient care or sub-acute facility providing psychiatric or SUD crisis residential services
- **IMPLEMENTATION DATE:** July 5, 2016

Delivery System Reform

Capitation Payment for Enrollee in an IMD

- Short term length of stay is **no more than 15 days within the month** for which the capitation payment is made
 - The 15 days may be in the aggregate within the month and the total length of stay must be no more than 15 days
 - The State may make a capitation payment for an enrollee with a stay in the IMD that is longer than 15 days for consecutive months *so long as* the length of stay within each month is no more than 15 days
- If an enrollee has a length of stay of **more than 15 days** within the month, the capitation payment **is not eligible for FFP**
- Must comply with contractual requirements for ILOS *except* that the utilization for inpatient psychiatric or SUD services must be priced at the setting covered under the State plan, i.e. general hospital

These provisions apply as of the effective date of the final rule

Delivery System Reform Incentive Arrangements

- An incentive arrangement is a payment mechanism where a **managed care plan** receives additional funds over and above the capitation rate for meeting targets specified in the contract
- **438.6(b)(2)** limits the amount of the incentive arrangement to 105% of the appropriate capitation payments attributable to the enrollees or services covered by the incentive arrangement

Delivery System Reform Incentive Arrangements

- The managed care plan contract with an incentive arrangement must provide that the arrangement is:
 - For a fixed period of time and performance is measured during the rating period for the contract;
 - Not renewed automatically;
 - Made available to both public and private contractors under the same terms of performance;
 - Does not condition managed care plan participation in the arrangement on the managed care plan entering into or adhering to an intergovernmental transfer agreement;
 - Necessary for the specified activities, targets, performance measures, or quality-based outcomes as specified in the State's quality strategy at 438.340

Delivery System Reform

Withhold Arrangements

- A withhold arrangement is a payment mechanism where a portion of the capitation rate is withheld from a managed care plan and a portion or all of the withheld amount is paid when the managed care plan satisfies the targets specified in the contract
- Distinguished from a penalty under the contract
- **438.6(b)(3)**: contract must ensure that the capitation minus any portion of the withhold that is not *reasonably achievable* is actuarially sound
- Same contractual requirements as an incentive arrangement (on previous slide)

Provisions apply for the rating period for contracts starting on or after

July 1, 2017

Delivery System Reform and Provider Payment Initiatives

- **438.6(c)(1) General Rule:** The State may not direct the managed care plan's expenditures except if permitted under statute or regulation
- **438.6(c)(1)(i)-(iii)** set forth three exceptions to the general rule so that States and managed care plans may partner in delivery system reform and provider payment initiatives

Provisions apply to the rating period for contracts starting on or after July 1, 2017

Delivery System Reform and Provider Payment Initiatives

- **438.6(c)(1)(i):** State may require managed care plans to implement value-based purchasing models
- **438.6(c)(1)(ii):** State may require managed care plans to participate in multi-payer for Medicaid-specific delivery system reform or performance improvement initiative
- **438.6(c)(1)(iii):** State may require managed care plans to:
 - Adopt a minimum fee schedule for network providers
 - Provide a uniform dollar or percentage increase for network providers
 - Adopt a maximum fee schedule so long as managed care plan retains ability to reasonably manage risk

Delivery System Reform and Provider Payment Initiatives

- **438.6(c)(2)** sets forth criteria to receive written approval prior to implementation, the arrangement must:
 - Be developed in accordance with 438.4, 438.5, and generally accepted actuarial principles and practices;
 - Based on the utilization and delivery of services;
 - Direct expenditures equally using same terms of performance for a class of providers providing service under the contract;
 - Expect to advance at least one goal in the quality strategy;
 - Have an evaluation plan to measure how arrangement advanced goal in the quality strategy;
 - Not condition network provider participation on the network provider entering into or adhering to an IGT agreement;
 - Not be renewed automatically

CMS intends to issue guidance on the approval process

Delivery System Reform and Provider Payment Initiatives

- In addition, arrangements for value-based purchasing or multi-payer/Medicaid-specific delivery system reform initiatives must:
 - Make participation available, using same terms of performance, to a class of providers providing services under the contract related to the reform/improvement initiative;
 - Use a common set of performance measures across all payers and providers;
 - Not set the amount or frequency of the expenditures; and
 - Not allow the State to recoup any unspent funds allocated for these arrangements from the managed care plan

Future Presentations

In the coming weeks, we will host in depth presentations on the following topics at 12:00-1:30 EST):

July 28 – Covered Outpatient Drugs

1-844-396-8222 PIN: 997 279 759

<https://meetings-cms.webex.com/meetings-cms/k2/j.php?MTID=t69d04d2711a0a0ce391453c2a9aa3d98>

Additional Questions?

Please send additional questions to the mailbox dedicated to this rule:

ManagedCareRule@cms.hhs.gov

While we cannot guarantee individualized responses, inquiries will inform future guidance and presentations

Questions

