Milliman

Health Care Authority Rate Setting Process

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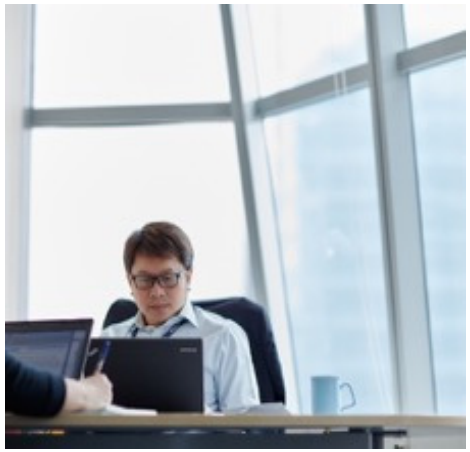
Actuarial Role

Key Players

CMS / HHS	States	Health Plans	Actuary
			
Primary financial responsibility (“buyer”) Regulation compliance	Secondary financial responsibility (“buyer”) Program design / operation	Contract performance (“seller”) implementation / day-to-day operations	Certification of compliance Independent opinion

Actuarially Sound

Section 42 CFR 438.4 definition of “Actuarially Sound Capitation Rates”:

- Have been developed in accordance with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered and the services to be furnished under the contract; and,
- Have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

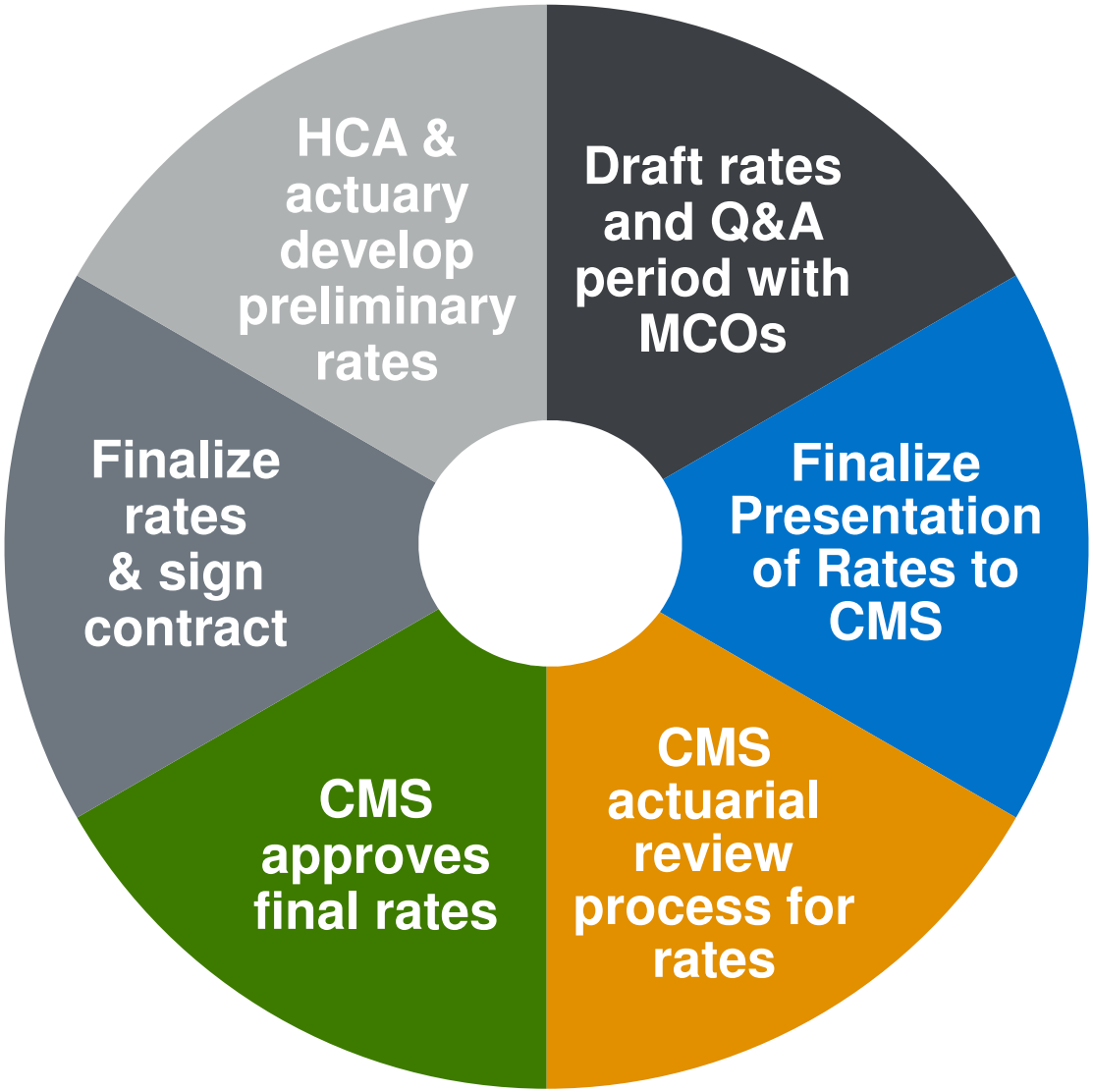
Actuarially Sound

ASOP 49, Medicaid managed care capitation rate development and certification

- Establishes guidance for actuaries preparing, reviewing, or giving advice on capitation rates for Medicaid programs, including those certified in accordance with 42 CFR 438.4.
- Effective for opinions and certifications issued on or after August 1, 2015.
- Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs.
- All certifying actuaries must comply with these standards of practice.

HCA Base Rate Development Process

Medicaid Rate Setting Cycle



Base Capitation Rate Development Process

Gather Data Sources

- Fee-for-service claims
- Managed care encounters
- Health plan financials

Apply Projection Adjustments

- Trends
- Managed care assumptions
- FFS coverage and policy changes
- State and legislative mandates
- Non-state plan services
- Reimbursement charges

Develop Blended Contracted Period Costs

Develop Base Rate Adjustments

- Administrative and contingency loads
- Other adjustment factors

Draft Base Rates

Base Data Sources

FFS Claims	Encounter Data	Health Plan Financials
– Covered services that paid on a FFS basis	– Submitted by health plans for the annual rate setting process – Includes details by hospital – Includes FFS and capitated provider payments made by the plans	– Submitted by health plans for the annual rate setting process – Includes provider payments made by the plans

Base Data Issues

FFS Claims Data

- Incomplete data set
- Inability to validate data
- Does not consider managed care differences (efficiencies, benefits, etc.)
- No provider contracting

Encounter Data

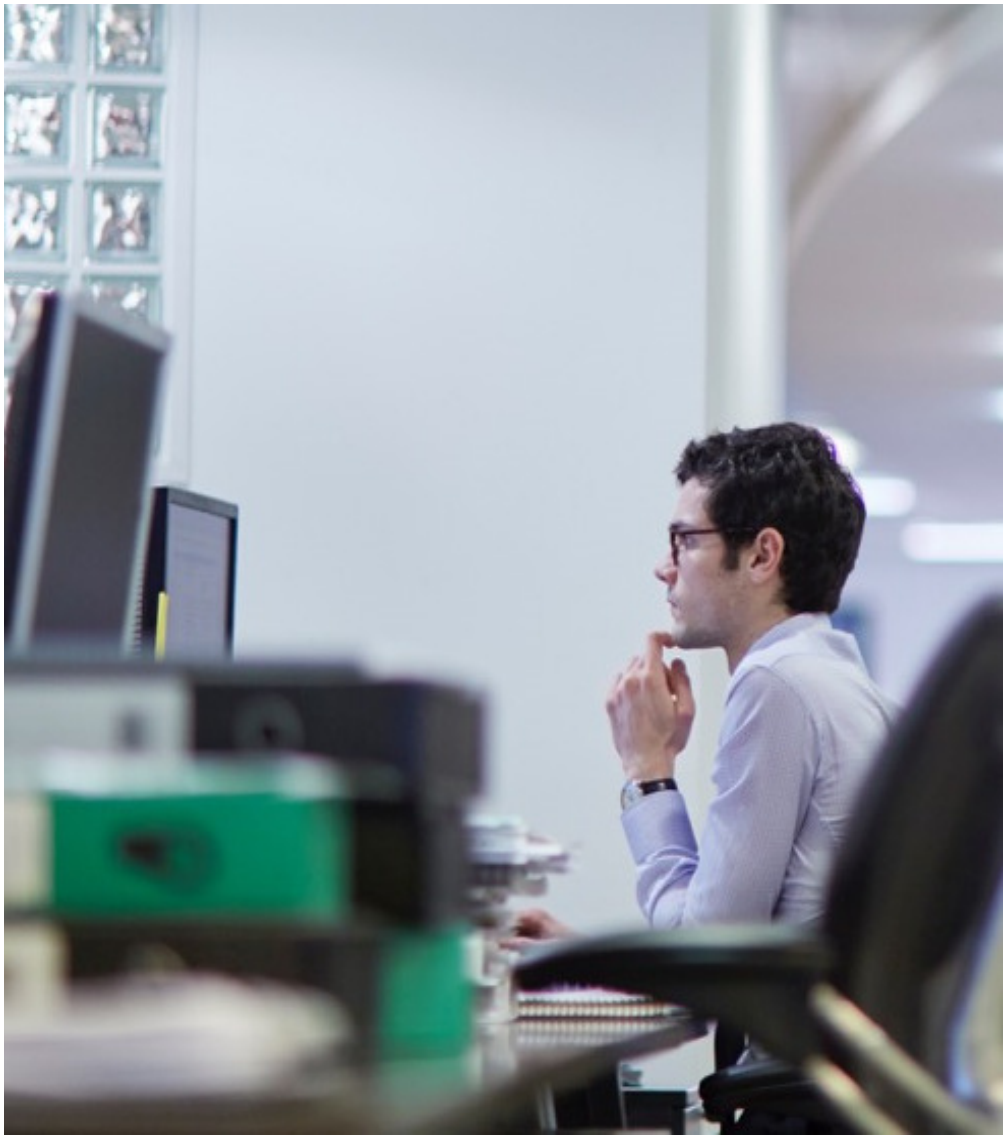
- Missing encounters
- Rejected, denied, and adjusted claims
- Incorrect paid information
- Lack of diagnosis / miscoding
- Reliance on sub-capitated vendors

Financials

- Restatement of IBNR
- Allocation / summarization of service categories
- Health plan reporting differences
- Lack of transparency
- Auditing requirements
- Comparisons to encounter data

Base Rate Adjustments

Incomplete Data Adjustments



- How do you know what is missing?
- Is the missing data a timing issue only (i.e. normal completion lag)?
- Is there also a time lag from paid to submission of encounter data?
- Are there claims that never get into data source due to edits or health plan reporting?
- What are the ways to compensate for missing data?

Managed Care Adjustments

- Is it appropriate to make further utilization adjustments to data reported by the health plans?
- What level of efficiency should be targeted?
- Which services are often targeted for additional managed care adjustments?
- What are appropriate adjustments for new programs, such as a fully integrated program?
- If using health plan cost data, how should provider reimbursement differences be considered?
- How do actuaries interpret the “attainable cost” component in the definition of actuarial soundness (AAA practice note)?

Program Changes

- How do you adjust for changes in the population or benefits from the base period to the capitation effective period?
- What adjustments should be included?
- Is there a materiality standard or probability standard?
- How do you avoid double-counting these impacts in the trend adjustment?
- Increased access to care?
- Policy changes that would modify future experience compared to historical experience?

Trend

- What is a reasonable inflation rate?
- What sources of data are available?
- How do you avoid double-counting program changes, managed care adjustments, and trend adjustments?
- Do trend rates include changes in state Medicaid fee schedules?

Integration Process

- Milliman has utilized the work done by Mercer related to MH/SA services.
- Allocate Mercer rates to Milliman program and rate cells in a budget neutral manner.
- Adjust for premium tax or costs not part of the prior contract.
- Apply Integration Adjustment if needed.
  - Developed based on prevalence by population of MH/SA needs and research related to integration saving for those with both medical and MH/SA needs.

Limitations

This presentation is intended for educational purposes only and does not replace independent professional judgment. The contents of this document are not intended to represent a legal opinion or interpretation on any matters.

This presentation is intended to support discussion during Health Care Authority meetings on Medicaid rate setting and is not complete without oral comment. Values are not to be relied upon and are for discussion purposes only.

The views expressed in this presentation are those of the presenter and not those of Milliman. Nothing in this presentation is intended to represent a professional opinion or be an interpretation of actuarial standards of practice.

This communication does not form a Statement of Actuarial Opinion under American Academy of Actuaries guidelines.

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Thank you

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