DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

2014 Managed Care Rate Setting Consultation Guide

September 2013

Introduction

Effective January 1, 2014 the Affordable Care Act (ACA) allows states to expand Medicaid eligibility to adults up to 138% of the federal poverty level based on Modified Adjusted Gross Income (MAGI) (hereinafter referred to as the new adult group). The new adult group is required to receive benefits established using an Alternative Benefit Plan (ABP). If a state intends to use health plans to deliver benefits to the new adult group, the state will need to incorporate this eligibility group into its managed care rate development process. Enactment of the ACA has not changed the requirement that states must comply with title 42 CFR 438.6 and 438.60 in the development of managed care rates that are based on appropriate assumptions and methodologies.

The Centers for Medicare & Medicaid Services (CMS) and states share the goal of developing managed care rates that accurately reflect the costs and risks of this eligibility group and any ABPs included in the managed care arrangement. Because the new adult group, and especially any expansion population included in this eligibility group, may present increased uncertainty regarding utilization and cost of health care services, CMS expects that states will submit 2014 rate setting documentation such that cost and utilization assumptions and trends, risk mitigation strategies and ABP pricing approaches are clearly specified and transparent. To assist states in this effort, CMS has developed a set of critical elements that should be considered as part of the rate development process and an associated set of questions that should be addressed in writing and submitted by states as part of their 2014 rate setting packages. These elements were developed after consultation with federal actuaries and states that have experience in both managed care and in serving expansion populations, including childless adults.

The critical elements of 2014 rate-setting include the following:

1. States should research and analyze projected costs and utilization using appropriate studies and data, as available, improve the accuracy of the rates as much as possible.

2. States should closely monitor the actual utilization and costs of the new adult group to quickly detect any significant variation from the assumptions that they factored into the managed care rates. States can take different approaches to mitigate this risk, including but not limited to setting risk corridors; establishing minimum and maximum medical loss ratios; and updating rates to reflect actual experience more often than currently done. CMS will also consider other approaches that States deem necessary and appropriate to address variation from rate-setting assumptions.

3. States should use the same assumptions to build the non-benefit component of the capitated rate for the new adult group as they use for current enrollees. Differential assumptions applied

solely to the new adult group will be considered by CMS when supported by sufficient justification.

4. The rate review package should contain adequate actuarial documentation to support the assumptions and methodologies utilized in the Alternative Benefit Package pricing. The actuary should provide sufficient documentation as described by the Actuarial Standards of Practice.

Questions

Utilization and Cost Data Sources and Assumptions

1. Please describe the data sources that the state intends to use for rate development for the new adult group.

    a) Will the state will be able to use its own encounter data and cost data when developing rates for the new adult group?
    b) What are the state-specific data sources that are being considered when developing rates? Are there national studies that have been determined relevant?
    c) Are there any other data sources being considered when developing rates for the new adult group?
    d) What utilization assumptions did the State use?
    e) If the state is using available existing data sources what, if any, adjustments to the base year utilization and cost data is being made to account for differences between that data and actual expected new adult group demographics?

2. If the state expects that Managed Care Organizations (MCOs) will have to pay higher rates to providers in order to build or maintain an adequate network to meet the needs of their expanded membership, please provide specifics of the assumptions made and how those higher rates are reflected in the cost assumptions. If these assumptions will apply only to rates for the new adult group and not to rates developed for current enrollees, please clearly disclose this approach and provide supporting narrative documenting why those higher fees will be isolated only to the provision of services to the new adult group.

3. Please describe what data sources the state intends to use to monitor the rates for the new adult group. Will the state collect actual encounter data submitted by MCOs along with the associated cost data that has been appropriately scrubbed and audited?

Risk Mitigation Strategies

1. What risk mitigation arrangements does the state expect to use to reflect the unusual level of uncertainty associated with the new adult group? Please describe both the method to be used and the parameters for the arrangement. If using a medical loss ratio, describe how the state defines medical expenses as well as administrative expenses for purpose of calculating the MLR.

2. How will the state review to effectively monitor and manage these arrangements properly? Identify specific data to be reviewed, frequency of review, etc.

3. If retrospective mitigation strategies are used, how long will it take after the end of the contract year to determine the outcome of the mitigation arrangements?

Development of Non-benefit Component of Capitated Rate

1. Please describe how the state will develop the non-benefit component of the rate (such as administrative costs, profits, reserves, etc.), including the assumptions used to build this part of the rate.

2. How do these compare to the current non- benefit component of the rates for current enrollees?

3. If different, describe the justification for any differences.

Alternative Benefit Plans Pricing (ABP)

1. How does the state anticipate pricing Alternative Benefit Plans (ABP)?

    a) If an ABP is intended to closely resemble the state's Medicaid State plan, please identify the key differences between current rate setting benefit assumptions and the ABP. In particular, please specifically identify the impacts of any substituted services (e.g. personal care for chiropractic).

    b) If an ABP is intended to closely resemble a commercial standard, please identify the key differences in benefits and the cost and/or utilization assumptions between the ABP and the current rate-setting benefit assumptions.

    c) If an ABP will include additional services or have different limitations on mental health/substance use disorder (MH/SUD) services to be consistent with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), please identify the different cost and/or utilization assumptions that will be used for these services in the ABP.

2. Please identify if any of the new adult group will be included in current rate cells/ranges, and provide justification for their inclusion.