

## **ATTACHMENT C**

### **Managed Care Capitation Rate Development (Two Plan and Geographic Managed Care Models)**

Capitation rate ranges for DHCS' managed care program are developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). In developing the capitation rate ranges, actuaries utilize selected base data such as reported encounter data, cost and utilization data reported by the managed care plans in a Rate Development Template (RDT) format, and other ad hoc data as needed. The most recently available Medi-Cal-specific financial reports submitted to the Department of Managed Health Care are also considered in the rate range development process. Adjustments are made to the selected base data to match the covered population risk and the approved benefit package for the contract period. Additional adjustments are then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Observed changes in the population case-mix and underlying risk of the plans from the base data period
- Budget neutral relational modeling for smoothing
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and Underwriting Profit/Risk/Contingency loading

Beginning with the rate year 2009/10 rate range development, DHCS took two additional steps in the measured matching of payment to risk for the Two Plan and GMC models:

1. Introduction of a maternity supplemental (kick) payment and
2. Introduction of risk-adjusted county average rates.

### **Timeline**

An RDT is typically sent to the plans in July of each year, with a requested return date to the Department of late September or early October. Plans submit RDTs for each county in which they operate. The RDT contains detailed utilization and cost experience for each category of aid and category of service. The RDT also requests information on the plans global sub-capitation arrangements, projected cost and utilization trends, enrollment, pharmacy data and other data determined to be necessary for rate development. The template includes a comparison of reported financial results to cost information.

Once the RDTs are received, the actuaries compile and analyze the information reported by the plans. Conference calls with individual health plans are scheduled beginning in December so the actuaries can review the data with plans and discuss any missing or questionable data. A discussion guide is provided to each plan prior to the call. The discussion guides typically include a summary of cost and utilization data provided in the RDT as compared to encounter data and other financial reports on file with the Department. Also included are questions regarding specific areas such as global sub-capitation arrangements, incentive payments, additional pharmacy information, and cost and utilization trends. The plan discussions typically extend through February. If any additional data needs are identified during this process, the plans are given the opportunity to amend their RDT filings and/or submit additional data as necessary. Data must be received timely in order to be included in the rate calculations.

Actuarial staff also meets with Department staff to discuss any necessary program changes to reconcile the base data to the rating period and any prospective program changes expected to be implemented during the rating period.

Once the RDT discussions are complete, the actuaries finalize their review of the base data, apply the trends and program changes, and make any managed care adjustments. These adjustments include the MAC adjustment and beginning in rate year 2012/13, the Potentially Preventable Admission (PPA) adjustment. Maternity costs are carved out of the resulting base costs and a maternity supplemental rate is developed based on projected births. A component is added for profit/loss/contingency resulting in a rate range spanning the lower to upper bound rates. An additional component is added for any taxes and quality assurance fees provided through legislation.

The resulting “base” rates are released to the Department’s fiscal forecasting division in March of each year for inclusion in the upcoming May Revise of the Governor’s Budget.

Subsequent to completion of the base rates, the actuaries continue to review data for risk analysis. Risk analysis relies on pharmacy encounter data so if the actuaries identify missing or incorrect pharmacy data from the study period, they may request additional or corrected data from the plans to complete the analysis.

Once the risk analysis is completed and rates are adjusted, any necessary updates are made to program changes to account for current policy activity. The final rates are typically released to the plans in early July, along with all available supporting documentation such as rate worksheets to allow the plans to determine how the rates were developed. Note that the State is precluded by law from releasing proprietary information obtained during the rate development process to other plans. If the rates are considered to be final, a financial package is prepared and forwarded to CMS along with the corresponding contract amendments or change orders from the Medi-Cal Managed Care Division (MMCD). CMS approval can take several months. Once the contract documents are approved by CMS, the rates can be implemented and rate adjustments will be calculated and paid by MMCD. All plan meetings and/or conference calls keep the plans updated as to the rate issues throughout the year.

## **RATE DEVELOPMENT PROCESS**

### **Base data**

The information used to form the base data for the rate range development is plan encounter data, requested plan RDT and ad hoc claims data, and Department of Managed Health Care (DMHC) required Medi-Cal-specific financial reporting. The encounter and RDT claims data include utilization and unit cost detail compiled by category of aid (COA) group, by county, by plan and by 12 consolidated provider types or categories of service (COS), including:

- Inpatient Hospital
- Physician Primary Care
- Other Medical
- Outpatient Facility
- Physician Specialty Professional
- Emergency Room Facility
- Pharmacy

- Transportation
- Long-Term Care Facility (LTC)
- Federally Qualified Health Center (FQHC)
- All Other
- Laboratory and Radiology

Utilization and unit cost information from the plan-specific encounter and RDT data is reviewed at the COA group and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost are then established for each COS within each COA group for both encounter and RDT data. This process in essence produces four potential data elements of utilization and unit cost for each COS within each COA group: 1) plan-specific encounter data; 2) plan-specific RDT data; 3) average encounter data; and 4) average RDT data. Credibility factors are applied to the data elements dependent upon the plan-specific data being reasonable and appropriate, and also based on the enrollment size of the population of the COA.

All selected base data is adjusted (as appropriate) to reflect the impact of historical program changes within the period. This is discussed further below in the “Program changes” section. The DMHC financial reporting Revenue, Expenses and Net Worth exhibits for each plan that are available at the time the rate ranges are being developed are reviewed and analyzed for insight into changes in population case-mix and underlying risk.

A requirement of 42 CFR 438.6(c)(4)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, plan encounter data serves as the starting base data for rate setting. Encounters undergo edits within DHCS to ensure quality and appropriateness of the data for rate-setting purposes. Base period plan eligibility and encounter data are extracted consistent with the appropriate COA and COS. Data and other information provided by the plans are relied on in the development of rate ranges. Mercer reviews the data and information for reasonableness, and determines if it is free of material error and suitable for rate range development purposes for the populations and services covered under the Two-Plan contracts. Mercer does not audit the data or information provided. However, Mercer does perform alternative procedures and analysis that provide a reasonable assurance as to the data’s appropriateness for use in capitation rate development under the State Plan.

### Category of Aid (Aid Code) groupings

The base data sets used to develop the capitation rate ranges are divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. (Note that GMC plans do not include separate COAs for AIDS beneficiaries.) These eight COA cohorts are:

- Adult & Family
- AIDS/Dual Eligible
- Disabled/Dual Eligible
- Aged/Disabled Medi-Cal Only
- AIDS/Medi-Cal Only
- Maternity
- Aged/Dual Eligible
- BCCTP

With the use of the maternity supplemental (kick) payment as well as risk-adjusted county average rates (each described in more detail later within this document), DHCS and Mercer are able to combine prior COAs with similar remaining underlying risk.

## Data smoothing

The managed care program is very large, covering millions of lives. In aggregate, each plan has a fully credible population base for rate-setting purposes. However, there are a number of COA groups within each county for which there is concern over specific COA group credibility. In those instances, Mercer analyzes data and information on a more aggregate level, and from this develops factors or relativities to overcome any excessive variation brought on by small membership or extraordinary (high or low) utilization or unit costs. Adjustments are made via a budget-neutral relational modeling process. No dollars are gained or lost in this process.

## Trend

Trend is 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. Mercer develops trend rates for each provider type or COS, separately by utilization and unit cost components. Trend information and data are gathered from multiple sources, including plan encounter and RDT data, plan financial statements, Medi-Cal fee-for-service experience, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and National Health Expenditures (NHE) updates, and multiple industry reports. Mercer also relies on professional judgment based upon their experience in working with the majority of the largest Medicaid programs in the country. Base data is trended forward to the mid-point of the rating period. Note that due to the relatively high level of legislatively-mandated changes surrounding LTC, LTC trends are handled through the "Program changes" section of the methodology.

## Program changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges are based on information provided by DHCS staff and reflect currently available Departmental policy and legislated changes. Program changes which are viewed to have a material impact on capitation rates are reviewed, analyzed and evaluated by Mercer with the assistance of DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch staff. Any program changes with an effective date prior to the RDT period are treated as retrospective changes.

Legislated policy changes such as Assembly Bill 1653 (AB 1653) and its successor legislation is incorporated into the actuarially sound capitation rate ranges. This policy change increased the Medi-Cal fee-for-service (FFS) inpatient payment levels in total approximately 40% and the Medi-Cal FFS outpatient hospital and emergency room payment levels in total approximately 92%. The associated managed care service category increases, being implemented at approximately 60% of the FFS increase levels, are applied to the managed care inpatient, outpatient hospital and emergency room unit costs. The specific program change for inpatient unit costs is 20.2% and the program change for outpatient hospital and emergency room unit costs is 51.0%. Because of the size of these increases to the hospital unit costs within the

capitation rates, the administrative costs and underwriting profit/risk/contingency PMPM amounts have been maintained at the levels established prior to applying the AB 1653 program change.

## Efficiency adjustments

Beginning with the 2011/12 rating period, DHCS introduced an adjustment to the capitation rates that analyzes the effectiveness of each plan's pharmacy cost management through a Maximum Allowable Cost (MAC) avoidable cost analysis. To identify potentially avoidable costs due to reimbursement inefficiencies, Mercer utilizes the plan's pharmacy data and reviews the reimbursement contracting for generic products. Each pharmacy claim is compared against a benchmark Medicaid MAC list for the same timeframe to create a cost savings amount for each claim. To calculate the cost savings amount, a derived paid amount which utilizes the unit price from the benchmark MAC list is calculated for each claim and subtracted from the actual paid amount on each claim. The total cost savings for each claim is then combined and aggregated for each plan to calculate the total cost savings for each plan. In instances where the actual paid amount is less than the derived paid amount (negative cost savings), the negative amount is counted against the cost savings amount.

Beginning with the 2012/13 rating period, DHCS is introducing an adjustment to the capitation rates that analyzes the effectiveness of each plan's management of inpatient admissions through a Potentially Preventable Admissions (PPA) avoidable cost analysis. To identify potentially avoidable costs due to preventable inpatient admissions, Mercer utilizes the plan's inpatient admission data and, using logic created by the Agency for Healthcare Research and Quality, analyzes various Prevention Quality Indicators and Pediatric Quality Indicators to determine how many admissions occurred during the study period for conditions that are determined to be avoidable. Plan results are compared to a benchmark for reasonableness. The costs savings identified is combined and aggregated for each plan to calculate the total cost savings for each plan.

## Maternity supplemental (kick) payment

To further enhance the measured matching of payment to risk, DHCS is utilizing a maternity supplemental (kick) payment. Costs for pregnant women are substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue in rates, DHCS includes a maternity supplemental payment which represents costs for the delivery event. (Pre-natal and post-partum care costs are not part of the kick payment, but remain within the respective COA capitation rates.) A plan receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified that a birth has occurred. Note that non-live birth expense data and non-live birth outcomes are excluded from the maternity supplemental payment analysis and the corresponding development of the maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the kick payment.

### Maternity kick – design

- Payment is made on delivery event that generates a state vital record
- One kick payment is allowed per delivery regardless of number of births
- There is one blended kick payment combining Caesarean and vaginal deliveries

- The kick payment varies by county, but not by plan within a county
- Kick payment reflects the cost of the delivery event only (mother and baby, excluding pre-natal and post-partum care)
- Maternity costs are carved out from the Adult & Family and Aged/Disabled Medi-Cal Only COA groups (99.9% of all deliveries)

#### Maternity kick – rate development approach

- Delivery costs are calculated by county from RDT data
  - Same general data selection process used as in regular rate range development
  - Developed smoothed data points to replace missing or unreasonable data and blend with plan-specific data
- Blend reported and smoothed costs from the plans to generate county-specific amounts
- Base costs are trended forward to the midpoint of the rating period
- Adjust for applicable program changes
- Add load for Administration and Underwriting Profit/Risk/Contingency
- Delivery counts by plan are calculated
- Calculate historical birth rates by plan (prior years reviewed for consistency)
- Project number of delivery events based upon birth rates and projected member months for applicable COA groups
- Back dollar amount from Adult & Family and Aged/Disabled/Medi-Cal Only costs by plan.

This methodology is budget neutral, projecting the same total dollar outlays under a pre- and post-maternity supplemental payment approach.

#### Risk adjustment

Capitation rates are risk adjusted using the latest version of the Medicaid Rx health-based payment model developed by the University of California at San Diego (UCSD). Risk-adjusted county average rates are blended with the historical “plan-specific” rate approach for each plan by county. The risk adjustment applies to the Adult & Family and Aged/Disabled/Medi-Cal Only COA groups only; capitation rates for other COA groups are not risk adjusted. Also, since a separate maternity supplemental payment rate has been developed, maternity costs are excluded from the risk-adjustment process. The application of risk adjustment to the capitation rates is to better match the payment to the risk. For the Aged and Disabled duals, non-pharmacy- (i.e., diagnosis-) based risk adjustment model, much of the claims history is captured through Medicare, and the majority of the dollars paid for all medical claims are covered by the Medicare benefit which complicates the use of risk adjustment for dual members. The capitation rates only represent the costs of the services not already covered through Medicare. The current cost weights developed for the Medi-Cal program assume that all managed care covered services are paid by the plans. Creating a risk-adjustment system for the dual populations would require a unique set of cost weights that account for services paid through Medicare and a methodology to overcome the data issues mentioned above. This additional level of resources with potentially limited benefit of better matching payment to the limited remaining risk for these dual eligible members is not performed. For BCCTP and AIDS, separate capitation payments are already developed for these members with narrowly defined disease conditions (e.g., breast and cervical cancer) that allow entrance into these COAs.

These separate capitation payments developed for the BCCTP and AIDS populations are not risk adjusted since they already appropriately match the payments to the risk.

The individual acuity factors in effect for the rating period are based on pharmacy encounters and claims incurred for a previous period (referred to as the study period). Lagged data is used to help complete the pharmacy claims and encounters. DHCS continues to validate encounter data and is working with the plans to support and monitor their efforts to continually improve the collection and reporting of encounter data. For example, prior to running the pharmacy encounter data through the Medicaid Rx classification system, the reasonableness of the pharmacy claims and encounter data volume is reviewed by calculating the monthly average number of claims per recipient across the plans. Additionally, analyses and reviews are performed on the pharmacy claims and encounters to measure claims without National Drug Code (NDC) information and evaluate the validity of reported NDCs.

The prospective Medicaid Rx model is used to evaluate risk differences between the participating plans. The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the twelve-month study period. Individuals who do not meet the six-month eligibility criterion are assigned the respective MCO's average risk factor associated with that individual's rating group. Individual acuity factors are developed for each recipient. The individual acuity factors are subsequently aggregated by COA group, plan and county. To ensure that the risk-adjustment process does not increase or decrease the total amount of capitation payments, the plans' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the plan risk-adjustment factors to yield a population average of 1.0000. Each plan's own risk-adjustment factors are applied to the county average base capitation rates to arrive at each plan's risk-adjusted rate. The risk-adjusted county average rates for each plan are then blended with the historical "plan-specific" rate approach. The Medicaid Rx model has been updated by UCSD and has been further adjusted to more closely align with the risk associated with covered benefits. For example, the cost weights reflected in the national Medicaid Rx model were developed assuming a comprehensive acute care and behavioral health benefit package, and utilized over 30 states' data. UCSD staff and Mercer modified the cost weights to reflect California Medi-Cal-specific data and services covered under California's managed care program.

### Blended "plan-specific" and risk-adjusted county average rates

In an effort to encourage and reward cost efficiencies and effectiveness, DHCS uses a blended "plan-specific" and risk-adjusted county average rates approach. Blending the approaches does not impact actuarial soundness, but enhances DHCS program goals.

"Plan-specific": While a large number of rate-setting factors/components/loads are **not** plan-specific (items such as utilization trend, unit cost trend, program changes, administration and underwriting profit/risk/contingency are model specific), at the mid-point the medical expense base data has a strong relationship to recent MCO claims experience. For this reason this approach has often been referred to as "plan-specific" ratesetting.

Risk-adjusted county average rates: County-specific rates are developed on a weighted average (using projected member months) basis to maintain budget neutrality. All health plan data/experience in a county considered in the "plan-specific" approach are considered here. The county-specific approach is obviously already done for the DHCS County Organized Health Systems (COHS) model. In Mercer's opinion, with two or more plans in a county, best practice

is to also incorporate the use of risk adjustment, where a plan's plan-specific budget-neutral risk scores are applied to the applicable county-specific rates. The blending is done in accordance with the percentages noted in MMCD All Plan Letter 11-015.

## Administration and underwriting profit/risk/contingency loading

The administration loading is developed in aggregate and is expressed as a percentage of the capitation rate (i.e., percent of premium). This mid-point percentage is developed from a review of the plans' historical reported administrative expenses. Mercer also utilizes its experience and professional judgment in determining the range of administrative load percentages to be reasonable. This provides an overall targeted aggregate administrative percentage; however, the administrative expense associated with each COA group varies from the overall percentage. The administrative component can be viewed in two pieces: a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting salaries, rent and information systems, while the variable cost component represents items such as claims processing and medical management costs per eligible. Allocating the administrative costs as a uniform percentage of each of the COAs is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

Certain COA groups have capitation rates ten (or more) times larger than other COAs. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive COA ten (or more) times larger than the administrative component for the less expensive COA groups. While a more expensive eligible is probably more administratively intensive, this ten (or more) to one relationship in administrative costs is most likely exaggerated. If the fixed component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation rate for the more expensive COA groups. This concept is applied in a budget-neutral fashion (no administrative dollars gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population. Mercer implicitly and broadly considers the cost of capital within the rating assumptions. Assumptions surrounding the underwriting profit/risk/contingency load, as well as income a plan generates from investments, are analyzed to determine if they are sufficient to cover at least minimum cost of capital needs for the typical health plan.

## Rate ranges

To assist DHCS, Mercer provides DHCS rate ranges which are developed using an actuarially sound process. The COA group-specific rate ranges are developed using a combination of a modeling process which varies the medical expense (i.e., risk) trend, the administration loading percentage and the Underwriting/Profit/Risk/Contingency loading percentage to arrive at both an upper and lower bound capitation rate. The final contracted rates agreed to between DHCS and each MCO fall within the rate ranges provided by Mercer. Typically, the State pays rates at the lower bound of the rate range. If funds can be located to replace the nonfederal portion of the rates, a rate increase may be granted up to the upper bound of the rate range.