Medicaid Managed Care Capitation Rate Development

House Committee on Appropriations Meeting

On Behalf of the State of Michigan Department of Health and Human Services (MDHHS), presented by:

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April 16, 2025

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Limitations

This presentation is intended to facilitate live discussion and should not be relied upon as a stand-alone document.

Agenda

- Rate setting roles and responsibilities
- Capitation rate development methodology
- Rate setting activity timeline
- Rate amendment considerations

Rate setting roles and responsibilities

Rate Setting Roles and Responsibilities

- Almost all states contract with an independent actuary to certify Medicaid managed care rates as part of risk-based managed care contracts
- Actuaries develop capitation rates in accordance with federal requirements under 42 CFR §438.4 – including actuarial soundness – and Actuarial Standards of Practice (ASOPs)
- Actuarial soundness requires rates to be:
  - Adequate to cover reasonable, appropriate costs
  - Developed using generally accepted actuarial principles
  - Certified by a qualified actuary
- States submit rate certification to CMS for federal review and approval
- CMS and its Office of the Actuary review all assumptions, trends, and methodologies to ensure rates align with federal standards

Note: further information regarding regulations and ASOPs for Medicaid rate setting is provided in the appendix of this presentation.

Rate Setting Roles and Responsibilities

State Medicaid Agency

- Sets policy goals & coverage design
- Defines assumptions for rate development (e.g., rating period, rate cells)
- Contracts with qualified actuary
- Submits rates to CMS for review
- Assess appropriateness of mid-year adjustments

Independent Actuary

- Develops actuarially sound capitation rates/amendments
- Prepares documentation & assumptions
- Certifies rates per federal and actuarial standards
- Provides certification materials for state review and final approval

CMS

- Reviews state-submitted rates/amendments
- Verifies compliance with federal rules
- Independent actuarial review (including assessing assumptions, trends, and methods)
- Ensures consistency across states
- Approves or requests changes to rates

Capitation rate development methodology

Michigan's Medicaid Managed Care Programs

Program Name	Contracted Provider	Program Description
Comprehensive Health Care Program	9 Medicaid Health Plans (MHPs)	All physical health services, adult dental, pharmacy, and mild-to-moderate mental health for the majority of Medicaid enrollees in the state
Behavioral Health Program	10 PIHPs	Specialty behavioral health and home-and-community-based individuals with SMI, SED, SUD, and IDD
MI Choice Program	20 MI Choice Waiver Agents	Nursing facility level of care (NFLOC) eligible residing in an HCBS setting
MI Health Link Program	9 Integrated Care Organizations (ICOs)	Medicaid and Medicare dual eligible beneficiaries in select regions
Healthy Kids Dental Program	2 Dental Care Organization (DCOs)	Comprehensive dental services excluding orthodontics for children under the age of 21

Projected benefit expense development

- Typically utilize experience from most recent completed prior year (SFY 2025 rates are developed from SFY 2023 experience)
- Project cost of providing services in a future rating period
- Consider emerging experience as available

Fully loaded capitation rates

Projected benefit expense

+

Non-benefit expense allowance

×

Regional and risk Adjustment

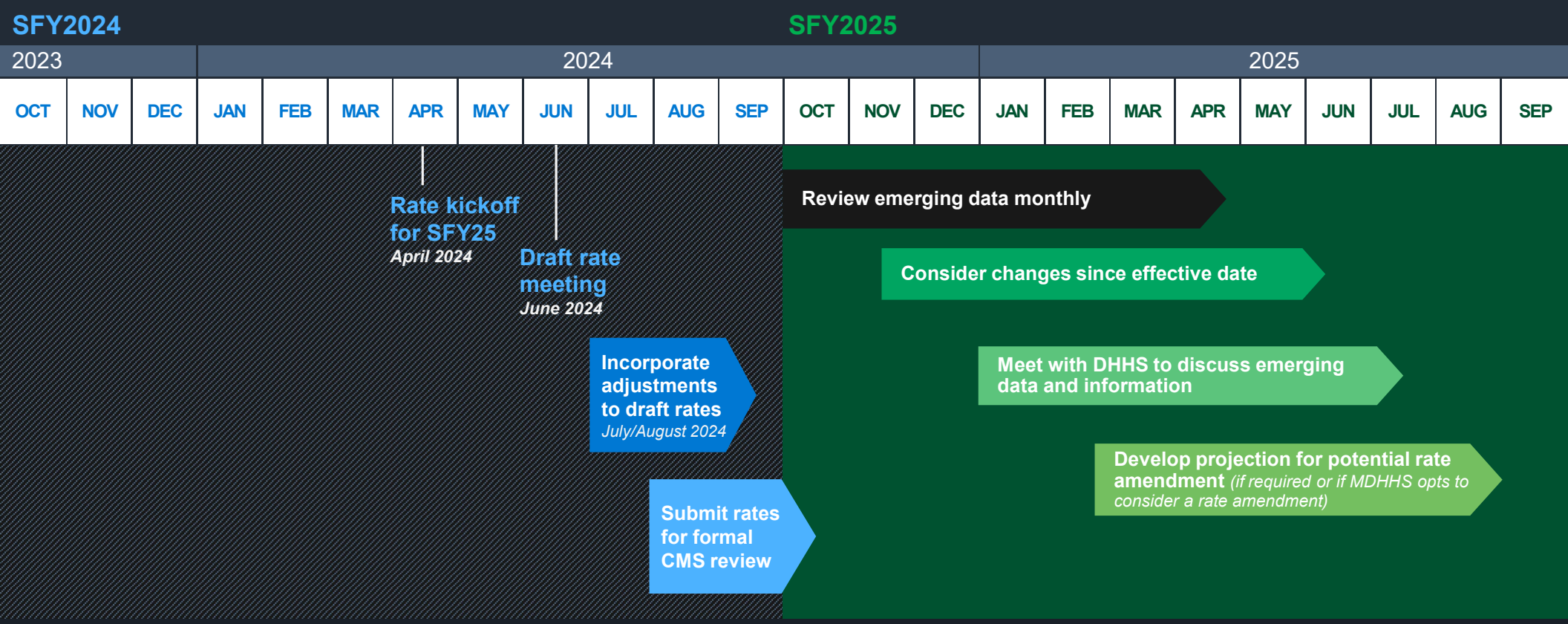
=

Plan-Specific Capitation Rates

Rate setting activity timeline

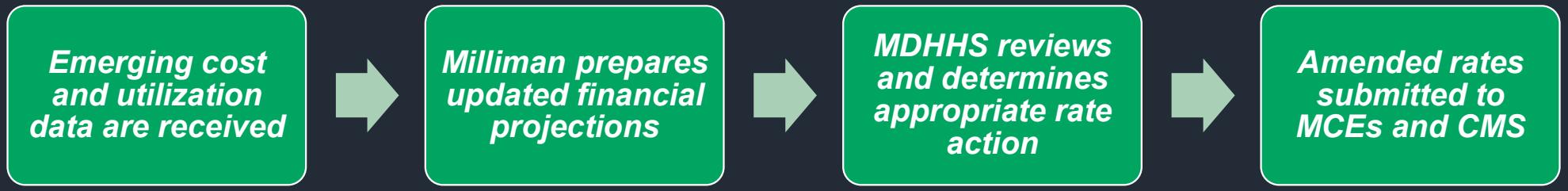
Timeline of rate setting activities

Timeline reflecting general rating activities prior to and during the SFY, illustrated for the SFY 2025 Rating Period



Rate amendment considerations

Rate amendment process



Milliman processes claim data monthly to support reviewing more recent information that was not available during rate development

Projection scenarios assess cost drivers by program including emerging data and policy/program changes

MDHHS provides guidance on rate decision following internal discussion

Note that certain changes may require specific rate changes per actuarial standards

Rate amendments are utilized by most states - Observed this for 15+ years

Things we are watching in SFY 2025

- ***State minimum wage and paid sick leave***
- ***Increased utilization of services, including but not limited to:***
  - *High intensity behavioral health services*
  - *ABA services*
  - *Office administered treatments*
- ***State fee schedule increases***
  - *Fee schedule increases tied to Medicare*
  - *Dental*
  - *Nursing facility*
- ***Continue to evaluate uncertainties associated with Public Health Emergency (PHE) unwinding impacts***
  - *American Academy of Actuaries: PHE "created unprecedented changes in healthcare policy and in the utilization and delivery of healthcare services"*
  - *Availability of post-PHE data provides more insight into these changes*

Limitations and Qualifications

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Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The presenters are members of the American Academy of Actuaries and meet the qualification standards for this presentation.

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Thank you

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Appendices/Reference Materials

Federal regulations and guidance

42 CFR 438.2. ***Capitation payment*** means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

42 CFR 438.4(a). Actuarially sound capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract.

CMS 2390-F. The Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) further define actuarial soundness and required additional transparency in the rate setting process.

CMS Guidance and Oversight. CMS releases a rate setting guide outlining all federal standards for rate development and describes information required in actuarial rate certifications. The CMS Office of the Actuary reviews each rate certification submitted to CMS.

https://www.medicaid.gov/medicaid/managed-care/downloads/2024-2025-medicaid-rate-guide-01222024.pdf

Additional standards and guiding principles

Actuaries must uphold Actuarial Standards of Practice (ASOPs), including but not limited to ASOP 49, which was specifically developed to support Medicaid managed care capitation rate setting.

Actuarial Soundness Definition from ASOP 49.

"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. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

As stated in ASOP 49, "the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual MCO".