
**A PRIMER ON MEDICAID MANAGED CARE CAPITATION RATES:
UNDERSTANDING HOW MASSHEALTH PAYS MCOs
(OCTOBER 2015)**

KEY POINTS COVERED IN THIS PRIMER

- **Payment accuracy is important to encourage appropriate access to care, to foster positive health outcomes for members, and to ensure financial viability and sustainability for Managed Care Organizations (MCOs) participating in the MassHealth program.** Capitation rates are the main mechanism for paying MCOs. It is important that the capitation payments be accurate, since capitation rates influence payment rates and the incentives that MCOs incorporate into contracts with their providers, which can in turn affect access and outcomes for enrolled members.
- **Risk mitigation tools help to support payment accuracy and provide important financial protections for both the state and the MCOs.** To improve payment accuracy, state Medicaid programs can use a variety of risk mitigation tools such as risk adjustment, reinsurance and risk corridors to address the risk that MCOs face. *Risk adjustment* is commonly used to adjust each MCO's capitation rates to reflect the risk (i.e., the health status or acuity) of their specific enrollees. *Reinsurance*, sometimes also referred to as stop-loss, is a tool to account for higher than expected costs experiences by an MCO at the individual (often referred to as "outliers") or aggregate level. In instances where costs at the individual or aggregate level exceed a threshold amount specified in the contract, the state will pay the MCO all or a portion of the costs beyond the threshold. *Risk corridors* are a tool to limit the amount of financial exposure for both MCOs and the state. Using risk corridors, the state agrees to partially offset high losses experienced by an MCO, but may also require the MCO to share "savings" back with the state if actual costs are below a particular threshold. Sometimes risk is unknown or uncertain due to a new population or new service being added to the Medicaid MCO's program. Risk mitigation is the state's way of recognizing these unknowns and uncertainties.
- **Capitation rates must meet federal actuarially-sound requirements.** Medicaid programs are required to pay Medicaid MCOs capitation rates that are actuarially sound, in accordance with federal requirements developed by the Centers for Medicare and Medicaid Services (CMS). This requirement obligates the state to ensure that MCO prospective capitation rates and other revenue sources provide for reasonable and appropriate payment for the population and services covered.
- **The capitation rate development process is only as good as the data, information and assumptions that are used in the process.** State Medicaid programs use a variety of data sources including, for example, information from their own eligibility and enrollment systems as well as from medical claims submitted by contracting MCOs that captures how MCO enrollees use health care. Data is sometimes incomplete, missing or unknown. Data is incomplete, for example, due to

the lag between service and payment, or unavailable if the rate being developed represents a new population or service. The actuarial development process addresses these issues through the use of “completion factors” to complete the data and through the use of other methods to set rates for new populations and new services. For unknown populations, the actuarial development process draws upon data for populations that are similar in risk, for example, which can then serve as a proxy for the new population.

- **MCOs must be able to build cash reserves to be ready for future financial uncertainties.** MCOs must be able to build reserves by setting aside some portion of their capitation rates or savings from their capitation rate into a “reserve” account to plan for the possibility or risk of future high costs. This is a critical step for the MCO to take to prevent insolvency and to protect members (i.e., to ensure the MCO has adequate capacity to pay for incurred claims). This is important for all MCOs including not-for-profits who assume responsibility for Medicaid members. All MassHealth MCOs currently meet all Division of Insurance (DOI) requirements, and are licensed by DOI.¹
- **MassHealth pays its MCOs on the basis of rating categories, which include two rating categories for the Traditional MCO program and two rating categories for the CarePlus program and includes additional mechanisms to address financial risk.** The capitation rates for the Traditional program are established on a per member per diem basis, while the rates for the CarePlus program are established on a per member per month basis.² Rating categories are developed for each program for five different regions in the state. To address risk that is not captured by the rating categories MassHealth’s payment approach also includes the use of risk adjustment, performed on a quarterly basis for all five regions and all four rating categories paid through the Traditional and CarePlus programs. In addition, both programs include the use of risk corridors. MassHealth also requires that all MCOs have reinsurance.
- **Any capitation rate-setting process is less than perfect.** Many factors that create financial pressures for MCOs are not addressed through this capitation rate-setting process, however. The data used to establish capitation rates, for example, might reflect certain health care disparities in access or outcomes for certain population groups. Risk adjustment does not address that common issue. And, no system of risk adjustment is perfect, which is why many state Medicaid programs use a variety of risk mitigation tools creatively. Finally, state budget imperatives often limit, within the overall boundaries of actuarial soundness, a state’s ability to propose rate increases, so the rate development process inevitably bumps up against state budget realities in trying to provide adequate payment and mitigate uncertainty or losses for the MCO.

¹ All MCOs currently under contract with MassHealth comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25 (a) and 211 CMR 43:07(1) and continue to maintain an adjusted net worth in accordance with M.G.L. c 176G § 25(b) and 211 CMR 43:07(2) which are the Commonwealth’s Division of Insurance regulations. These requirements are set forth in Section 2.16 B of the contract between MassHealth and MCOs.

² All cash payments to MCOs are made on a monthly basis, however.

SECTION 1. INTRODUCTION

This primer includes an explanation of how state Medicaid programs generally pay their MCOs, the overall process for setting Medicaid managed care capitation rates and the various tools that states use to mitigate the risks that MCOs face when they assume financial responsibility for Medicaid members.

NOTE: This primer does not cover the new 2016 Medicaid Managed Care Rate Development Guide that has been released by the Centers for Medicare and Medicaid Service (CMS). This guide will apply to the setting of rates for rating periods starting in calendar year 2016 for any managed care program that is subject to the actuarial soundness requirements in 42 CFR § 438.6.

The Importance of Payment Accuracy to Access, Outcomes, and Financial Sustainability

Capitation rates are the main mechanism for paying Managed Care Organizations (MCOs). Capitation rates are a fixed amount of money, commonly expressed as a per-member per-month (PMPM) rate, that the Medicaid program pays the MCOs to assume responsibility for providing the covered populations with the covered services. The capitation rate or fixed amount that the Medicaid program will pay the MCOs depends on many variables including who the population is and what services are covered under the contract. The state Medicaid program determines how much to pay MCOs through the capitation rate development process, an important effort that the state staff conducts with its actuaries to develop an accurate payment rate for the MCO.

Accuracy is important with regard to the capitation payments, since capitation rates influence payment rates and the incentives that MCOs incorporate into contracts with their providers. This can, in turn, affect access and outcomes for enrolled members. Appropriate payment rates that adequately cover expenses, and provide MCOs the ability to make some contribution to reserves to protect against potential future expenses (which is discussed later), is critical to MCO viability and the sustainability of the MassHealth MCO program.

State Medicaid programs also use one or more risk mitigation tools including: risk adjustment, reinsurance and risk corridors. Risk mitigation tools are needed by states to address the uncertainty around the capitation rates. For example, *risk adjustment* is a tool to adjust the “base” capitation rate for the risk expected based on the health status of an MCO’s actual enrollees. *Reinsurance*, sometimes also referred to as stop-loss, is a tool to account for higher than expected costs experiences by an MCO at the individual (often referred to as “outliers”) or aggregate level. In instances where costs at the individual or aggregate level exceed the threshold specified in the contract between the MCO and reinsurer, the reinsurer will pay the MCO all or a portion of the costs beyond the threshold.³ MCOs may also opt to self-insure⁴. *Risk corridors* are a tool to limit the amount of financial exposure for both MCOs and the state. Using risk corridors, the state agrees to partially offset high losses experienced by an MCO, but may also require the

³ Per Section 4.8A of the contract between MassHealth and the MCO.

⁴ Per Section 4.8C of the contract between MassHealth and the MCO.

MCO to share “savings” back with the state if actual costs are below a particular threshold. In different ways, these tools are ways for states to make payments outside of the base capitation rates to improve the adequacy and accuracy of the capitation rates.

Finally, any strong payment system must be supported by a Medicaid program that monitors, measures and tracks access, quality and outcomes by having clear and measurable metrics.

Federal Actuarial-Soundness Requirements

Because Medicaid is a joint federal-state program, the Centers for Medicare and Medicaid Services (CMS), within the federal Department of Health and Human Services, is responsible for ensuring that capitation rates meet CMS actuarial-soundness requirements. Capitation rates are determined to be “actuarially sound,” when they are certified by an actuary and meet CMS conditions (see graphic below). CMS must approve all capitation rates, in addition to any risk mitigation provisions to ensure compliance with CMS actuarial-soundness requirements. Capitation rate ranges include a floor and a ceiling, within which state Medicaid programs are allowed to pay their MCOs. Medicaid programs cannot pay below the floor or above the ceiling of the CMS-approved rate range.

CMS ACTUARIAL-SOUNDNESS REQUIREMENTS		
Condition #1	Condition #2	Condition #3
They are certified by an actuary that meets the standards set forth in 42 CFR Section 438.6.	They are appropriate for the covered population and services.	They have been developed in accordance with generally accepted actuarial practices and principles.

The Challenge to Improve Access and Outcomes for Members

Improving access, quality and outcomes for Medicaid members is a challenging goal. Medicaid Managed Care Organizations (MCOs) serve a diversity of members from mothers and children to persons with chronic conditions and disabilities. Many members face significant adversity in their lives. Some experience significant mental health challenges, others experience homelessness, and still others experience long-term joblessness. These are all challenges that can significantly affect health care costs and outcomes, but are very difficult to capture through the rate-setting process. Yet, the desire to improve outcomes is exactly one of the major reasons why states contract with MCOs. State Medicaid programs contract with MCOs to provide members with strong care coordination, care management, and a well-organized network of providers.

SECTION 2. THE BASICS ABOUT CAPITATION RATES AND RISK MITIGATION

This section provides an explanation of how state Medicaid programs pay their Medicaid MCOs including how they develop capitation rates and the tools that state Medicaid programs may use to mitigate the risks facing MCOs. The section also highlights the importance of reserves to creating financial solvency and protecting Medicaid enrollees.

Capitation Rate Development Process

State Medicaid programs work through a complex, detailed and analytical process to develop capitation rates that are appropriate for their MCO programs.

Medicaid programs generally hire an outside actuary or rate-development team that includes an actuary. This rate-setting team works collaboratively to develop actuarially-sound capitation rates for the MCO program. The work generally begins during the months preceding the contract year for which the capitation rates are being established. During 2014, for example, the rate-setting team will develop the proposed 2015 capitation rates. The process to develop actuarially-sound capitation rates is a multi-step one; this process is both an art and a science.

As illustrated in the graphic below, the process used to develop a capitation rate can be divided into four steps. This graphic surely oversimplifies the process and is not intended to replicate the steps taken by an actuary. It is nonetheless relevant to understanding how capitation rates are developed.



Step 1. Develop the base data

The rate-setting team's first task is to pull together the best data to use for rate development. Data is needed on the use of health care services and the costs of these services for the populations eligible to enroll in the MCOs or already enrolled in the MCOs. The state draws from many sources including Medicaid eligibility files and enrollment files, medical claims files, and possibly data collected from participating MCOs (referred to as "encounter data" because it is intended to capture, for example, when an individual has had an "encounter" with a medical professional or medical services). Other sources of information are used in this process too, including the financial reports submitted by the contracted MCOs to the state.

Data on the MCO-eligible population and health care costs and use is summarized and combined into one large Excel workbook containing very detailed information about the Medicaid populations eligible to enroll in MCOs. This workbook includes detailed information covering demographic information such as age, gender, eligibility status, disability status, and geographic region, and health care cost information

such as health status and historical service utilization. The data is analyzed to assess spending across region and demographic factors (for example, spending by age and gender) and to assess trends in spending, such as growth in utilization of certain services.

One of the most important steps during this process is to create population groups, based on demonstrated differences in health care use and costs that are meaningful to capitation rate development. These population groups are called “rating categories” or “rate cells” and establish the framework for rate-setting. Rating categories, for example, separate persons with disabilities from those without disabilities; they also separate members into one of five regions. They are also used to separate persons with relatively more comprehensive service coverage from those with relatively less comprehensive services. Rating categories are also a form of risk adjustment because they recognize that there are differences in health care use and costs among certain population groups or benefit packages.

Assuming that the state Medicaid program started the process to develop 2015 capitation rates during 2014, the state will very likely use data from 2011, 2012, and part or all of 2013. As such, the data used for this effort will always reflect past experience.

Step 2. Adjust the base data

During this process, important adjustments are made to the assembled data to account for important factors such as missing or incomplete data. During this step, often services that are not covered by the MCO are also excluded from the capitation rates. This step produces the “adjusted base data” upon which the projects are made for the contract rate year.

Step 3. Trend the base data for the contract year

The third step in the process involves trending the adjusted base data for any expected changes in utilization, costs, and mix of services between the base year period and the contract rate year (the year in which the capitation rates will take effect). This step produces the base data for the rate year. Step 3 is a critical step in the process for capturing any future trends in price and use of services. This is important since, as was described above, the data used to develop initial base capitation rates is based on past experience and does not capture populations that may become newly eligible or enrolled in the program or changes in service utilization patterns that might impact estimated rates.

Step 4. Calculate administrative and other costs

The final step, as described in this primer, is to project additional costs including general administration, care coordination, a small margin for MCO risk and gain, and taxes and fees.

Steps 1 through 4 produce a projected per member per month (PMPM) capitation payment in each rating category – a monthly payment amount that reflects the average cost for the population in the rating category for the covered services, and appropriate to the contract rate year.

Use of Risk Mitigation Tools Including Risk Adjustment

The three most commonly used tools to mitigate risk, risk adjustment, reinsurance and risk sharing, are described below.

Many states risk adjust their capitation rates for the risk facing each MCO to address the underlying acuity or disease burden of each MCO’s enrolled population. Put another way, this adjustment accounts for the relative acuity of participating MCOs. State Medicaid programs may also determine it necessary to use other risk mitigation tools such as reinsurance and risk corridors to ensure that overall payments are appropriate and actuarially sound.

RISK MITIGATION TOOLS - THE THREE RS	
Tool 1. Risk Adjustment	<ul style="list-style-type: none"> This tool is used to improve the ability of Medicaid to match payment to risk by accounting for health status differences of enrollees in the MCOs. The market for risk adjustment includes a variety of tools. MassHealth uses DxCG as its modeling software to assess risk. Capitation rates are adjusted up or down depending upon the risk of each MCO’s enrolled population relative to the average risk. Some MCOs may have enrollees with higher than average risk; other MCOs may have enrollees with lower than average risk. Risk adjustment of the capitation rates is cost neutral, which means that upward adjustments are offset by downward adjustments that net to no new costs for the state Medicaid program.
Tool 2. Reinsurance	<ul style="list-style-type: none"> This tool is used to provide financial coverage or protection to the MCOs for costs in the aggregate or at the individual level that exceed a pre-determined amount. This tool is also known as “stop-loss.”
Tool 3. Risk Corridors	<ul style="list-style-type: none"> This tool is used to offer protection against uncertainty in the estimating process, such as when a new population or new service is being introduced. It is intended to result in the MCO and the state sharing the unknown cost or savings associated with the new variable (e.g., population, medical service, or pharmaceutical).

Simple Examples to Illustrate How Risk Mitigation May Affect MCO Revenues

An Example of Risk Adjustment

Through the state's risk-adjustment process, MCO enrollees are assigned a "risk score," based on historical claims data. This process might be conducted by the state on an annual, semi-annual or more frequent basis. In this example, assume the following: (1) that the average risk score for the MCO population is 1.0; and, (2) that the "base" capitation rate for the contract rate year for the MCO program for a particular population group is \$100.

Assume also that there are two MCOs, and the overall risk score for enrollees in MCO A is higher than average and the overall risk score for enrollees in MCO B is lower than average.

- MCO A has an overall score of 1.2 for its enrollees, and would receive a 20% add on to its base capitation rate, or $\$100 \times 1.2 = \120 .
- MCO B has an overall score of .8 for its enrollees, and would receive 80% of the base capitation rate, or $\$100 \times .8 = \80 .

As the example above shows, the state will pay MCO A \$120 (higher than the base rate) and MCO B \$80 (lower than the base rate).

An Example of Reinsurance

Like all risk mitigation tools, reinsurance can take on many forms. This example assumes that that state establishes a reinsurance policy for high-cost individuals enrolled in the MCO program. This tool serves as a form of insolvency protection for the MCO. The state offers the MCO the opportunity to purchase this reinsurance from the state for a fixed per member per month amount, and specifies the policy provisions. For example, the state will cover 80 percent of the cumulative annual medical claims for individuals whose medical claims exceed a threshold of \$100,000 for the year.

In this example, the MCO has two individuals whose medical claims exceed \$100,000. Individual A has \$150,000 in medical claims, and Individual B has \$200,000 in medical claims. They are both eligible for coverage from the state. The state will pay the MCO 80% of the amount spent above the threshold.

In this example, the state pays the MCO 80% for Individual A's costs exceeding \$100,000 and 80% of Individual B's costs exceeding \$100,000.

State payment = $(.8 \times 50,000) + (.8 \times \$100,000)$
State pays \$120,000 to the MCO.

An Example of Risk Corridors

The table below describes a hypothetical set of risk corridors and a risk-sharing arrangement between the state and the MCO.

There are three risk corridors in this example to protect the MCO from the uncertainty around the capitation rates, and to mitigate the impact of significant gains and losses. Assume that the capitation rate for medical services is \$100, and the MCO spends \$108 or 108% of the capitation rate. For this example, assume the following risk corridors:

Corridor	Gain Corridors MCO spending < capitation rate		MCO capitation rate	Loss Corridors MCO spending > capitation rate	
	Corridor 3	Corridor 2	Corridor 1	Corridor 2	Corridor 3
	Below 92% of the capitation rate (Beyond 8 percentage points)	Below 97% through 92% of the capitation rate (Next 5 percentage points)	97%-103% of the capitation rate (within 3 percentage points of the capitation rate)	Above 103% through 108% of the capitation rate (Next 5 percentage points)	Above 108% of the capitation rate (Beyond 8 percentage points)
Plan risk share	20%	50%	100%	50%	20%
State risk share	80%	50%	0%	50%	80%
Spending	\$91.99 and below	\$96.99-\$92	\$97-\$103	\$103.01-\$108	\$108.01 and above

In this case, the state and the MCO would share in losses accordingly.

- Risk corridor 1. The MCO would assume 100% responsibility for the losses between \$100 and \$103, or \$3 x 100% = a loss of \$3 per enrollee. (The state would not cover any losses at this level)
- Risk corridor 2. The MCO would assume 50% of the responsibility for the losses above \$103 and through \$108, or \$5 x 50% = a loss of \$2.50 per enrollee.
- Risk corridor 3. The MCO would assume 20% of the responsibility for losses above \$108.

DOI Provisions | Reserves

All MassHealth MCOs currently meet all Division of Insurance (DOI) requirements, and are licensed by DOI.

In accordance with Section 2.16 B of the contract between MassHealth and its MCOs, all MCOs must comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25 (a) and 211 CMR 43:07(1) and continue to maintain an adjusted net worth in accordance with M.G.L. c 176G § 25(b) and 211 CMR 43:07(2), which are the Commonwealth's Division of Insurance regulations.

Source: MassHealth.

MCOs, like any insurance carrier, must be able to build reserves to ensure the financial solvency and stability of the company. This is as much a matter of good business practice as it is a way to protect enrollees from harm. This means being able to put money “in the bank” to deal with the potential for higher costs in the future. Building reserves is important for all MCOs, including non-profit MCOs. The ability of an MCO to build reserves depends upon its ability to manage within Medicaid capitation rates, including appropriate contributions to reserves. This is key to attracting both large, and small plans.

SECTION 3. OVERVIEW OF MASSHEALTH PAYMENT STRUCTURE

This section provides an overview of how MassHealth pays its MCOs and a high level overview of the populations enrolled in the MCO programs that constitute specific rating categories. Persons who are eligible for the MCO program include persons covered under Medicaid only and who are under 65 years of age. In preparing this overview, a variety of sources were used including the expertise and knowledge of former MassHealth officials, and sections of the 2015 contract between MassHealth and the MCO.

MassHealth Overview

Within the Executive Office of Health and Human Services, MassHealth is responsible for establishing all payment provisions between the Medicaid program and contracted MCOs, including the responsibility to develop capitation rates and to make decisions about using risk mitigation tools. As of July 2015, the MassHealth contracts with six MCOs: Boston Medical Center HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Tufts Health Plan-Network Health.⁵

MassHealth has much experience in developing capitation rates; the MCO program has been operating for close to two decades now. According to the 2015 contract between MassHealth and its MCOs, MassHealth has a comprehensive payment approach that includes the development of actuarially-sound capitation rates and the use of all risk mitigation tools that affect the total payments that MCOs receive.

⁵ MassHealth contracts with all six plans for the new CarePlus program established to cover the Medicaid expansion implemented as a result of the Affordable Care Act. CeltiCare is not available to members enrolled in the Traditional MCO program.

As noted above, total payments to any MCO must remain within the approved actuarial soundness rate range.

MassHealth Capitation Rates and the Use of Risk Mitigation Tools

MassHealth has four different capitation rates for its MCOs. In accordance with the contracts with its MCOs, MassHealth pays a per enrollee per day fixed fee for the Traditional program and on the basis of a per enrollee per month for the CarePlus program. These are known as a PMPD, or per member per day amount, and as a PMPM, or per member per month amount, respectively.

Rating categories have long served as the first step in MassHealth’s capitation-rate development process as a way to group individuals, based upon coverage type (MassHealth Standard and CarePlus) and eligibility status.

MCOs are paid on the basis of two rating categories – Rating Categories I and II - for populations covered under MassHealth Standard, also referred to as the “Traditional” MCO program. MCOs are paid on the basis of two rating categories – Rating Categories IX and X - for populations covered under MassHealth CarePlus. Based on the general process described in the last section, MassHealth first develops the base capitation rates for each of the four rating categories, and then adjusts these base capitation rates for the risk of each individual MCO.

The table on the following page provides an overview of the four rating categories that are used currently by MassHealth to pay its MCOs and summarizes how MassHealth uses risk mitigation tools.

OVERVIEW OF MASSHEALTH PAYMENT PROVISIONS FOR MCOs				
Capitation Rate Structure for Medicaid-Only MCOs, Under 65 Years of Age				
	The Traditional MCO Program		The CarePlus Program	
	MassHealth Standard		MassHealth CarePlus	
Rating Category	I	II	IX	X
Covered Populations	Includes Temporary Aid to Needy Families (TANF)	Includes persons with disabilities	Includes persons under Affordable Care Act (ACA) Expansion	Includes persons formerly eligible under MassHealth Basic and eligible for Emergency Aid to Elderly, Disabled, and Children (EAEDC)
Use of Risk Mitigation Tools				
Risk Adjustment	MassHealth uses a DxCG risk adjustment model to adjust the base capitation rates paid to MCOs for the risk of its enrollees. Using the DxCG system, MassHealth assigns a risk score to each individual that is based on the diagnosis recorded on the inpatient and outpatient records for the individuals. (This cannot be done for new populations if there are records to use.) The individual scores are used to develop a composite score for each rating category served by each MCO.			
Reinsurance	The MassHealth program requires MCOs to have reinsurance.			
Risk Corridors	<p>MassHealth has three risk corridors for the MCOs which apply to all rating categories. It is important to note that risk corridors only apply to the medical component of the capitation rates.</p> <ul style="list-style-type: none"> • Risk corridor 1: MCOs at 100% risk of gain or loss between 97% and 103% of the rate. • Risk corridor 2: MCOs are at 50% above or below 3% through 20% of the rate. • Risk corridor 3: MCOs are at 100% risk of gain or loss beyond 20% above or below the rate. 			

Glossary of Key Terms

Actuarially Sound Capitation Rates – capitation rates that, as described in 42 CFR 438.6, 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, have been certified as meeting the requirements of 42 CFR 438.6 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, and have been approved by CMS.

Claim – a bill for services, a line item of service, or all services for one Enrollee within a bill.

Minimum Medical Loss Ratio – a provision that states that no less than a stated percent of the capitation rate must be used for medical or care management expenditures.

Rating Category – An identifier used by EOHHS to identify a specific grouping of Enrollees based on assignment plan and disability status, as determined by EOHHS or the Social Security Administration, for which a discrete Capitation Rate applies pursuant to the Contract.

Source: MassHeath MCO Contract.