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Medicaid Unwinding

# Use of Emerging Experience in Capitation Rate Setting

In October 2024, The Alliance of Community Health Plans (ACHP) and Association for Community Affiliated Plans (ACAP) sent a letter to HHS and CMS[1] expressing concerns with the adequacy of 2024 rates and concerns about actuarial soundness in the development of 2025 rates, which are in progress or near completion for most states. These comments echoed similar public comments made by leaders of several national Medicaid health plan leaders, and generally centered around 2024 and 2025 capitation rate development not sufficiently addressing emerging experience in 2024 due to acuity, utilization, and unit cost trends higher than anticipated in rate setting.

In a series of issue briefs, Wakely will unpack some of the issues we see in states during this unprecedented time. Our first issue brief summarized state approaches to acuity adjustments during the Public Health Emergency (PHE) and unwinding. This second issue brief will focus on emerging experience during and post unwinding, and balancing risk-based contracting with risk mitigation.

In 2020, In response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Act (FFCRA) to support states and promote health coverage stability during the PHE. The FFCRA allowed for a 6.2% increase to a state's Federal Medical Assistance Percentage (FMAP) if certain criteria were met, including providing continuous Medicaid eligibility to members enrolled as of March 18, 2020, or anytime thereafter[2].

At the end of 2023, the enhanced FMAP was phased out, and as of the writing of this issue brief, most states have shifted focus from unwinding to other priorities such as behavioral health, long-term services and supports, addressing workforce shortages, and budgetary pressures[3]. The direct and indirect effects of program changes made to address these priorities must also be priced into capitation rates for 2024 and 2025, which can make it challenging for actuaries to determine where costs will ultimately land. While state budgetary pressures do not change the need for actuarially sound rates, they can make conversations between states and Managed Care Organizations (MCOs) more challenging than usual.

*25 of 41 states sought amended capitation rates during the unwinding*

*9 of 14 states will use emerging 2024 experience to inform 2024 or 2025 rates*

To gain an understanding of the landscape of approaches taken by states and their actuaries during this time, Wakely surveyed MCOs in 27 states on issues ranging from the rating approach used for acuity, use of emerging experience, and risk mitigation approaches. We supplemented this information with other publicly available analysis and survey data to provide additional context around these challenges.

## Summary of Findings

This survey of Wakely consultants serving association and Health Plan clients was conducted between October 14 and October 22, 2024, and was supplemented by limited rate certification review from HMAIS rate certifications (including for some non - Wakely clients) and additional information from Kaiser Family Foundation (KFF) 2022 Budget Survey for risk corridors.

Table 1 includes high-level findings from analysis of emerging experience and its use in rate setting.

**Table 1: Summary of Findings**

| Topic | Question Asked: How Many States are… | Summary Findings |
|---|---|---|
| **Access and Workforce Challenges** | Implementing changes to improve beneficiary access to care | 48 of 51 states increased rates in their fee for service program for at least one provider type in FY2024 with HCBS and Outpatient BH seeing increases in 39 and 34 states respectively[4].<br>CMS approved 21% more distinct requests for state directed payments in 2024 than they did in 2023, resulting in a 60% increase in state-reported spending estimates, with the majority of these intended to improve access to care[5].<br>Many states have recently passed laws to limit the use of prior authorization due to concerns about their impact on access to care, and an increasing number have exercised greater control of Preferred Drug Lists (PDLs) [6].<br>If these program changes are successful, states will see increased utilization of services, which can be challenging to appropriately price into capitation rates. |
| **Acuity Adjustment True-Up** | Updating assumptions during the unwinding | At least 12 of the 27 actuaries surveyed included a process to review and/or true-up estimates of acuity differentials, count of members in each cohort, or both.<br><br>25 of 41 states responding to the annual KFF Medicaid officials survey indicated that they have sought a capitation rate amendment from CMS to address acuity shifts due to the unwinding for rating periods beginning in FY2024 and/or FY 2025[7]. |

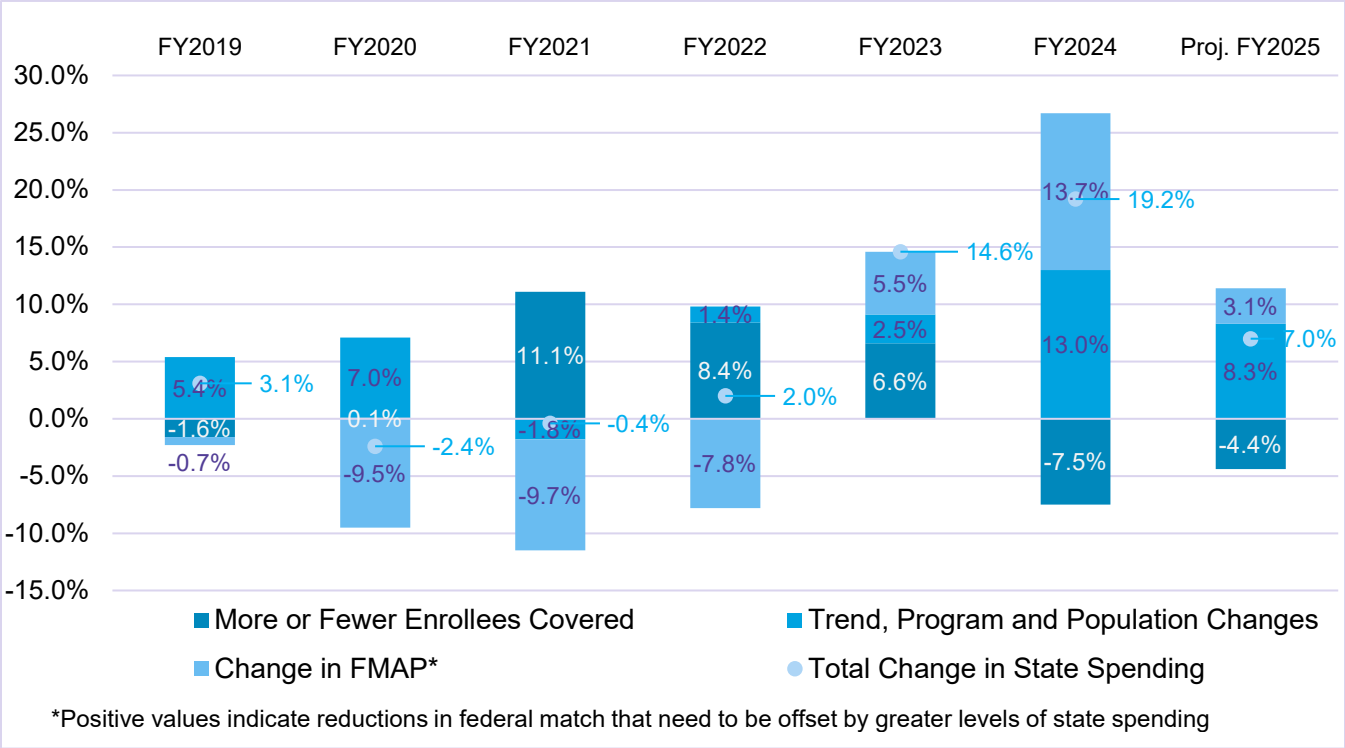
| Topic | Question Asked: How Many States are… | Summary Findings |
|---|---|---|
| **Emerging Experience** | Using 2024 emerging experience in the development of 2025 rates? | 9 of 14 States may or will use emerging experience, some for periods beginning in 2024. This ranges from informing trends for a subset or for all services to committing to revise rates if individual assumptions or overall experience varies from initial assumptions by a certain amount.<br>5 States have determined that they will not utilize this emerging experience.<br>13 States have not decided, or we do not know their decision. |
| **Risk Corridors and other Risk Mitigation** | Re-implementing risk corridors that had been in place during the COVID Pandemic? | 15 States did not implement a corridor for the PHE.<br>6 States implemented a corridor during the PHE that were removed prior to the unwind.<br>6 States have added corridors during the PHE and have retained them through the unwind.<br>38 of 41 states reported a minimum MLR is always in place as of July 1, 2024, with more than three quarters requiring a remittance and others describing other one-sided risk mitigation mechanisms to limit MCO gains. |

## Overall Medicaid Enrollment and Spending Context

Over the course of the PHE, enrollment growth was the primary driver of increases to total Medicaid spending, and the increased FMAP more than offset this growth, resulting in a cumulative decrease in state expenditures over the period FY2020 - FY2022[8].

The expiration of the enhanced FMAP combined with increasing spending per enrollee was not similarly offset by immediate enrollment reductions, so that state spending increased dramatically in FY2023 and FY2024, and is not expected to moderate until FY2025.

**Figure 1: Annual Change in State Medicaid Spending by Source**




**Source:** FY 2024-2025 spending data and FY 2025 enrollment data are derived from the annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024. 50 states submitted survey responses by Oct. 2024; state response rates varied across questions. Historic data reflects growth across all 50 states and DC and comes from various sources. See Methods of Medicaid Enrollment & Spending Growth: FY 2024 & 2025 for more information. Medicaid Enrollment & Spending Growth: FY 2024 & 2025 | KFF

## Actuarial Soundness Considerations

Regardless of economic or budgetary factors, actuarially sound rates must provide for all reasonable, appropriate and attainable costs for covered services provided to covered populations under the contract between managed care plans and state Medicaid agencies[9]. The rates are developed by actuaries serving State Medicaid Agencies and submitted with appropriate documentation to CMS, who reviews and approves them as part of their oversight of managed care contracts. CMS requires documentation to demonstrate that they are developed following a specific set of steps including the selection of an appropriate base data set, and projection of that data to the rating period using appropriate assumptions, including estimates of utilization and unit cost trends, and the expected impact of any population or program changes between the base and rating periods[10].

## Program Changes, Utilization and Unit Cost Trends

When annual trends by service category are consistent from year to year, and when there have been minimal program changes, the development of appropriate utilization and unit cost trends can be accomplished by reviewing historical changes with a lag of one or two years to allow claims to complete. If significant changes are occuring within those one or two years, however, additional steps may be needed to adjust projected expenditures to be consistent with emerging experience.

States contract with Managed Care Plans to accomplish a range of program goals, including applying downward pressure to cost trends. However, not all changes in costs are within MCO control, and downward pressure may not be appropriate when historical utilization of high value services has been suppressed for certain populations due to barriers to access to care, workforce challenges, or other systemic factors[11].

Provider payment rates in Medicaid have long been significantly lower than Medicare and Private Insurance provider payment rates. While this differential contributes to the financial sustainability of the program, it also raises concerns about access to care for Medicaid beneficiaries, which the April 2024 Access to Medicaid Services Final Rule was partially written to address[12].

As economywide inflation was making headlines in 2021-2023, we entered a rare period where healthcare price increases were overshadowed by increases for all other goods and services. In late 2023, this trend largely reversed, and around the same time, price increases for Medicaid services began to increase significantly beyond historical levels, outpacing Medicare and Private Insurance price increases[13].

Some of these price increases were related to efforts to address workforce challenges[14] and associated barriers to access to care. For example, the American Rescue Plan (ARP) included one additional source of enhanced FMAP which expired in 2023 for states to expand their workforce for home and community based services through efforts that could continue into 2025. All 51 states took advantage of this additional funding, planning or completing more than 1,400 activities to enhance, expand, or strengthen HCBS, including 30 states which implemented time-limited fee schedule increases for these services[15].

It appears that this investment may be having the intended effect: while price growth fell from 6% to 1% from September 2023 to September 2024, taking home health from the leading the the last category for price growth, implicit health care utilization has only continued to grow, and is the leader among all service categories as of August 2024 at 10%[16].

Many states have implemented other program changes to address access to care including increasing provider rates for other service types, implementing limitations to prior authorization requirements, and exercising greater control over uniform preferred drug lists[6,17]. Each of these changes can have the effect of increasing utilization, price, and/or utilization trends beyond what has been historically observable.

Over this same period, the average acuity of the underlying population was decreasing[1819], resulting in population-level reductions in utilization that may have masked or dampened utilization increases that

could have been observed on a constant member-mix basis. While rapid increases in GLP-1 utilization and spending make national headlines, these other increases to utilization and unit costs may be more challenging to detect, but the effect of all of these changes taken together contribute to the upward pressure on per person costs and add complexity to what was already a challenging year for capitation rate setting.

### Prospective Rate Setting, Rate Amendments and Risk Contracts

Capitation rates are normally set prospectively in the spirit of consistency with the transfer of risk from states to Managed Care entities under Managed Care contracts. Medicaid Managed Care final rule changes in 2020 prohibiting retroactive application of risk mitigation mechanisms were consistent with this philosophy. However, this prohibition of retroactive changes does not apply to rate amendments, if they are supported by an appropriate rationale and sufficient data, assumptions and methods.[20]

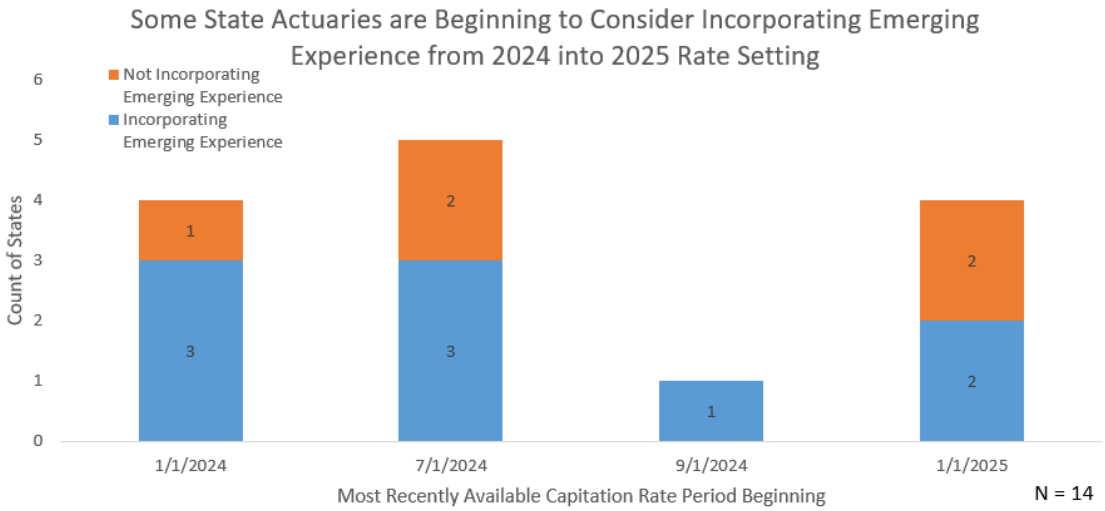
State Medicaid programs are typically judicious in using risk corridors because they can weaken MCO incentives to achieve state goals and increase administrative burden for states and MCOs[21]. However, state policy and rate setting decisions can impact the risk and cost borne by MCOs in ways that are beyond MCO control and may be difficult for State Actuaries to price. As a result, material deviation between emerging experience and projections may sometimes warrant a mid-year rate amendment[22].

## Survey Findings

### Use of Emerging Experience

Given the extraordinary conditions related to utilization and unit cost trend changes, it should not be surprising that nine of the fourteen States in our survey which are setting rates in 2024 or 2025 are using directly or considering emerging experience in 2024 for rate setting.

**Figure 2: Use of Emerging Experience by Rating Period**



The most common approach we observed was consideration of experience through Q1 and Q2 directly or indirectly for trend or base data development, particularly for pharmacy. Some states are committing to review emerging experience and review and potentially update specific assumptions within the rate development if appropriate based on agreed-upon variance thresholds for overall costs relative to pricing. Some respondents did not have information on this question, so the responses are incomplete.

In several cases, survey respondents had complete capitation rate information about an earlier period but were in conversations about a future period, so the results above may be inconsistent or nuanced. For example, the three respondents with most recently available capitation rates for periods beginning 1/1/2024 could confirm that the 2025 rates would include emerging experience from 2024 even though they did not have complete information about the rates for that period at the time the survey was conducted. By contrast, the respondent with capitation rate information for a period beginning 9/1/2024 confirmed that the emerging 2024 experience was used in that same rating period.

## Mid-Year Rate Amendments

Drawing from recent lessons learned from the COVID pandemic, the American Academy of Actuaries' Medicaid work group suggested that prospectively defining situations in which capitation rates can be adjusted mid-year would be helpful for later discussions between plans and states[22], and CMS's rate setting guide for 2024 and 2025 includes a requirement that the rate certification include a list of known amendments that will be provided to CMS in the future, and why the current certification cannot account for changes that are anticipated to be made to the rates.

Our survey identified at least twelve acuity adjustment methodologies that indicated a future amendment would be made under this approach, to adjust for disenrollment patterns different than anticipated, or relative costs of disenrolling members different from initial assumptions.

KFF's recent Medicaid Director Survey went further, identifying 25 states that had sought or would seek a rate amendment among the 41 they surveyed. It was not clear from the survey design whether these amendments were prospectively defined or not.

**Figure 3:**

**States Seeking Capitation Rate Amendments to Address Acuity Shifts Due to the Unwinding for the Rating Periods Beginning in FY 2024 and/or FY 2025**

n = 41 MCO states

| | # of States | States |
|---|---|---|
| Have sought and/or will seek a rate amendment | 25 | AR, AZ, CA, CO, GA, IA, IN, KS, KY, LA, MD, MI, MN, MO, MS, NC, ND, NE, NH, NM, NV, TN, TX, VA, WV |
| Rate amendment undetermined | 4 | NJ, NY, OK, SC |
| Have not and do not plan to seek a rate amendment | 12 | DC, DE, HI, IL, MA, OH, OR, PA, RI, UT, WA, WI |

Note: FL did not respond to 2024 survey. States' 12-month rating periods vary.

Source: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2024

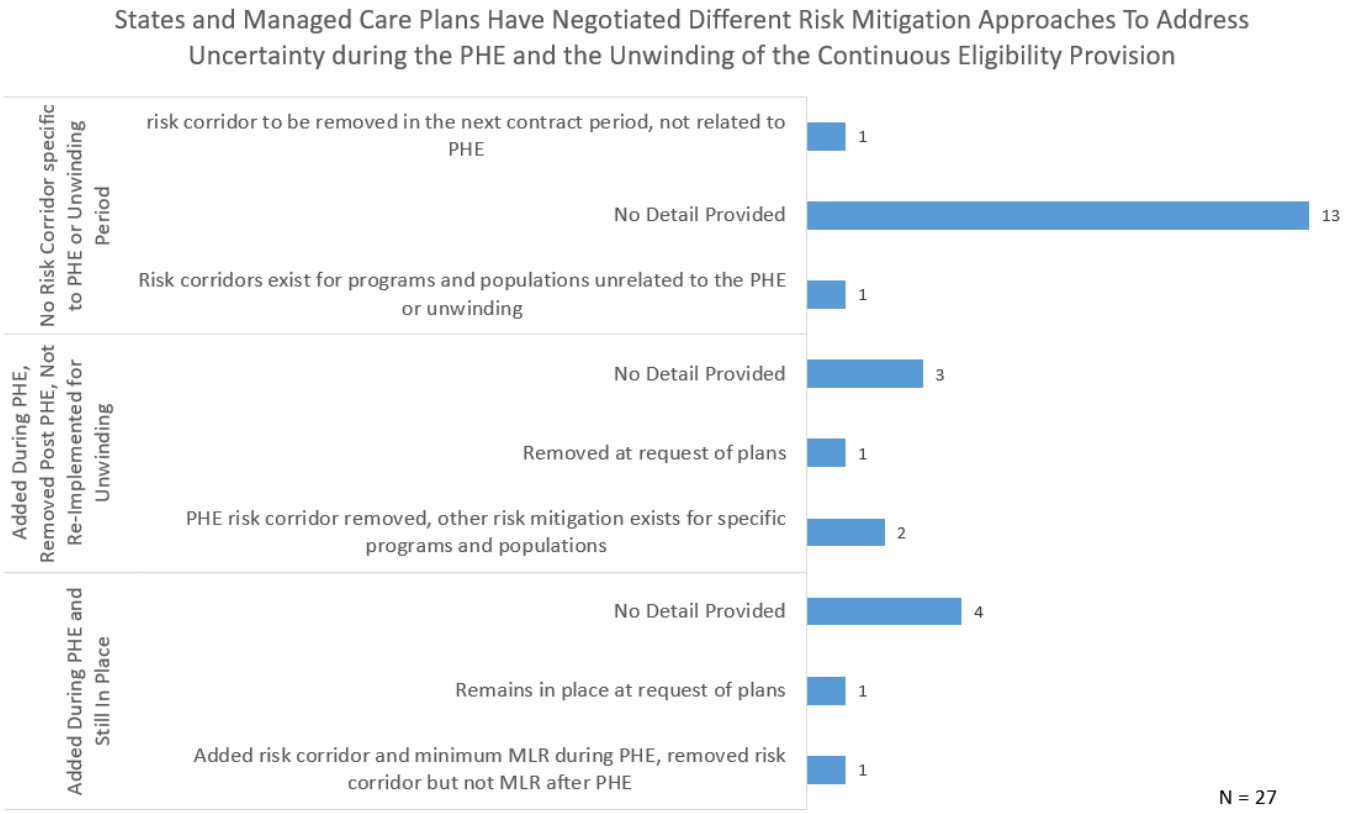
KFF

## Risk Corridors and other Risk Mitigation

CMS recommended that states implement or continue 2-sided risk mitigation strategies until enrollment is expected to stabilize[23], and in retrospect, this type of risk mitigation would have been very welcome to address the emerging experience we've been describing. However, none of the participants in our survey proposed to add a new risk corridor specifically for the unwinding.

By contrast, one-sided risk mitigation approaches remain quite popular: Thirty-four states (including DC) have Minimum Loss Ratio (MLR) requirements that require remittance from MCOs to states if their medical costs fall below a certain threshold as of July 1, 2024[24].

**Figure 5: Risk Corridor Changes**




Wakely's survey included a sample of 27 states anonymized to protect confidentiality. Certifying actuaries represented include Milliman, Mercer, Optumas and other consulting firms. Differences in approach do not generally indicate outliers between actuarial consulting firms but seem to be more state-specific.

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## OUR STORY

**Five decades.** Wakely began in 1969 and eventually evolved into several successful divisions. In 1999, the actuarial arm became the current-day Wakely Consulting Group, LLC, which specializes in providing actuarial expertise in the healthcare industry. Today, there are few healthcare topics our actuaries cannot tackle.

**Wakely is now a subsidiary of Health Management Associates.** HMA is an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. We serve government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations. Every client matters. Every client gets our best. With more than 30 offices and over 700 multidisciplinary consultants coast to coast, our expertise, our services, and our team are always within client reach.

**Broad healthcare knowledge.** Wakely is experienced in all facets of the healthcare industry, from carriers to providers to governmental agencies. Our employees excel at providing solutions to parties across the spectrum.

**Your advocate.** Our actuarial experts and policy analysts continually monitor and analyze potential changes to inform our clients' strategies – and propel their success.

**Our Vision:** To partner with clients to drive business growth, accelerate success, and propel the health care industry forward.

**Our Mission:** We empower our unique team to serve as trusted advisors with a foundation of robust data, advanced analytics, and a comprehensive understanding of the health care industry.

Learn more about Wakely Consulting Group at [www.wakely.com](http://www.wakely.com)

[1] https://achp.org/achp-acap-letter-medicaid-rates/

[2] https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

[3] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-future-outlook/

[4] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-provider-rates-and-taxes/

[5] https://www.macpac.gov/wp-content/uploads/2024/10/Directed-Payments-in-Medicaid-Managed-Care.pdf

[6] https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf

[7] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-delivery-systems/

[8] State Fiscal Years vary but most run July – June so that this period generally corresponds with July 2019 through June 2022.

[9] https://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

[10] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

[11] https://www.actuary.org/sites/default/files/2022-08/RiskAdjust.8.22.pdf

[12] https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-final-rule-cms-2442-f

[13] https://altarum.org/sites/default/files/Altarum-October-2024-HSEI-Combined.pdf

[14] https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/

[15] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/arp-sec9817-overview-infographic.pdf

[16] https://altarum.org/sites/default/files/HSEI-Price-Brief_October_2024.pdf

[17] https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-cost-containment-and-utilization-control-strategies/

[18] https://www.wakely.com/wp-content/uploads/2024/04/end-medicaid-continuous-coverage-programmatic-and-rate-setting-considerations.pdf

[19] https://www.wakely.com/wp-content/uploads/2024/11/Medicaid-Unwinding-Survey-White-Paper_20241029_Acuity.pdf

[20] https://www.federalregister.gov/d/2020-24758/p-159

[21] https://www.healthmanagement.com/wp-content/uploads/White-Paper_Risk-Corridors_HMA_May-2021-5.7.21-v3.pdf

[22] https://www.actuary.org/sites/default/files/2021-11/COVID19.ImpactMedicaid11.21.pdf

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

[24] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-delivery-systems/