STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
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March 5, 1996

Mr. Bruce Vladeck, Administrator
Health Care Financing Administration
2000 Independence Avenue, S.W.
HHH Building, Room 314
Washington, D.C. 20201

Dear Mr. Vladeck:

This is in response to your letter of February 5, 1996, concerning the rate methodology employed by the California Department of Health Services (DHS) in setting contract rates for prepaid health plans (PHPs) for State Fiscal Year (SFY) 1994/1995. You indicate that you still need documentation that the rates were developed on an actuarially sound basis. You gave two basic reasons for why you found the DHS response of November 20, 1995 lacking.

First, you said that you do not feel that just because capitation rates are set at a level below an actuarially determined fee-for-service (FFS) upper limit, the rates are necessarily "actuarially sound." You noted that 42 Code of Federal Regulations, section 434.61 requires that "it is the final capitation rates, after reductions from FFSE, that must be actuarially sound." Second, you indicated that DHS has never adequately explained why it deviated from what you refer to as its "de facto standard of actuarial soundness."

Federal Law and Actuarial Soundness

Section 434.61 simply says that the agency must "determine that the . . . payments provided for in the contract are computed on an actuarially sound basis." Section 434.61 does nothing more than paraphrase the requirement in federal statute at 42 United States Code section 1396b(m)(2)(A)(iii) that payments be "made on an actuarially sound basis."

While the Health Care Financing Administration (HCFA) may have never expressly stated that payment rates set below an actuarially sound FFS upper limit equate to actuarially sound payments, there is nothing in federal statute, regulation, or other federal guidelines that sets forth any other specific criteria for establishing payments that are actuarially sound. As indicated above, section 434.61 only begs the issue by restating the requirement already set forth in federal statute that payments be actuarially sound.

According to DHS actuaries, the concept of "actuarial soundness" refers to the application of sound actuarial methods to estimate a number. There is nothing inherent in the term "actuarially sound" that provides any guidance as to what number is to be determined on an actuarially sound basis. Mr. Gordon Trapnell, HCFA's consulting actuary, seemed to agree with this view when he stated that "it is not clear what the term actuarial soundness might mean in connection with a lawsuit concerning the rates offered to PHPs for Medicaid beneficiaries." (Pages 3-4 of January 9, 1995 internal memo attached to April 5, 1995 letter from Mr. Bruce Vladeck to Mr. John Rodriguez.)

The number to be determined on an actuarially sound basis must be located in other specific guidelines or directives. For example, insurance company actuaries may be directed to estimate, by the application of sound actuarial methods, the amount of insurance premium needed to keep an insurance fund solvent. Actuaries in some businesses may be directed to estimate, by the application of sound actuarial methods, the amount that must be charged for a product to achieve a specified profit margin. In title 2 of the Social Security Act, which governs the Old Age, Survivors, and Disability Insurance programs, Congress requires "generally accepted" actuarial methods that assure an "actuarial balance" between estimated disbursements and expected income in Social Security trust funds. (42 U.S.C. § 401(c).) Under the Medicare program, Congress has directed the use of actuarial principles in establishing what is in essence a Medicare fee-for-service upper limit. (42 U.S.C. § 1395mm(a)(1)(C).)

There is nothing inherent in the term "actuarially sound" that imposes a sufficiency of payment standard with respect to PHPs, such as assuring that payments be adequate to compensate all PHP costs. Such a minimum payment standard has been suggested by the plaintiff in Watts Health Foundation v. Belshé, a pending lawsuit against DHS. Such a minimum standard of payment would be contrary to the concept that a PHP contract is a "risk" contract, in which a PHP assumes the risk that it may lose money. Such a minimum standard of payment is also contrary to the federal regulatory requirement that payments be below the FFS upper limit. Therefore, the term "actuarially sound" simply describes a method. Other sources of authority must be looked to in order to know what number is to be determined by an actuarially sound method.

PHP contracts require that PHPs provide full access to covered services at a level that is comparable to that available to the general public and require that each PHP comply with strict quality of care requirements, including those imposed by the California Knox-Keene Act. When a PHP contracts with DHS at the rate DHS offers, the PHP contractually obligates itself to provide full access to quality health care services. If a PHP believes that it can no longer provide full access to quality health care at the payment rate DHS offers, it may voluntarily terminate its contract.

In response to public comments concerning the enactment of 42 Code of Federal Regulations, section 434.61, HCFA indicated that "as long as a state follows accepted actuarial principles, it is free to determine what constitutes a sound actuarial basis." (Volume 48 Federal Regulation 54018, November 30, 1983.) The only specific guideline provided in federal statute or regulation concerning PHP capitation rates has been the FFS upper limit requirement at 42 Code of Federal Regulations, section 447.361. This regulation has historically been the only specific guideline in federal law concerning the number that the states are to calculate on an actuarially sound basis. In response to public comments on section 447.361, HCFA stated that:

> "[I]t is preferable for each State to determine whether it needs to impose a lower limit than the fee-for-service rates and take whatever legislative action is required." (Volume 48 Federal Regulation 54019, Nov. 30, 1983.)

HCFA has consistently approved capitation rates that are set at a percentage of the FFS upper limit. For example, State Medicaid Manual section 2087.1 provides that a contract rate may be expressed as "a specified percentage of the FFS-UPL (e.g., 95 percent)." In a recent study conducted for DHS, Tucker-Alan Inc. surveyed how the states determined PHP rates. This study found that the actuarial methods applied by almost all of the states are directed toward determining the FFS upper limit (Arizona was an exception because it did not have a FFS reimbursement system). Tucker-Alan found the actuarial methodology that DHS used to determine the FFS upper limit to be "one of the most precise used by a state agency." The practice of the states is to set PHP rates at between 88 and 99 percent of the FFS upper limit.

The Comments of HCFA's Consulting Actuary On
The Actuarial Soundness of DHS Methodology

On page 1 of his internal memo of January 9, 1995, Mr. Gordon Trapnell, HCFA's consulting actuary, commented on the actuarial soundness of the DHS methodology for determining the FFS upper limit. He stated that:

> "California has developed a very thorough approach to the joint problems of forecasting future Medicaid expenditures and the corresponding fee for service equivalent costs per capita for different types of eligibles."

He further indicated that:

> "[The] methodology is similar in concept and procedure that (sic) used by HCFA to determine the AAPCC rate book for Medicare risk contracts, and **takes additional variables into account.**" (Emphasis added.)

He indicated that DHS produces "extensive documentation of the data sources, methodology, and elements of the calculation of both the budget projections and the capitation rate methodologies" that "are more comprehensive, open, and detailed than those found in other state (sic). "Finally, on page 3 of his internal memo, Mr. Trapnell stated that DHS "has gone to considerable effort to establish what should constitute actuarially sound rates, calculated such rates and failed to promulgate them." Therefore, as far as Mr. Trapnell is concerned, if DHS had set rates at a percentage of the FFS upper limit determined by the DHS actuarial methodology, the rates would be actuarially sound.

Why DHS Did Not Follow The Methodology It Used In 1990-1991

You indicate that DHS has not adequately explained why it deviated from what you refer to as its "de facto standard of actuarial soundness." In light of Mr. Trapnell's comments, we assume you are referring to setting rates at 97 percent of the FFS upper limit for each PHP as determined in accordance with the basic actuarial methodology used by DHS actuaries in 1990/1991. The reasons DHS decided to deviate from setting rates based on a percentage of the actuarially determined FFS upper limit are set forth below.

The last year in which DHS set its payment rates at a percentage (i.e., 97 percent) of the actuarially determined FFS upper limit was SFY 1990/1991. DHS actuaries determined the FFS upper limit for each PHP for every year from 1991/1992 through 1993/1994, using the same basic actuarial methodology that was used for 1990/1991 rates, and which Mr. Trapnell and other experts believe to be actuarially sound. The actuaries further provided calculations of what the rates would be for each PHP if set at 97 percent of the actuarially determined FFS upper limit determined for these years. The primary reason these rates were not implemented was because they would have resulted in rate decreases for most PHPs as a result of declining FFS upper limits. The smaller FFS upper limits were a result of declining FFS cost per eligible. DHS has determined that a major cause of this was an influx of new beneficiaries during the recession of the early 1990s.

The immediate reason that DHS chose to freeze rates at 1990/1991 rate levels during the period 1991/1992 through 1993/1994 was because of a concern that reducing the rates might cause some PHPs to cease participation in the Medi-Cal program. This was during a time period when DHS was developing plans to expand the use of managed care health care delivery systems. The decision to freeze rates was also based on the concepts of "efficiency, economy, and quality of care" contained in 42 United States Code section 1396a(a)(30)(A).

42 United States Code section 1396a(a)(30)(A) requires payments for health care to be "consistent with efficiency, economy, and quality of care" and "sufficient" to assure adequate access. DHS has construed section 1396a(a)(30)(A) as obligating a state to assure access to quality health care services for Medicaid beneficiaries by administering its provider payment system in an efficient and economic manner. Generally, this means achieving access to quality health care for beneficiaries in a manner that is least costly for the program. However, in some instances, making higher provider payments than necessary to achieve adequate access to quality health care in the short run, may result in long-term cost savings for a state Medicaid program (e.g., paying a higher rate of payment to encourage use of a particular type of service with the potential of reducing the need for other more costly services). There is nothing in the language of section 1396a(a)(30)(A) or its legislative and regulatory history indicating that the "efficiency, economy, and quality of care" provision was ever intended to establish a specific minimum standard of payment. HCFA has construed the "efficiency, economy, and quality of care" provision as imposing an upper limit on aggregate spending by states on health care services (e.g., 42 C.F.R. §§ 447.272, 447.321, & 447.331). According to 42 C.F.R. 447.300, the FFS upper limit requirement was enacted to implement the "efficiency, economy, and quality of care" provision of section 1396a(a)(30)(A).

DHS discussed the view above in more detail in a 92-page report (including Addendum) on a Rate Study that it conducted in 1993-1994, entitled "Efficiency, Economy, Quality of Care and Access With Respect to Changes in Medi-Cal Reimbursement for Hospital Outpatient Services." In March 1995, a federal court judge issued a decision in Orthopaedic Hospital, et al. v. Belshé, agreeing with the views expressed in the Rate Study report and concluding that it demonstrated DHS had established payment rates for hospital outpatient services in a manner consistent with "efficiency, economy, and quality of care."

DHS has recognized the potential for achieving access to quality health care in a more efficient and economic manner through managed care in its strategic plan for "Expanding Managed Care." In the Executive Summary of that document, DHS noted that:

> "Managed Care, broadly stated, is a planned, comprehensive approach to the provision of health care that combines clinical services and administrative procedures with an integrated, coordinated system that is carefully construed to provide timely access to primary care and other necessary services in a cost-effective manner. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive services and thus reduce the unnecessary use of emergency rooms for ambulatory care and to eliminate preventable hospitalizations. In addition, quality of care can better be assured in managed care systems than in fee-for-service (FFS). Unlike FFS, providers operating in a managed care environment are formally and systematically linked in a manner that allows quality of care to be rationally assessed and accountability for care to be established and monitored."

DHS also noted that:

> "[R]esearch indicates that managed care systems can moderate the rate of cost increases when compared to FFS arrangements, and that improved member health status may lead to modest long term savings. Even modest savings can be significant when applied across a population as large as that enrolled in California's Medi-Cal program."

Volume 9 of the Administrative Record filed by DHS in the pending Watts Health Foundation lawsuit contains various articles and studies demonstrating how a well-managed care plan should be expected to provide access to better quality health care at less cost. The methods for accomplishing this include reducing unnecessary high cost care and putting greater resources into preventive care.

In summary, DHS was concerned that a major reduction in some PHP rates would drive some PHPs from the program. Therefore, such a reduction might be counter-productive to the expansion of managed care, and the "efficiency, economy, and quality of care" objectives DHS sought to attain through managed care. HCFA never indicated that it had a problem with the DHS decision to freeze PHP rates for these three years.

The Reduction in PHP Spending for 1994/1995

In SFY 1994/1995, if DHS had set rates at 97 percent of the actuarially determined FFS upper limit for each PHP, many PHPs would have received much larger decreases from the frozen rates in effect from 1990/1991 through 1993/1994. DHS planned to continue the freeze in rates in 1994/1995. The Governor's proposed budget for PHP spending for 1994/1995 was $708,944,029. This number was based on the amount that would be paid based on estimated PHP eligibles for 1994/1995 if PHP rates continued to be frozen. The State Legislature reduced $36 million from the Governor's proposed Budget. This reduction in the appropriation was based on a report of the Legislative Analyst. The report indicated that about $36 million needed to be reduced from the PHP appropriation to bring total PHP spending below the amount that was estimated to be spent on all

PHP enrollees if they were in the fee-for-service system. As can be seen in Exhibit 1, discussed below, this estimate was not too far off the mark. In summary, the intent of the Legislature's $36 million reduction was to comply with FFS upper limit requirement.

Subsequent to the Budget Act, the Governor signed another law that repealed authorization for paying for California Children's Services (CCS) for new PHP contracts entered into after August 1, 1994. This resulted in another $8,709,955 in reduced payments from the amount originally forecast in the Governor's proposed budget.

As a result of the $36 million Budget Act reduction and the elimination of funding for CCS services in certain new contracts, DHS had authority to spend $664,234,034 on PHP payments in 1994/1995. Therefore, payment rates had to be revised downward to levels that, when multiplied by the estimated PHP enrollees for SFY 1994/1995, would result in aggregate spending of $664,234,034 or less.

Alternatives for Reducing PHP Spending in 1994/1995

DHS had two basic alternatives for reducing rates to levels that, when multiplied by the estimated number of PHP enrollees in 1994/1995, would result in aggregate spending that did not exceed $664,234,034.

Alternative 1 would have been to follow the same basic methodology DHS actuaries used for determining the FFS Upper limit for each PHP from 1990/1991 to the present and set rates at 97 percent of each PHP's upper limit. As indicated above, Mr. Trapnell and others have found the basic DHS methodology for determining the FFS upper limit to be actuarially sound. On page 3 of his memo, Mr. Trapnell states that "given the formal methodology followed by the State, it is very unlikely that any recalculation would have produced rates meeting the budget requirements without obvious manipulation." To the contrary, Exhibit 1 shows that if DHS had set PHP rates at 97 percent of each PHP's 1994/1995 FFS upper limit as determined in accordance with the basic DHS actuarial methodology, PHP spending based on estimated PHP enrollees for 1994/1995 would have been even less than the $664,234,034 target (i.e., about $647,623,925).

Exhibit 1 was prepared in early October 1995 and has been filed with the court in the Watts Health Foundation lawsuit. It reflects PHP payments for 1994/1995 based on DHS estimates of PHP enrollees for that year rather than actual PHP enrollees. Since DHS had only estimates of PHP enrollees to work with at the time it set the 1994/1995 rates, this Exhibit more accurately reflects the monetary numbers that DHS was working with when it adopted the 1994/1995 rates.

Exhibit 1 shows a comparison of the estimated amounts that would have been spent on each PHP for SFY 1994/1995 based on the actual rates paid (95.5 percent of the 1990/1991 FFS upper limit) and the estimated amounts that would have been spent on each PHP for SFY 1994/1995 based on setting rates at 97 percent of the 1994/1995 FFS upper limit determined under the basic DHS actuarial methodology. Aggregate spending would have been approximately $647,623,925, well below the $664,234,034 limit imposed by the State Legislature. Twenty-six PHPs would have ended

up with a bigger decrease in rates than those actually paid in SFY 1994/1995. For some PHPs, this would have meant rates more than 20 percent smaller than the rates actually paid in 1994/1995.

While rates paid to some PHPs in 1994/1995 were above the PHP specific FFS upper limits, estimated aggregate PHP spending was below the estimated amount that would have been spent under the FFS system in the aggregate if all PHP enrollees were instead in the FFS system. The estimated aggregate FFS upper limit for 1994/1995 was $667,653,530, determined by dividing $647,623,925 by .97. Exhibit 1 indicates that estimated aggregate PHP spending based on the actual rates paid in 1994/1995 was about $660,640,700, and therefore, below the aggregate FFS upper limit.

DHS was concerned that, because of the greater rate reductions that would have resulted, implementation of alternative 1 could have driven some PHPs from the program, which in turn could lead to other problems, such as continuity of care for some PHP enrollees. A loss of PHPs from the program would have also been counter to the DHS goal of expanding managed care as a health care delivery system, which, as indicated above, was consistent with the objective of "efficiency, economy, and quality of care." Therefore, DHS decided not to implement alternative 1 for the same reason that it froze PHP rates from 1991/1992 through 1993/1994.

Alternative 2 was the method DHS ultimately chose to achieve the legislatively approved PHP spending level. DHS believes it was the best approach because it resulted in the least disruption to then existing PHP rates, spread the reduction in available spending in an equitable manner among all PHPs, and avoided the potential problems with alternative 1.

Under alternative 2, the direct financial impact of the spending reduction was lessened to a large degree by reducing PHP contract responsibilities. This was accomplished by eliminating Short-Doyle mental health services as a contract responsibility for those PHPs that had previously been responsible for providing those services. For these PHPs, the Short-Doyle component of their 1990/1991 FFS upper limit was eliminated. The CCS component was eliminated from the 1990/1991 FFS upper limit of PHPs that were no longer responsible for that service under the recently enacted state legislation referred to earlier. The elimination of Short-Doyle mental health services and CCS services from some PHP contracts, and the resulting downward revision in their 1990/1991 FFS upper limit that had been used to set rates since that year, achieved a significant portion of the reduction in PHP spending required by the Legislature.

The final step in alternative 2 was to reduce each PHP rate to the percentage of each PHP's 1990/1991 FFS upper limit necessary to meet the estimated aggregate PHP spending level of $664,234,034. Based on data available to DHS at the time it was setting the rates, it was determined that the rates would have to be reduced to 95.5 percent of each PHP's 1990/1991 FFS upper limit to achieve aggregate PHP spending of $664,234,034 for SFY 1994/1995.

Conclusion

DHS believes there was only one viable alternative, consistent with federal law, to the PHP rates that were actually set for 1994/1995. That alternative would have been to set PHP rates below the

actuarially determined FFS upper limit for each PHP. The reasons that DHS did not follow that alternative from 1991/1992 to the present have already been discussed in detail. While the current rates for some PHPs exceeded their actuarially determined PHP specific FFS upper limit, aggregate PHP payments were below what DHS estimated as the aggregate FFS upper limit for 1994/1995. Consequently, the decision DHS made in establishing 1994/1995 PHP rates was consistent with the ultimate objective of 42 United States Code section 447.361, which is for states not to spend more on services provided by PHPs than would be spent if all PHP enrollees were instead in the FFS system.

Please advise us if you feel that DHS must change PHP rates so that they fall below the FFS upper limit actuarially determined for each PHP. However, we hope that you will agree that the decision DHS made concerning the 1994/1995 rates was consistent with federal requirements.

We believe it is in the best interests of both the State and Federal government to reach a satisfactory resolution of the issues discussed herein. We will be happy to meet with you to discuss resolution of the issue, or to provide any additional information you may require. If you have any questions or concerns, or wish to schedule a meeting, please contact me at (916) 654-0391, or Mr. Joseph A. Kelly, Chief of the Medi-Cal Managed Care Division, at (916) 654-8076.

Sincerely,

John Rodriguez
Deputy Director
Medical Care Services

Enclosure

Exhibit 1 - Page 1 of 2

Projected Dollars 10/1/94 - 9/30/95 *

		Based on 95.5% of 90/91 Rate Book	Based on 97% of FY 94/95 FFSE	Change
Old PHPs				
Plan Names	County			
C.I.G.N.A.	Los Angeles	$128,530,871	$132,010,967	2.7%
Family Health Plan	Los Angeles	1,633,371	1,785,811	9.3%
Family Health Plan	Orange	2,231,921	2,548,078	14.2%
Foundation	Los Angeles	60,388,905	47,670,379	(21.1%)
Universal	Los Angeles	20,436,214	16,777,480	(17.9%)
Universal	Orange	26,196,297	25,377,579	(3.1%)
Kaiser South	Los Angeles	39,387,157	40,487,078	2.8%
Community Health Group	San Diego	41,450,400	41,685,627	.6%
United Health Plan	Los Angeles	57,237,432	56,392,794	(1.5%)
Contra Costa	Contra Costa	13,017,329	11,606,577	(10.8%)
Foundation	San Bernardino	10,240,117	10,243,936	.0%
Foundation	Ventura	9,027,232	9,371,202	3.8%
Kaiser South	Orange	4,167,855	4,549,045	9.1%
Kaiser South	Riverside	5,393,630	5,145,855	(4.6%)
Kaiser South	San Bernardino	8,840,002	9,278,866	5.0%
Kaiser South	San Diego	8,518,068	8,748,556	2.7%
Kaiser North	Alameda	3,985,398	3,752,677	(5.8%)
Kaiser North	Marin	321,929	361,667	12.3%
Kaiser North	Sacramento	3,919,222	3,789,607	(3.3%)
Kaiser North	Santa Clara	3,173,114	3,481,509	9.7%
Kaiser North	Sonoma	514,870	554,186	7.6%
Kaiser North	San Francisco	2,881,888	2,741,184	(4.9%)
LA Community Health Plan	Los Angeles	15,926,652	12,533,416	(21.3%)
Kaiser North	Contra Costa	5,010,142	4,557,887	(9.0%)
Molina	Los Angeles	18,239,258	17,952,947	(1.6%)
Total Old PHPs		$490,669,273	$473,404,913	(3.5%)

* These numbers are based on estimated eligibles.

Exhibit 1 - Page 2 of 2

Projected Dollars 10/1/94 - 9/30/95 *

		Based on 95.5% of 90/91 Rate Book	Based on 97% of FY 94/95 FFSE	Change
CAHMO				
Plan Names	County			
Maxicare	Los Angeles	$2,189,565	$2,272,410	3.8%
Maxicare	Kern	678,249	692,874	2.2%
Maxicare	San Bernardino	3,848,832	4,034,784	4.8%
Maxicare	Riverside	4,130,880	4,160,832	.7%
Health Net	Los Angeles	2,179,944	2,290,410	5.1%
Health Net	Riverside	1,232,400	1,349,010	9.5%
Health Net	San Bernardino	1,322,685	1,308,060	(1.1%)
Health Net	San Francisco	1,302,600	1,260,285	(3.2%)
Health Net	San Diego	2,051,730	2,254,608	9.9%
Health Net	Santa Clara	1,917,552	1,876,368	(2.1%)
Health Net	Contra Costa	2,269,176	2,021,760	(10.9%)
Health Net	Fresno	1,852,968	1,799,616	(2.9%)
Pacificare	Los Angeles	3,924,738	4,088,082	4.2%
Pacificare	Riverside	3,506,118	3,533,838	.8%
Pacificare	San Bernardino	3,248,784	3,414,180	5.1%
Pacificare	San Diego	3,432,198	3,708,936	8.1%
Pacificare	Alameda	996,957	870,246	(12.7%)
Pacificare	Tulare	765,414	761,319	(.5%)
Pacificare	Kern	5,887,800	6,014,700	2.2%
Pacificare	Contra Costa	1,486,925	1,288,838	(13.3%)
Pacificare	Fresno	4,592,484	4,393,116	(4.3%)
Blue Cross	San Bernardino	2,919,840	3,099,096	6.1%
Total CAHMO		$55,737,839	$56,493,368	1.4%
New PHPs				
Plan Names	County			
Foundation	Alameda	$770,580	$677,610	(12.1%)
Foundation	Riverside	572,400	580,800	1.5%
Kaiser North	San Joaquin	685,020	677,355	(1.1%)
Family Health Plan	Los Angeles	999,234	1,032,774	3.4%
Universal	Los Angeles	13,399,560	13,931,370	4.0%
Molina	Yolo	8,573,040	9,275,472	8.2%
Molina	Riverside	8,495,280	7,834,320	(7.8%)
Molina	San Bernardino	8,046,000	8,560,800	6.4%
Molina	El Dorado	3,896,852	4,216,141	8.2%
Molina	San Joaquin	1,587,600	1,572,240	(1.0%)
LA Community Health Plan	Los Angeles	9,168,120	9,531,990	4.0%
Chinese Community	San Francisco	1,102,200	1,066,395	(3.2%)
Care America	Los Angeles	9,168,588	9,633,195	5.1%
Sharp	San Diego	9,882,675	10,809,315	9.4%
National Health Plan	Stanislaus	4,330,359	4,295,997	(.8%)
National Health Plan	Los Angeles	18,350,640	19,044,960	3.8%
National Health Plan	San Bernardino	6,661,440	6,983,280	4.8%
National Health Plan	Riverside	7,944,000	8,001,600	.7%
Total New PHPs		$113,633,588	$117,725,614	3.6%

* These numbers are based on estimated eligibles.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

NOV 17 1995

John Rodriguez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear John:

On April 5, 1995 I sent you a letter concerning the actuarial soundness of your agency's rate-setting methodology for Medi-Cal managed care plans. That letter included an actuary's report which indicated that the $36 million reduction in managed care plan capitation rates imposed by the State of California during California State Fiscal Year (SFY) 1995 was not actuarially sound. We recommended that the State work with contracting plans to reach a capitation rate payment resolution that meets Federal requirements.

As a followup to my letter, Nancy Dapper, Acting San Francisco Regional Administrator, sent you a letter on May 2, 1995 requesting the State's response to our concerns about the actuarial soundness of the SFY 1995 rates. The Regional Office was in the process of reviewing the managed care contracts submitted by California that were affected by the rate reductions. Her letter to you detailed the Federal requirements that needed to be satisfied. Ms. Dapper stated that, if the rates provided for under the contracts were not determined on an actuarially sound basis, we would be required to proceed with formal disallowance procedures of all Federal Financial Participation (FFP) in expenditures under the SFY 1995 contracts in question.

We have yet to receive a final written response from you on either of these letters. If we do not receive notification from the State by December 1, 1995 indicating what steps have been taken to restore the rates to the levels prior to the reductions, HCFA will proceed immediately with a disallowance of all FFP expenditures under the SFY 1995 contracts.

While we understand that California was faced with difficult budgetary problems that prompted the rate reductions, we cannot allow deviations from established actuarial methodologies in setting managed care rates that assure Medicaid beneficiaries access to quality health care.

Sincerely,

Bruce C. Vladeck
Administrator

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY
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HHS HCFA
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REGION IX
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Mr. Bruce Vladeck, Administrator
Health Care Financing Administration
2000 Independence Avenue, SW
GHH Building, Room 314
Washington, DC 20201

Dear Mr. Vladeck:

This is in response to your letter of April 5, 1995, concerning the capitation rate methodology employed by the California Department of Health Services (DHS) in the health maintenance organization (HMO) contracting program. We appreciate the Health Care Financing Administration's (HCFA) concern on this matter; however, given the information contained in the letter and the accompanying analysis, it appears that there may be a misunderstanding of the events that precipitated your letter.

Let me begin by addressing the reasons for the length of time we have taken in formally responding to your letter. My staff met with Ms. Rita Johnson of HCFA's Office of Managed Care on May 23, 1995, to discuss this and other issues of mutual concern. In that meeting we discussed California's rate setting methodology, and discussed the best approach to formally responding to your concerns. Since we believed that your staff had a number of misunderstandings concerning the setting of rates for the 1994/1995 State Fiscal year, and that your letter of April 5, 1995 was in part based on these misunderstandings, we wished to follow an approach that would be constructive and discreet, and that would provide you the basis for rescinding that letter. At this meeting, Ms. Johnson recommended that instead of responding directly to you, we should submit our response to her in draft form, and that she would advise us on the appropriate phrasing and structure so as to be able to provide you with the information you required. We accepted this recommendation, and submitted our draft response to her on June 29, 1995. Although we have met with Ms. Johnson and HCFA staff on several occasions since then and have had a couple of conference call discussions on related issues, we have never received any feedback from her or from HCFA staff concerning this letter. Accordingly, we now have little choice but to provide you with our formal response.

Since the early days of California's managed care contracting program, DHS has employed professional actuaries in its Rate Development Branch. In the memorandum that was enclosed with your letter, your staff note that, "Unlike accountants, actuaries have no formal status under the laws of most states. In general, anyone wishing to style themselves as an 'actuary' ...may do so." While we have no reason to dispute this statement as it pertains to other states, the actuaries employed by DHS are required to meet the rigorous

DEC 20 1995

educational and performance standards for professional actuaries promulgated by both the Society of Actuaries and the American Academy of Actuaries.

These actuaries developed the State's methodology for setting HMO rates using a fee-for-service equivalent (FFSE) cost method. Documentation of this methodology has been submitted to HCFA on several occasions in the past, and all California managed care contracts that have been submitted to and approved by HCFA during at least the past ten years have included rates that were established in accord with this methodology. In addition, the actuarial firm of Milliman and Roberts determined that the methodology was appropriate in a study commissioned by an association of our managed care contractors.

We infer from your letter and the enclosed memorandum that you and your actuarial staff agree with the findings of California's actuaries. Specifically, in your letter you note that California's rates for the previous three fiscal years, "although frozen at the State Fiscal Year (SFY) 1991 level, appear to have been based on a sound methodology." Moreover, in the memorandum enclosed with to your letter, your staff note that DHS employs an actuarially sound and accepted FFSE cost methodology which is derived through "a very thorough approach" that is "more comprehensive, open, and detailed than [rate documentation] found in other state [sic]."

It is true that in response to unprecedented continuing shortfalls in State revenue collections, the California Legislature reduced numerous budgetary appropriations in enacting the 1994-95 State budget, and that among these were several reductions in the Medicaid program, including funding for HMOs. Nevertheless, California did not change its FFSE cost method of rate determination when it established HMO rates for 1994-95. Instead, the State merely lowered the percentage of FFSE to be paid in the rates that it was already using. These rates had initially been developed for the 1990-91 rate year. Set at 97 to 99 percent of FFSE, these rates had been frozen for the 1991-92, 1992-93, and 1993-94 rate years due to reductions in FFSE per capita costs that would otherwise have required the State to reduce capitation rates to our HMOs. The decision to freeze rates was based in part on the assumption that the reductions in per capita FFSE costs was temporary. The rate development methodology used to develop the 1990-91 rates was the same basic methodology that the State has used for many years, which you and your staff acknowledge is more thorough and accurate than any other state. Unlike the Federal budget, states must pass balanced budgets, and California firmly believes it is within the State's prerogative to establish its own budgetary appropriations and that reducing the percentage of FFSE paid to HMOs in no way affects the actuarial soundness of the State's rate setting methodology.

Federal regulations at Title 42, CFR Section 447.361, require that payments to a contractor under an at-risk contract not exceed the "cost to the agency" of providing the same services on a fee-for-service (FFS) basis, to an "actuarially equivalent" nonenrolled population group. In order to comply with this requirement, State actuaries have historically been used to determine the cost to the State of providing the same services to an actuarially equivalent group under FFS. As long as the HMO rates have been set below the actuarially determined FFS upper limit pursuant to the requirements of Section 447.361, both the state and the federal government have historically considered the rates to be "actuarially sound." The 1991-92 rates, which subsequently became the rates for two additional years, were set at 97 percent of the actuarially determined FFS level. At all times these rates were in compliance with 42 CFR section 447.316. Further, during the four year period these rates were in effect, HCFA approved HMO contracts containing these rates. In so doing, it was our view that the federal government was accepting not only the contracts, but both the rates and rate methodology behind the contracts as well. Certainly, it would not have been logical for us to have concluded otherwise.

HCFA has previously indicated that it is up to each state to decide at what percentage of the actuarially determined FFS upper payment limit to set the rates. Therefore, once a state has established an actuarially determined FFS upper limit pursuant to Section 447.361, there is nothing in federal law to indicate that in order for rates to be actuarially sound, they must be set at one hundred percent of the upper payment limit. We should also note that in prior discussions with Ms. Johnson, she has stated that HCFA has not, and will not, require a state to use a particular percentage of FFSE costs to establish a capitation rate, as long as the rate does not exceed the upper payment limit. She advised us that this decision was the State's to make, that HCFA's concern was whether the rates were sufficient to ensure adequate access and quality of care. It should be noted that during the rate year in question, none of California's Medicaid managed care plans chose to terminate their contracts, although all were legally able to do so. In addition, during this year they continued to demonstrate their ability to provide access and assure quality of care in accord with California's strict standards.

We are troubled by the memorandum enclosed with to your letter that states, "It is very unlikely that any recalculation would have produced rates meeting the budget requirement without obvious manipulation." To the contrary, applicable federal law indicates that a state could legitimately reduce its HMO rates to a lower percentage of FFS costs to achieve legislatively mandated budgetary savings. It appears to us that it is this reduction in the percentage of FFS costs that is the source of confusion that may have led you to believe that we had deviated from our rate methodology. We hope it is clear from the above description of our process that we have not engaged in any sort of "manipulation." It was solely by

reducing the percentage of PFS costs that we reduced rates paid to our HMOs to comply with a legitimate action taken by this State's Legislature during a time of fiscal crisis.

In December 1994, when HCFA made its first inquiries concerning current HMO rates, DHS provided the requested information in a timely manner to both the Baltimore and San Francisco (Region IX) offices of HCFA. We anticipated that this information, including the rate manual, would alleviate concerns and establish that California is setting capitation rates appropriately using an actuarially sound methodology. I hope that the information above will remove any questions that remain and satisfy all parties that California acted with proper care and concern for its impact on health plans and within all applicable regulations.

We believe that it is in the best interests of both the State and Federal government to reach closure on the issues raised in your April 5, 1995 letter. To that end we will be happy to meet with you to pursue resolution, or to provide you any additional information you may require. If you have any questions or concerns, or wish to schedule a meeting, please contact me at (916) 654-0391, or Mr. Joseph A. Kelly, Chief of the Medi-Cal Managed Care Division, at (916) 654-8076.

Sincerely,

Original signed by
John Rodriguez

John Rodriguez
Deputy Director
Medical Care Services

cc: See next page.

NOV 8 0 1995

cc: Ms. Rachel Block, Director
Office of Managed Care
3030 Independence Avenue, SW
Cohen Building, Room 4360
Washington, DC 21201

Ms. Rita Johnson-Mills, Director
Medicaid Managed Care Team
Office of Managed Care
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Mr. Richard Chambers
Health Care Financing Administration
75 Hawthorne Street, 5th Floor
San Francisco, CA 94105

SCG
cc: WFIG

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P. O. Box 942732
SACRAMENTO, CALIFORNIA 94234-7320
(916) 654-0391

PETE WILSON, Governor

November 30, 1995

Mr. Bruce Vladeck, Administrator
Health Care Financing Administration
2000 Independence Avenue, SW
GHH Building, Room 314
Washington, D.C. 20201

Dear Mr. Vladeck:

I am in receipt of your letter of November 17, 1995 in which you inform me that unless you "... receive notification from the State by December 1, 1995 indicating what steps have been taken to *restore the rates to the levels prior to the reductions*, (italics added) HCFA will proceed immediately with a disallowance of all FFP expenditures under the SPY 1995 contracts."

By now you have received our formal response which was mailed to you on November 20, 1995. In that letter, you will note that the reason we had not formally responded earlier was that your staff requested that we give them the opportunity to work with our draft response prior to submitting in final. You will also note that while there have been a number of discussions on this issue between your staff and ours, HCFA staff have not provided any reaction to the State's draft response. During the past two months, the State has asked Region IX on three occasions as to the status of the review of our draft response and was on all occasions informed that there were unspecified "concerns" among "various factions" at the head office, and that it would probably take "a couple more weeks" to get a response back. Finally, during the second week of November, we determined to provide you with our formal response without the promised input from your staff.

In view of the above, any action by you to either direct us to restore the rates to the previous levels or to disallow FFP as threatened would be premature. We request that you review our formal response on this issue, and that you meet and confer with us to clarify any points about which you or your staff may have questions.

If you have any questions or concerns, or wish to schedule a meeting, please contact me at (916) 654-0391. Thank you for your consideration.

Sincerely,

John Rodriguez
Deputy Director
Medical Care Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB 5 1996

Mr. John Rodriguez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street - Room 1253
Sacramento, California 95814

Dear Mr. Rodriguez:

I am writing in response to both your November 20 and 30 letters regarding the actuarial soundness of the State's rates under its Prepaid Health Plan (PHP) program for State Fiscal Year (SFY) 1995.

We continue to need documentation from the State that the rates in question were developed on an actuarially sound basis. We find your response lacking for the following reasons:

1. Your November 20th response confuses the actual capitation rates paid to HMOs with the fee-for-service equivalent (FFSE) amount, which operates as an upper payment limit on such capitation rates. As clearly stated in § 434.61, it is the final capitation rates, after reductions from FFSE, that must be actuarially sound. Thus, the State's assertion that "...reducing the percentage of FFSE paid to HMOs in no way affects the actuarial soundness of the State's rate setting methodology" is incorrect. Likewise, the State's assertion that "As long as the HMO rates have been set below the actuarially determined FFS upper limit..., both the State and the Federal government have historically considered the rates to be 'actuarially sound'." HCFA has never taken the position that any payment rate would be considered "actuarially sound."

2. The State has not yet responded to HCFA's assertion that California established a *de facto* standard of actuarial soundness and then deviated from it for budget-driven reasons for which it has yet to provide actuarial justification. Therefore, we renew our request for information documenting the actuarial soundness of the rates in question. The State could document the actuarial soundness of the rates through the following methods:

a. Submit experience data showing that the new rates paid by the State adequately cover claims and administrative expenses attributable to Medicaid enrollees under the plans in question.

b. Provide documentation demonstrating that there are negotiated rates in current use for comparable plans which are commensurate with the rates in dispute.

c. Identify specific reductions from the FFSE rates that a managed care organization should be able to achieve, after allowing for the cost of all additional services required of HMOs and additional administrative costs beyond the allowance in the FFSE, and provide convincing data that the reductions are, in fact, feasible.

In order to resolve this matter expeditiously, please respond to the concerns listed above within 30 calendar days of the date of this letter. If we do not receive the State's response by then, HCFA will have no other alternative but to proceed as previously indicated with the denial of all Federal Financial Participation for the SFY 1995 PHP contracts at issue.

Should you have any questions about this, please feel free to contact me or Rachel Block, Acting Director of the Medicaid Managed Care Team, at (410)786-9507.

Sincerely,

Bruce C. Vladeck
Administrator

OFFICE OF INTERGOVERNMENTAL AFFAIRS
DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Room 630F
Washington, DC 20201

FAX COVER SHEET

DATE: 1/29/96

TO: Diana Fortuna **PHONE:**
FAX:

FROM: John Monahan **PHONE:** (202) 690-6060
Director **FAX:** (202) 690-5672

RE:

CC:

Number of pages including cover sheet: 3

Message:

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

TO PAT + RETURN

CLOSE HOLD FAX TO GRANTLAND

The Administrator
Washington, D.C. 20201

October 27, 1995

Eyes Only

Note to: Chief of Staff

Subject: California Capitation Rates--Alert

This is to alert you to a potential disallowance action against California Medicaid that could amount up to $500 million in Federal funds for the period 10/1/94 to the present.

Background

The State of California now operates Medicaid managed care in a number of counties involving contracts with 16 prepaid health plans. Approximately 500,000 MediCal beneficiaries are enrolled in these plans. The initial capitation for these contracts was set in 1991; the rates were then frozen for the next three years. For State Fiscal Year (SFY) 94/95, California cut $36 million from the managed care budget and issued notices to the plans in November 1994 that their capitation rates for remainder of SFY 94/95 would be reduced to accommodate the $36 million cut. There was no consultation or negotiation with the plans; the rate cut was announced by edict. The State and HHS are being sued by one of the plans concerning this rate cut. HHS/OGC staff are working with the Department of Justice in preparation of the court case.

By Medicaid regulation, HCFA has to approve all State contracts with prepaid health plans. In the case of California, these contracts, which the State put into effect on October 1, 1994, were not submitted to the regional office for approval until March 1995. In April and May, separate letters from the HCFA Administrator and Acting Regional Administrator were sent to the State Medicaid Agency Director asking for an explanation of the rate cut and reminding the State that, under the statute, States must use actuarially sound methods to set capitation rates. Specifically, the regional office asked the State to provide an explanation about whether the lower 1995 rates were actuarially sound since the rates seemed to have been lowered simply to comply with State budget constraints.

The entire amount of Federal matching funds that have been paid to the State for these unapproved contracts, up to $500 million, would be disallowed by HCFA if is finally determined that the capitation rates are not actuarially sound.

...1

It is important to note the relationship of the SFY 94/95 capitation rates to the rates proposed under the California "Two Plan Model" freedom of choice waiver that is currently pending in HCFA. The Two Plan Model waiver proposes to phase-in an additional 2.5 million MediCal beneficiaries into managed care beginning in January 1996. The proposed rates under the Two Plan Model are similar to the current SFY 94/95 rates. Thus, if we take the disallowance because the 1995 rates are not sound, there is a good probability we will have serious conflict with the State over the Two Plan Model rates.

A coalition of providers (public and private), counties, local initiative plans, commercial managed care plans, advocacy for beneficiaries, the medical and hospital associations have met with regional and central office HCFA and HHS representatives to press the Department to fight the State over what are clearly inadequate rates under the Two Plan Model.

Current Status

HCFA staff have received a draft State response to the April and May letters from HCFA. HCFA believes the draft response does not adequately address our concerns about the actuarial soundness and adequacy of the capitation rates. The State is awaiting our comments on their draft letter prior to proceeding with a final letter.

We are prepared to tell the State that we do not agree with their response, and that the $36 million in rate cuts must be restored to the capitation rates or HCFA will proceed with a disallowance of the entire $500 million in Federal payments under the contracts.

Bruce Vladeck

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

15-Feb-1996 11:04am

TO: Carol H. Rasco
TO: Martha Foley
TO: Marcia L. Hale

FROM: Diana M. Fortuna
Domestic Policy Council

CC: John B. Emerson

SUBJECT: Development at HHS

FYI, you will recall we had discussed a letter that HHS was planning to send to the state of California asking for justification of a cut in their managed care rates within 30 days, or else face a $180 million disallowance. Our understanding with HHS last week was that they were not planning to send the letter until they got a better sense of where the state was coming from in resisting this documentation. However, apparently the letter went out unintentionally a few days ago.

HHS talked to the state after they received the letter. Apparently the state said they were more or less expecting such a letter, and they do plan to comply with the letter's request and submit documentation within 30 days. I assume HHS will let us know their plans after they get the documentation.

THE WHITE HOUSE

WASHINGTON

February 1, 1996

MEMORANDUM FOR LEON PANETTA

FROM: Diana Fortuna
Domestic Policy Council

SUBJECT: Potential Medicaid disallowance in California

You had asked for some background information on a potential $180 million Medicaid disallowance in California.

The issue is whether the reimbursement rates that the state pays to managed care plans are "actuarially sound," as Federal law requires. The state froze these rates for three years in a row. Then, last year the state legislature cut these rates across the board by $36 million, as part of the state budget.

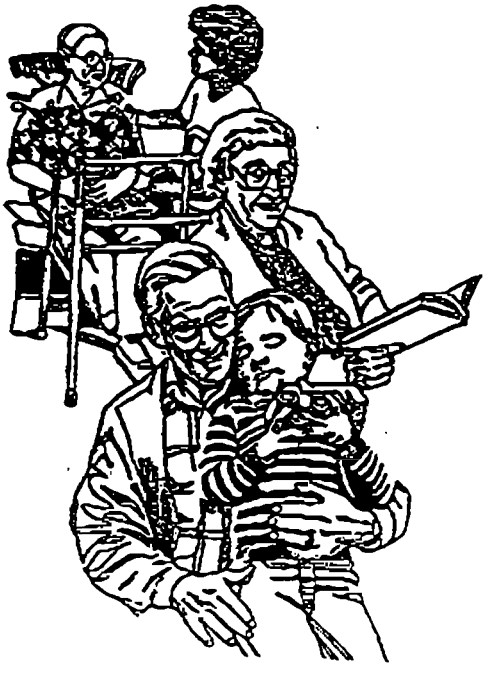
This rate reduction is opposed by providers, including public and private physicians and hospitals, managed care plans, counties, and advocates. One of the managed care plans has sued the state and the Federal government over the rate reduction.

In April, HHS informed the state that the rate cut appeared to be arbitrary and driven by budget constraints, and asked the state for some justification. Since the term "actuarially sound" is open to interpretation, it would not appear to be difficult for the state to submit an analysis defending their action. However, the state has not yet done so. HHS does not know why.

HHS may inform the state late next week that it must provide documentation for the rates within a certain time frame, or else face a disallowance of $180 million. In the meantime, HHS is trying to learn more about the state's motivations. If further discussions were to fail and HHS were to disallow these funds, the state would not lose the cash until the appeals process was exhausted.

cc: Carol Rasco
John Emerson
Alice Rivlin
Martha Foley

HEALTH CARE FINANCING ADMINISTRATION



ADDRESSEE:
Diana Fortuna 456-7028 5570
Jennifer O'Connor 456-7929
Emily Bromberg 456-2889

PHONE:

FROM: Mary Oppenheimer for Kathy King

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726
FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:
C+15		1/16/96

REMARKS:

Attached is:

A) Background memo on 2-plan waiver

B) Draft letter to California and earlier letters on disallowance issue

(Tried to send on Thursday; trying again!)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

December 28, 1995

MEMO TO: Kevin Thurm
Chief of Staff, OS

FROM: Bruce C. Vladeck
Administrator, HCFA

SUBJECT: California "Two-Plan" Waiver

HCFA is currently in the final stages of reviewing California's request for 1915(b) waivers to implement the State's "Two-Plan Model". Scheduled for implementation in twelve counties, it would be the largest Medicaid managed care program implemented to date. The proposal is both complex and unique to the characteristics of California's health care financing and delivery system.

HCFA's analysis to date supports the approval of this waiver as soon as practicable before the legally prescribed deadline of January 22, 1996. Due to the scope, complexity and controversy associated with the waiver, I thought it would be helpful to describe the proposal, the key issues that we have addressed during review, and the conditions we will place on the waiver's implementation once approved.

Summary of California's "Two-Plan Model"

California's waiver request to implement the "Two-Plan Model" was received in June 1995. It represents the culmination of two years of planning and discussion to develop the State's strategy for expansion of Medicaid managed care. A detailed description of the background and rationale is provided in the report Expanding Medi-Cal Managed Care, a copy of which is attached for your information.

The key elements of the "Two-Plan Model" are as follows: Medi-Cal beneficiaries in twelve counties will be offered a choice of two managed care plans - a "Mainstream Plan", which is a commercial HMO, and a "Local Initiative Plan." The commercial plans have been selected based on a competitive procurement process. The Local Initiative Plan will be comprised of existing County hospitals and health care facilities, as well as other providers (including FQHCs and RHCs). The "Two-Plan Model" will not become operational in a given county until the State has certified that access and quality requirements can be met by both the Mainstream and Local Initiative Plans.

Twelve counties have been designated to implement the "Two-Plan Model": **Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare**. Enrollment will be limited to Medi-Cal beneficiaries who are in AFDC and AFDC related categories; SSI and other disabled beneficiaries will not be enrolled. A total of 3.3 million Medi-Cal

beneficiaries are expected to enroll, of whom 2.4 million will be enrolled on a mandatory basis.

Key Issues in the "Two-Plan" Waiver

We find the proposed waiver is consistent with Medicaid's goals, and meets statutory requirements with respect to access, quality and cost effectiveness. In reaching this conclusion, there are a number of key issues that we have identified which are summarized below.

- State administrative capacity. Numerous studies conducted by HCFA and outside organizations have documented the lack of adequate State staffing of key operational functions necessary to effectively administer California's previous Medicaid managed care initiatives. In response to these reports, and at HCFA's urging, the State has made significant progress and is now well on the way to recruiting and hiring more than 80 additional staff who will directly and indirectly support implementation of the "Two-Plan Model" and other Medi-Cal managed care programs.

- Adequacy of Rates. Based on past problems in this area, we carefully scrutinized the proposed "Two-Plan Model" rates. HCFA is satisfied that the rates are actuarially sound and adequate to ensure access to Medi-Cal services as required by federal law.

- Beneficiary Enrollment Process. California, like other States, has experienced problems in its Medicaid managed care enrollment process, ranging from fraudulent marketing by health plans to confusing or inaccurate information about beneficiaries' rights and responsibilities. I am pleased that the State has elected to use an independent enrollment contractor for this program as recommended in HCFA's model guidelines for Medicaid managed care marketing and enrollment. We will carefully scrutinize and evaluate this facet of the program prior to implementation.

Conditions for Approval

HCFA normally prescribes various conditions regarding State implementation of a new or expanded managed care program. In addition to the standard conditions, we have reached agreement that implementation will not commence in any given county until:

(1) HCFA has conducted a satisfactory "readiness" review in that county based on the proposed phase-in schedule which will focus on beneficiary enrollment, access and quality concerns;

(2) the State has selected a qualified organization for the federally-mandated external quality review; and

(3) the State has demonstrated to HCFA's satisfaction that its staffing and systems are sufficient and appropriate to operate this large and complex program.

Additional Considerations

Two additional concerns, while not essential to HCFA's managed care review process, may affect the State's short- and long-term success.

- Commercial plan procurement process. In preparation for implementation of the "Two-Plan Model", the State issued a request for proposals and has selected several managed care organizations to serve as the commercial plans in the twelve counties. However, the State elected to limit this selection to one commercial plan for each county. The unsuccessful bidders have challenged the State's commercial plan selection in eight of the twelve counties.

  As a result, the State plans to begin implementation of the "Two-Plan Model" in the uncontested counties: **Alameda, Kern, San Joaquin and Tulare**. The legal challenges in the remaining counties are proceeding in appropriate State administrative and judicial proceedings. However, continued legal challenges may delay implementation in some or all of the "contested" cases.

- County workforce issues. Throughout the country, publicly-operated health care facilities and systems are subject to growing fiscal pressure, forcing them to down-size and restructure in order to survive with limited resources and increased managed care competition. We have received comments from local officials and organizations representing county health care employees concerned with the short- and long-term effects of increased competition and increased Medicaid managed care activities.

We have engaged in constructive negotiations with California to ensure that this waiver is consistent with Medicaid's goals. In addition to support from the State, we have received a letter from Congressman Stark urging HCFA's approval of the "Two-Plan Model" waiver. HCFA and the State will face significant challenges in the months ahead, and we expect to work closely with them to ensure that the "Two-Plan Model" is implemented successfully.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DRAFT

Mr. John Rodriguez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street - Room 1253
Sacramento, California 95814

Dear Mr. Rodriguez:

I am writing in response to both your November 20 and 30 letters regarding the actuarial soundness of the State's rates under its Prepaid Health Plan (PHP) program for State Fiscal Year (SFY) 1995.

We continue to need documentation from the State

~~Your response did not demonstrate~~ that the rates in question were developed on an actuarially sound basis. We find your response lacking for the following reasons:

1. November 20th Your response confuses the actual capitation rates paid to HMOs with the fee-for-service equivalent (FFSE) amount, which operates as an upper payment limit on such capitation rates. As clearly stated in § 434.61, it is the final capitation rates, after reductions from FFSE, that must be actuarially sound. Thus, the State's assertion that "...reducing the percentage of FFSE paid to HMOs in no way affects the actuarial soundness of the State's rate setting methodology" is incorrect. Likewise, ~~(Imagine the extreme case of reducing the percentage to zero.)~~

2. The State's assertion that "As long as the HMO rates have been set below the actuarially determined FFS upper limit..., both the State and the Federal government have historically considered the rates to be 'actuarially sound'." HCFA has never taken the position that any payment rate would be considered "actuarially sound."

3. The State has not yet responded to HCFA's assertion that California established a *de facto* standard of actuarial soundness and then deviated from it for budget-driven reasons for which it has yet to provide actuarial justification. Therefore,

move to immediately after Therefore on preceding page

We renew our request for information documenting the actuarial soundness of the rates in question. The State could document the actuarial soundness of the rates through the following methods:

1. Submit experience data showing that the new rates paid by the State adequately cover claims and administrative expenses attributable to Medicaid enrollees under the plans in question.

2. Provide documentation demonstrating that there are negotiated rates in current use for comparable plans which are commensurate with the rates in dispute.

3. Identify specific reductions from the FFSE rates that a managed care organization should be able to achieve, after allowing for the cost of all additional services required of HMOs and additional administrative costs beyond the allowance in the FFSE, and provide convincing data that the reductions are, in fact, feasible.

In order to resolve this matter expeditiously, please respond to the concerns listed above within 30 calendar days of the date of this letter. If we do not receive the State's response by then, HCFA will have no other alternative but to proceed as previously indicated with the denial of all Federal Financial Participation for the SFY 1995 PHP contracts at issue.

Should you have any questions about this, please contact Rachel Block, Acting Director of the Medicaid Managed Care Team, at (410)786-9507.

Sincerely,

Bruce C. Vladeck
Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

NOV 17 1995

John Rodriguez
Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear John:

On April 5, 1995 I sent you a letter concerning the actuarial soundness of your agency's rate-setting methodology for Medi-Cal managed care plans. That letter included an actuary's report which indicated that the $36 million reduction in managed care plan capitation rates imposed by the State of California during California State Fiscal Year (SFY) 1995 was not actuarially sound. We recommended that the State work with contracting plans to reach a capitation rate payment resolution that meets Federal requirements.

As a followup to my letter, Nancy Dapper, Acting San Francisco Regional Administrator, sent you a letter on May 2, 1995 requesting the State's response to our concerns about the actuarial soundness of the SFY 1995 rates. The Regional Office was in the process of reviewing the managed care contracts submitted by California that were affected by the rate reductions. Her letter to you detailed the Federal requirements that needed to be satisfied. Ms. Dapper stated that, if the rates provided for under the contracts were not determined on an actuarially sound basis, we would be required to proceed with formal disallowance procedures of all Federal Financial Participation (FFP) in expenditures under the SFY 1995 contracts in question.

We have yet to receive a final written response from you on either of these letters. If we do not receive notification from the State by December 1, 1995 indicating what steps have been taken to restore the rates to the levels prior to the reductions, HCFA will proceed immediately with a disallowance of all FFP expenditures under the SFY 1995 contracts.

While we understand that California was faced with difficult budgetary problems that prompted the rate reductions, we cannot allow deviations from established actuarial methodologies in setting managed care rates that assure Medicaid beneficiaries access to quality health care.

Sincerely,

Bruce C. Vladeck
Administrator

NOV 3 0 1995

cc: Ms. Rachel Block, Director
Office of Managed Care
3030 Independence Avenue, SW
Cohen Building, Room 4360
Washington, DC 21201

Ms. Rita Johnson-Mills, Director
Medicaid Managed Care Team
Office of Managed Care
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Mr. Richard Chambers
Health Care Financing Administration
75 Hawthorne Street, 5th Floor
San Francisco, CA 94105

reducing the percentage of FFS costs that we reduced rates paid to our HMOs to comply with a legitimate action taken by this State's Legislature during a time of fiscal crisis.

In December 1994, when HCFA made its first inquiries concerning current HMO rates, DHS provided the requested information in a timely manner to both the Baltimore and San Francisco (Region IX) offices of HCFA. We anticipated that this information, including the rate manual, would alleviate concerns and establish that California is setting capitation rates appropriately using an actuarially sound methodology. I hope that the information above will remove any questions that remain and satisfy all parties that California acted with proper care and concern for its impact on health plans and within all applicable regulations.

We believe that it is in the best interests of both the State and Federal government to reach closure on the issues raised in your April 5, 1995 letter. To that end we will be happy to meet with you to pursue resolution, or to provide you any additional information you may require. If you have any questions or concerns, or wish to schedule a meeting, please contact me at (916) 654-0391, or Mr. Joseph A. Kelly, Chief of the Medi-Cal Managed Care Division, at (916) 654-8076.

Sincerely,

Original signed by
John Rodriguez

John Rodriguez
Deputy Director
Medical Care Services

cc: See next page.

Federal regulations at Title 42, CFR Section 447.361, require that payments to a contractor under an at-risk contract not exceed the "cost to the agency" of providing the same services on a fee-for-service (FFS) basis, to an "actuarially equivalent" nonenrolled population group. In order to comply with this requirement, State actuaries have historically been used to determine the cost to the State of providing the same services to an actuarially equivalent group under FFS. As long as the HMO rates have been set below the actuarially determined FFS upper limit pursuant to the requirements of Section 447.361, both the state and the federal government have historically considered the rates to be "actuarially sound." The 1991-92 rates, which subsequently became the rates for two additional years, were set at 97 percent of the actuarially determined FFS level. At all times these rates were in compliance with 42 CFR section 447.316. Further, during the four year period these rates were in effect, HCFA approved HMO contracts containing these rates. In so doing, it was our view that the federal government was accepting not only the contracts, but both the rates and rate methodology behind the contracts as well. Certainly, it would not have been logical for us to have concluded otherwise.

HCFA has previously indicated that it is up to each state to decide at what percentage of the actuarially determined FFS upper payment limit to set the rates. Therefore, once a state has established an actuarially determined FFS upper limit pursuant to Section 447.361, there is nothing in federal law to indicate that in order for rates to be actuarially sound, they must be set at one hundred percent of the upper payment limit. We should also note that in prior discussions with Ms. Johnson, she has stated that HCFA has not, and will not, require a state to use a particular percentage of FFSE costs to establish a capitation rate, as long as the rate does not exceed the upper payment limit. She advised us that this decision was the State's to make, that HCFA's concern was whether the rates were sufficient to ensure adequate access and quality of care. It should be noted that during the rate year in question, none of California's Medicaid managed care plans chose to terminate their contracts, although all were legally able to do so. In addition, during this year they continued to demonstrate their ability to provide access and assure quality of care in accord with California's strict standards.

We are troubled by the memorandum enclosed with to your letter that states, "it is very unlikely that any recalculation would have produced rates meeting the budget requirement without obvious manipulation." To the contrary, applicable federal law indicates that a state could legitimately reduce its HMO rates to a lower percentage of FFS costs to achieve legislatively mandated budgetary savings. It appears to us that it is this reduction in the percentage of FFS costs that is the source of confusion that may have led you to believe that we had deviated from our rate methodology. We hope it is clear from the above description of our process that we have not engaged in any sort of "manipulation." It was solely by

educational and performance standards for professional actuaries promulgated by both the Society of Actuaries and the American Academy of Actuaries.

These actuaries developed the State's methodology for setting HMO rates using a fee-for-service equivalent (FFSE) cost method. Documentation of this methodology has been submitted to HCFA on several occasions in the past, and all California managed care contracts that have been submitted to and approved by HCFA during at least the past ten years have included rates that were established in accord with this methodology. In addition, the actuarial firm of Milliman and Roberts determined that the methodology was appropriate in a study commissioned by an association of our managed care contractors.

We infer from your letter and the enclosed memorandum that you and your actuarial staff agree with the findings of California's actuaries. Specifically, in your letter you note that California's rates for the previous three fiscal years, "although frozen at the State Fiscal Year (SFY) 1991 level, appear to have been based on a sound methodology." Moreover, in the memorandum enclosed with to your letter, your staff note that DHS employs an actuarially sound and accepted FFSE cost methodology which is derived through "a very thorough approach" that is "more comprehensive, open, and detailed than [rate documentation] found in other state [sic]."

It is true that in response to unprecedented continuing shortfalls in State revenue collections, the California Legislature reduced numerous budgetary appropriations in enacting the 1994-95 State budget, and that among these were several reductions in the Medicaid program, including funding for HMOs. Nevertheless, California did not change its FFSE cost method of rate determination when it established HMO rates for 1994-95. Instead, the State merely lowered the percentage of FFSE to be paid in the rates that it was already using. These rates had initially been developed for the 1990-91 rate year. Set at 97 to 99 percent of FFSE, these rates had been frozen for the 1991-92, 1992-93, and 1993-94 rate years due to reductions in FFSE per capita costs that would otherwise have required the State to reduce capitation rates to our HMOs. The decision to freeze rates was based in part on the assumption that the reductions in per capita FFSE costs was temporary. The rate development methodology used to develop the 1990-91 rates was the same basic methodology that the State has used for many years, which you and your staff acknowledge is more thorough and accurate than any other state. Unlike the Federal budget, states must pass balanced budgets, and California firmly believes it is within the State's prerogative to establish its own budgetary appropriations and that reducing the percentage of FFSE paid to HMOs in no way affects the actuarial soundness of the State's rate setting methodology.

Orig: WPT-TG
cc: SCG

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P. O. Box 942732
SACRAMENTO, CALIFORNIA 94234-7320
(916) 654-0391

PETE WILSON, Governor

HHS HCFA DIVISION OF MEDICAID REGION IX

NOV 27 10 00 PH '95

NOV 2 0 1995

Mr. Bruce Vladeck, Administrator
Health Care Financing Administration
2000 Independence Avenue, SW
GHH Building, Room 314
Washington, DC 20201

Dear Mr. Vladeck:

This is in response to your letter of April 5, 1995, concerning the capitation rate methodology employed by the California Department of Health Services (DHS) in the health maintenance organization (HMO) contracting program. We appreciate the Health Care Financing Administration's (HCFA) concern on this matter; however, given the information contained in the letter and the accompanying analysis, it appears that there may be a misunderstanding of the events that precipitated your letter.

Let me begin by addressing the reasons for the length of time we have taken in formally responding to your letter. My staff met with Ms. Rita Johnson of HCFA's Office of Managed Care on May 23, 1995, to discuss this and other issues of mutual concern. In that meeting we discussed California's rate setting methodology, and discussed the best approach to formally responding to your concerns. Since we believed that your staff had a number of misunderstandings concerning the setting of rates for the 1994/1995 State Fiscal year, and that your letter of April 5, 1995 was in part based on these misunderstandings, we wished to follow an approach that would be constructive and discreet, and that would provide you the basis for rescinding that letter. At this meeting, Ms. Johnson recommended that instead of responding directly to you, we should submit our response to her in draft form, and that she would advise us on the appropriate phrasing and structure so as to be able to provide you with the information you required. We accepted this recommendation, and submitted our draft response to her on June 29, 1995. Although we have met with Ms. Johnson and HCFA staff on several occasions since then and have had a couple of conference call discussions on related issues, we have never received any feedback from her or from HCFA staff concerning this letter. Accordingly, we now have little choice but to provide you with our formal response.

Since the early days of California's managed care contracting program, DHS has employed professional actuaries in its Rate Development Branch. In the memorandum that was enclosed with your letter, your staff note that, "Unlike accountants, actuaries have no formal status under the laws of most states. In general, anyone wishing to style themselves as an 'actuary' ...may do so." While we have no reason to dispute this statement as it pertains to other states, the actuaries employed by DHS are required to meet the rigorous

CA County

Brief
428-7

1115

$364 – add'l
$253 – from P/H

1915b

Two plan model

disallowing entity

--- enrollment guarantee for public plan
--- vol. enrollment into a private mc plan

can we put this limit / restriction in state law ...

Emily
Bromley

John 362-3461

HEALTH CARE FINANCING ADMINISTRATION
WEEKLY REPORT
JANUARY 7 - JANUARY 27, 1996

KEY DEPARTMENT NEWS

California Proposal for Medicaid Managed Care Under Final Review: The State of California has requested approval of a waiver of Medicaid's freedom of choice provisions to enable it to implement the largest and most ambitious Medicaid managed care initiative to date. Medicaid beneficiaries in 12 counties would be offered a choice of two managed care plans - a "Mainstream Plan", which is a commercial HMO, and a "Local Initiative Plan." After full implementation, a total of 3.3 million Medi-Cal beneficiaries are expected to enroll, the overwhelming majority of whom are AFDC and AFDC-related beneficiaries. Twelve (12) counties designated to implement the **Two-Plan Model**: *Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.* The Health Care Financing Administration must make a decision on the Two-Plan Model by January 22, the 90th day and statutory deadline for action.

Contact Person: Rachel Block, Office of Managed Care, (410) 786-9507

California Officials to Meet with Department on Statewide 1115 Demonstration: Department staff and California and Los Angeles County senior officials are tentatively scheduled to meet on January 18 in Washington to discuss the significant issues with the State's most recent working draft section 1115 demonstration application, submitted on November 21. Significant issues to be discussed include the lack of a plan to restructure the Los Angeles County public health care system, the request to recalculate disproportionate share hospital payments to include services provided in free standing clinics, and budget neutrality. In addition, there will be a discussion concerning the 23 additional counties in California that have expressed interest in participating in the section 1115 demonstration application that Los Angeles County submitted.

Contact Person: Gina Clemons, Office of Reseach and Demonstrations, (410) 786-9644

Nancy -
Pls call Jeff Markowitz directly - changes. 7/60 (I have 690 - He's on to pick up my daughter)
Joyce

THE WEEK IN REVIEW

FBI and Inspector General Announce Multiple Count Fraud Indictment

On January 11, the Federal Bureau of Investigations and the Department's Regional Inspector General, Denver, announced a 30 count indictment of a licensed physical therapist for mail fraud and fraudulent claims in connection with Medicare, Colorado Compensation Insurance Authority, the State of Colorado worker's compensation insurer. and other insurers.

Contact Person: Judy Berek, Office of the Administrator, 690-8162

We're trying to get IG to report more info. We have no real info. on amt. of money involved (beyond ~$300,000)