Aon Hewitt
Consulting | Health and Benefits

This unsigned document has minor changes from the certification that was submitted to CMS. The submitted certification is still in CMS review and may be subject to additional minor changes that are expected to have no impact on DMS' rates offered in this RFP.

Commonwealth of Kentucky

Department of Medicaid Services

Medicaid Rates for the Contract Period

July 1, 2015 through June 30, 2016

April 2, 2015

April 2, 2015

Mr. Neville Wise
Deputy Commissioner
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

Re: Medicaid Actuarial Rate Ranges for Kentucky's Medicaid Managed Care Organization (MCO) Program for the period July 1, 2015 through June 30, 2016

Dear Mr. Wise:

On behalf of the Department of Medicaid Services within the Commonwealth of Kentucky's Finance and Administration Cabinet, we have calculated the actuarially sound rate ranges for the Medicaid Managed Care Organization (MCO) Program for the contract period July 1, 2015 through June 30, 2016.

Actuarially Sound Rate Ranges for Non-ACA and ACA Populations

Aon Hewitt has worked closely with the DMS to ensure that rate ranges reflect the Commonwealth's program for State Fiscal Year 2016 (SFY 2016).

This report contains actuarially sound rate ranges for two groups of MCO enrollees: the traditional Medicaid population and the expansion populations. Throughout this report, we reference these two groups as Non-ACA and Affordable Care Act (ACA), respectively.

The rate ranges for the Non-ACA and ACA populations were developed with and without the Health Insurance Fee (HIF). This approach was taken to support transparency in the rates that Kentucky will pay its contracted MCOs and to support Kentucky's goal to establish a new HEDIS incentive program in SFY 2016.

MCO-submitted claims data was used as the base data in the development of the rate ranges for SFY 2016. The base data was adjusted for all relevant factors including changes and trends in population, cost, and utilization between the base year and the rate year. Aon Hewitt's use and validation of the claims data from contracted MCOs represents an important quality improvement step in developing actuarially sound rate ranges for SFY 2016.

SFY 2016 Improvements Planned for Kentucky's Medicaid MCO Program

For a start date of July 1, 2015, DMS is currently in the process of re-procuring its MCO network. One of the major goals of this RFP is to retain and attract MCOs that are committed to providing high-quality care to Medicaid members on a statewide basis. MCOs will be asked to accept capitation rates set by DMS within the actuarially sound rate range. At the same time, DMS plans include a new HEDIS incentive program to encourage participating MCOs to improve their performance.

Report Navigation

The following report describes the data and methods used by Aon Hewitt for calculating the SFY 2016 actuarially sound rate ranges for Kentucky's Medicaid MCO Program, in accordance with the rate-setting checklist that has been developed by the Centers for Medicare and Medicaid Service to review state Medicaid rate ranges for actuarial soundness.

All Exhibits contained in the Appendix section of this report provide and validate the steps taken by Aon Hewitt to develop actuarially sound rate ranges for SFY 2016.

Please give me a call if you have any questions regarding these capitation rates or the methods that were used in the calculation.

Sincerely,

Aon Consulting, Inc., an Aon Hewitt company

Russell H. Ackerman

RHA:sdr

Table of Contents

Overview of Report

This report provides an actuarial certification of the actuarially sound rate ranges for the Commonwealth of Kentucky Medicaid Managed Care Organization (MCO) Program for the contract period effective July 1, 2015 through June 30, 2016. This contract period is consistent with State Fiscal Year 2016 (SFY 2016) for the Commonwealth of Kentucky.

This report has been structured around the rate-setting checklist which the Centers for Medicare and Medicaid Services (CMS) will use in reviewing the rate ranges for actuarial soundness.

A comprehensive capitation rate development data book is provided in its entirety in the Appendix section of this report. Appendix A contains all Exhibits relevant to the development of actuarially sound rate ranges for the Medicaid traditional population (Non-ACA); please refer to Exhibits 1-11. Appendix B includes all tables relevant to the expansion population (ACA) population (Exhibits 12-17). The Exhibits are ordered in sequence of the steps taken to develop these rate ranges. Note that all rate ranges are shown without the Health Insurance Fee (HIF). Appendix C provides Exhibit 19, which shows total projected expenditures based on SFY 2015 rates as compared to the rate ranges for SFY 2016.The purpose of the information contained in Exhibit 19 is to provide an analysis of the fiscal impact of the SFY 2016 rate ranges on SFY 2015 expenditures for DMS, holding enrollment constant.

Limitations on the Use of Information Contained in this Document

The information contained in this document, including the Appendices, has been prepared for DMS for the purpose of filing actuarially sound rates with CMS for the Commonwealth of Kentucky's MCO Program. It is our understanding that the information contained in this document may be utilized in a public document. To the extent that the information contained in the document is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling to avoid a misinterpretation of the data presented.

The information contained in this document was prepared as documentation of the July 2015 through June 2016 Medicaid MCO actuarially sound capitation rates for the Commonwealth of Kentucky. The information may not be appropriate for any other purpose.

Additionally, the rates are developed in aggregate for the Medicaid MCO program and may not be appropriate for any particular MCO. Each MCO should evaluate the rates in the context of their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the DMS.

Data Reliance and Validation Process

The information contained in this document was developed from data and information provided to Aon Hewitt by DMS and MCOs under contract with Kentucky's Medicaid MCO Program. Detailed claims data from the MCOs has been validated to financial records provided by DMS. The data was not audited, but it was reviewed for reasonableness and consistency in addition to the financial record validation. To the extent the data, information or any guidance provided to Aon Hewitt was not complete, accurate, or consistent with the costs, design or structure of the program, the capitation rates presented in this document may require modification to ensure actuarial soundness.

Summary of Actuarially Sound Rate Ranges

Aon Hewitt has calculated actuarially sound rate ranges for the twelve month contract period of July 2015 through June 2016, otherwise known as SFY 2016, for Kentucky's Medicaid MCO Program. DMS administers the Medicaid MCO Program.

Actuarially Sound Rate Ranges for Non-ACA and ACA MCO Enrollees

Actuarially sound rate ranges were developed for two groups of MCO enrollees: Medicaid traditional enrollees, and Medicaid expansion enrollees. Expansion enrollees are represented by individuals made eligible under the expanded eligibility rules established under the ACA.

Throughout this report, Aon Hewitt will refer to the two groups of enrollees as the Non-ACA and ACA populations, respectively, and will address any differences in methodology used to develop the rate ranges.

Overview of Methodology

Actuarially sound rate ranges were calculated by Aon Hewitt for SFY 2016 to reflect all MCO-covered services provided to the Non-ACA and ACA populations. The rate ranges include a percent for administration to reflect an allowance for general administration, care coordination, and a small margin for MCO risk and profit as a percent of premium.

The methodology used for developing the actuarially sound rate ranges is explained below in sequence of the process followed by Aon Hewitt, first explaining the rate ranges for the Non-ACA population, and then for the ACA populations. The data from the MCOs was first adjusted for the Non-ACA population, and then adjusted for the ACA population to reflect actuarially appropriate differences in risk and DMS policy between the two population groups. Data smoothing techniques were applied in a cost neutral manner.

Adjustments for Non-ACA Actuarially Sound Rate Ranges

Actuarially sound rate ranges were developed using base period data MCO-submitted claims data for the period April 1, 2013 through March 31, 2014 paid through June 30, 2014. MCO-submitted claims data was validated for reasonableness by Aon Hewitt and validated against eligibility files from Kentucky Medicaid. The MCO base period data was adjusted for several factors, including: (1) incurred but not reported claims (IBNR); (2) non-system expenses including Graduate Medical Expenses, expenses for the Commission for Children with Special Health Care Needs (CCSHCN), risk sharing, pharmacy rebate costs, sub-capitation, and supplemental provider payments. MCO data was provided net of Third Party Liability (TPL), so no adjustment was necessary; (3) MCO risk selection, due to Spirit's exit from the program; (4) Kentucky's schedule of copayments; (5) expanded benefit coverage that took effect on January 1, 2014, (concurrent with expanded eligibility). This adjustment was made because the MCO-submitted data included only three months of data for the period January 1, 2014 through March 31, 2014, and as such, the data did not fully reflect the expanded benefit coverage. The data was actuarially adjusted to reflect the expansion of benefits for: mental health/substance abuse, private duty nursing, allergy services, elimination of pharmacy drug limits, PT/OT/ST therapies (physical therapy, occupational therapy and speech therapy) and BRCA gene testing. The elimination of pharmacy drug limits was determined to have no effect on the data; (6) the addition of the Personal Care Home population, a population that stands 1,200 in number and is currently served by Medicaid fee-for-service; (7) the data was adjusted for both medical and pharmacy trends; and, (8) the administrative cost of the program to reflect an allowance for general administration, care coordination and a margin of 1 percent for risk and profit. The Health Insurance Fee was separately calculated.

Specific Adjustments for ACA Actuarially Sound Rate Ranges

Actuarially sound rate ranges were developed for the ACA population based on the adjusted base data for the Non-ACA population. The adjusted base year data for the Non-ACA population was further adjusted for the following, including: (1) the exclusion of maternity-related to correspond with DMS policy to move pregnant women in the ACA rate cells to Non-ACA rate cells ; and, (2) differences in risk selection, including morbidity, between the Non-ACA and ACA populations, and expected pent-up demand in the ACA population.

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Health Insurance Fee

The rate ranges were calculated prior to adding the HIF. The HIF was then calculated to reflect DMS policy's plans to pay the HIF as an "add-on" to the capitation rates paid to contracted entities.

Section 9010 of the ACA requires each non-exempt health insurer to pay a portion of the total 2016 HIF amount based on the insurer's share of total non-exempt net written health insurance premiums in calendar year 2015. This includes Medicaid MCOs. This fee and the tax consequence of the fee being non-tax deductible must be included in the capitation rates to maintain the actuarial soundness of the capitation rates.

Aon Hewitt has calculated an actuarially sound add-on rate range for the HIF, based on the expected cost of the fee. The range is between 0-4.6 percent including the income tax on the HIF. This HIF add-on rate range is broad enough to recognize potential future variability and to include all participating MCOs. MCOs not subject to the HIF would fall at the bottom of the range, where DMS could set HIF rates for MCOs that are subject to HIF at other points within the range.

In accordance with the CMS-approved contract between DMS and its MCOs, DMS will determine an appropriate per member per month "add-on" amount to pay MCOs that are subject to the HIF. MCOs that are not subject to the HIF will not receive an "add-on" rate. DMS will determine a fixed "add-on" amount based on a percent of the estimated total premium Medicaid revenue for applicable MCOs, which will later be reconciled by DMS on an MCO basis for the actual HIF amount owed by the MCO.

Location of the Actuarially Sound Rate Ranges in Appendix

Appendix A includes all Exhibits relevant to the development of actuarially sound rate ranges for MCO-covered services without HIF for the Non-ACA population and with the HIF. The ranges are provided by region for all eligibility groups, by age and by gender. Appendix A, Exhibits 9, 10 and 11 provide a summary of the actuarially rate ranges for the Non-ACA population without the HIF. Exhibit 11 includes the HIF ranges.

Appendix B includes all Exhibits relevant to the development of actuarially sound rate ranges for MCO-covered services without the HIF for the ACA population and with the HIF. The ranges are provided by region for all eligibility groups, by age and by gender. Appendix B, Exhibits 15, 16, and 17 provide a summary of the actuarially rate ranges for the ACA population without the HIF. Exhibit 17 also includes the rates with the HIF.

Appendix C includes only one exhibit, Exhibit 19, which provides a statewide comparison of rates and a projection of expenditures with current MCO capitation rates compared to expenditures under both the low and high points of the actuarial rate range.

CMS Checklist

This report is structured around the subsections covered in the checklist developed by CMS relative to the approval process for the actuarially sound capitation rates for all at-risk Medicaid Managed Care Programs.

- Subsection AA.1. General
- Subsection AA.2. Base Year Utilization and Cost Data
- Subsection AA.3. Adjustments to the Base Year Data
- Subsection AA.4. Establish Rate Category Groupings
- Subsection AA.5. Data Smoothing, Special Populations and Catastrophic Claims
- Subsection AA.6. Risk Sharing: Stop-loss Limits, Corridors, Reinsurance
- Subsection AA.7. Incentive Arrangements

Subsection AA.1: General

AA.1.0 Overview of Rates Being Paid Under Contract

CMS Checklist: DMS will specify the payment rates, the time period for the rates, any risk-sharing mechanisms, and the actuarial basis for the rates and mechanisms.

Aon Hewitt established the full risk actuarially sound rate ranges for Kentucky's Medicaid MCO Program for the contract period effective July 1, 2015 through June 30, 2016. Rate ranges were developed without the HIF, and then the HIF was developed as an add-on rate range.

Appendix A shows the Non-ACA rate ranges without the HIF. Rate ranges without the HIF are shown in Exhibit 9, and with the HIF add-on in Exhibit 11.

Appendix B shows the ACA rate ranges without the HIF. Rate ranges without the HIF are shown in Exhibit 15, and with the HIF add-on in Exhibit 17.

Comprehensive Rate Structure

Kentucky's Medicaid MCO Program rests upon a comprehensive rate structure to support actuarially sound rate ranges. Per member per month (PMPM) actuarially sound capitation rate ranges were developed for the Non-ACA and ACA populations. Rate ranges were developed by region, by eligibility group, by gender, and by age.

Kentucky's Medicaid MCO Program utilizes a total of 39 rate cells for each region, of which there are eight. This creates 312 rate cells in total. The actuarially sound rate ranges (312 in number) were developed for rate ranges without the HIF, and then for the HIF as an add-on rate range. Rate cells for the Non-ACA populations are 216 in number (27 rate cells by eligibility group/gender/age x 8 regions); rate cells for the ACA populations are 96 in number (12 rate cells by eligibility group/gender/age x 8 regions), which together sum to 312.

Actuarial Basis

The actuarial development process involved a detailed analysis of the enrollment data from DMS, medical claim data from contracted MCOs, and validation of the data for reasonableness using MCO financial data reported to DMS using the MCO Reconciliation Template (MRT), a report created by Aon specifically for this rate development process.

Base Year Utilization and Cost Data

Several sources of data were examined to determine the best base period data to use for actuarial rate development, including MCO encounter data, MCO claims data, and MCO financial data.

Refer to Subsection AA.2 for more details on base year cost and utilization. The base data is shown in Appendix A, Exhibit 1.

An overview of the actuarial basis for analysis follows.

Aon Hewitt determined that the MCO claims data was the best data to use for rate development for SFY 2016. MCO claims data covered a period of twelve months from April 1, 2013 through March 31, 2014, paid through June 30, 2014.

The use of MCO encounter data was pursued for this analysis. It was determined, however, that the data was incomplete when compared to the MCO claims data and the MRT reports provided by MCOs to DMS.

Aon Hewitt reviewed the base year data for reasonableness, correcting the data for differences between the MCO claims data and the MRT reports.

Aon Hewitt also made a determination that the base period data would be suitable for the Non-ACA populations but not for the ACA populations. This was determined on the basis that MCO claims data included only three months of experience for the ACA populations. Coverage for the ACA populations began on January 1, 2014, rendering the data for the three month period from January 1, 2014 through March 31, 2014 too immature to fully reflect the per member per month experience for the ACA populations for the development of SFY 2016 rate ranges.

Adjustments to the Base Year Data for the Non-ACA Population

The base data was summarized by rate cell for the Non-ACA populations, and then adjusted for several factors to create actuarially sound rate ranges for the Non-ACA populations for SFY 2016.

These adjustments are described more fully in Subsection AA.3, and shown in Appendix A, Exhibits 2 through 6.

Adjustments to the Base Year, and include: (1) IBNR Development; (2) Non System Expenses; (3) MCO Risk Selection; (4) Medicaid Copayments; (5) Benefit Adjustments; (6) Personal Care Home Population (7) Trends; and, (8) Administration.

Specific Adjustments to the Base Year Data for the ACA Population

The adjusted base year data for the Non-ACA populations was used to develop actuarially sound rate ranges for the ACA populations. Two specific adjustments were made to the adjusted base data, (which was used for the Non-ACA population) to create the base year data for the ACA populations.

These adjustments are described more fully in Subsection AA.3, and shown in Appendix B, Exhibit 12.

Adjustments to the base year data for the ACA populations included: (1) the exclusion of maternity-related costs to correspond with DMS policy to move pregnant wowen in ACA rate cells to Non-ACA rate cells; and, (2) differences in risk selection, including morbidity, between the Non-ACA and ACA populations, in addition to an upward adjustment for expectations about pent-up demand in the ACA population.

AA.1.1 Actuarial Certification

CMS Checklist: The State must provide the actuarial certification of the capitation rates and all payments under the contract.

I, Russell Ackerman, am employed with the firm Aon Hewitt. I am a member of the American Academy of Actuaries and am an Associate of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. Aon Hewitt has been employed by the DMS and I am generally familiar with the program, eligibility rules, and benefit provisions.

The capitation rate ranges provided with this certification are considered actuarially sound for purposes of 42 CFR 438.6(c), according to the following criteria:

- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and services to be furnished under the contract; and,
- The capitation rate ranges meet the requirements of 42 CFR 438.6(c).

For the purposes of this certification "actuarial soundness" is defined as follows:

Medicaid benefit plan capitation rate ranges are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums including expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income – provide for all reasonable, appropriate, and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any government-mandated assessments, fees, and taxes, and the cost of capital.

The assumptions used in the development of the actuarially sound capitation rate ranges have been documented in our correspondences with DMS. This certification documents the assumptions used to create the actuarially sound capitation rate ranges for the July 1, 2015 through June 30, 2016 including the HIF adjustment to those rate ranges.

The actuarially sound capitation rate ranges are based on a projection of future events. It is expected that actual experience will vary from the experience assumed in the rate ranges.

In developing the actuarially sound capitation rate ranges, we have relied upon data and information provided by the MCOs and DMS. Detailed data has been validated to financial records provided by DMS. We did not audit the data, but we reviewed the data for reasonableness and consistency in addition to financial record validation.

The MCOs should evaluate the capitation rates in the context of their own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with DMS. Individual MCOs may require capitation rates above, equal to, or below the actuarially sound capitation rates that are associated with this certification.

Russell Ackerman, A.S.A. M.A.A.A.

Member, American Academy of Actuaries
Associate, Society of Actuaries

AA.1.2 Projection of Expenditures

CMS Checklist: The State must provide a fiscal impact of its expenditures.

Appendix C provides a comparison of statewide rates and a projection of total expenditures for the current twelve-month period July 1, 2014 through June 30, 2015 using the average SFY 2016 rate ranges for the period July 1, 2015 through June 30, 2016.

The fiscal impact is calculated on a statewide level by comparing the total expenditure under the average SFY15 rates and the total expenditures under the rate ranges for the period July 1, 2015 through June 30, 2016. The enrollment mix and levels are held constant using enrollment for March 2014.

The projected increases are reasonable, given the impact of benefit changes, expected trend, impact of the Hepatitis C treatment and other factors.

AA.1.3 Risk Contract

CMS Checklist: The entity assumes risk for the cost of MCO-covered services.

The MCOs assume risk for the cost of MCO-covered services under the contract and incur losses if the costs of furnishing the services exceed the payments under the contract. The MCOs must accept as payment in full the amount paid by the state for all services and eligible populations defined in the special terms and conditions of the contract.

AA.1.4 Rate Modifications

CMS Checklist: The State has made program and rate changes that have affected the cost and utilization under the contract. This might include: (1) rate changes including medical cost and utilization trend factors based on State-specific data and national/regional medical market basket factors applicable to the State; and, (2) Programmatic changes including additions and deletions to the contractor's benefit package, adding a new benefit package or new rate cohorts, increases or decreases in the eligible population, other changes, and FFS changes.

Rate and programmatic modifications were incorporated into the calculation of actuarially sound rate ranges for SFY 2016.

- Rate modifications including PMPM trend factors to account for changes in price and utilization.
- Programmatic modifications including implementation of the expansion of benefits that took effect on January 1, 2014 but were not fully reflected in the base period data, including: mental health and substance abuse, private duty nursing, expansion of therapy benefit, allergy services, and BRCA gene testing. The pharmacy cap limit was eliminated on January 1, 2014 but Aon determined that this effect was already captured in the base data.
- Programmatic modifications including the seamless transition of the Medicaid-only personal care home population from fee-for-service Medicaid to managed care. The personal care home population is a high-cost group of individuals, about 1,200 in number, who will move into the MCO program on July 1, 2015. MCOs currently serve Medicaid-Medicare individuals in the Personal Care Home population.

AA.1.6 Limits on Payments to Other Providers

CMS Checklist: The State must ensure that no payment is made to a provider other than the entity for services available under the contract, except for DSH payments, FQHC wraparound payments, and GME payments that have been excluded from the capitation rate calculation.

Aon Hewitt has not included any payment for services other than those services that are included in the capitation payments. The State can ensure that no payment has been made to a provider other than the entity for services available under the contract.

AA.1.7 Risk and Profit

CMS Checklist: Reasonable amounts for risk and profit may be included in the capitation rates.

Aon Hewitt has developed actuarial rate ranges that build in a margin of risk and profit of 1 percent. A margin of 1 percent is consistent with DMS policy and spending priorities. This margin is also consistent with Aon Hewitt's development of capitation rate ranges in other states including Kansas and Tennessee.

AA.1.8 Family Planning Enhanced Match

CMS Checklist: Methodology for isolating family planning provided to enrollees who can receive such services.

Aon Hewitt has developed actuarial rate ranges that include family planning. The Kentucky Medicaid MCO Program will claim 90 percent federal funding for family planning services and the administrative portion associated with the delivery of those services.

AA.1.9 Indian Health Service (IHS) Facility Enhanced Match

CMS Checklist: State must indicate whether IHS or Tribal Services are included in the MCO contract and capitated rates.

Aon Hewitt has developed actuarial rate ranges that do not include IHS or Tribal services.

AA.1.10 Newly Eligible Enhanced Match

CMS Checklist: State should establish rates for the newly eligible population consistent with existing CMS guidance.

Aon Hewitt has developed actuarial rate ranges for all newly eligible populations (ACA) in a manner consistent with existing CMS guidance. These rates ranges are provided in the Exhibits contained within Appendix B of this report.

AA.1.11 Retroactive Adjustments

CMS Checklist: State may make retroactive adjustments to the capitation rates paid in the prior two years. State may not make retroactive adjustments to capitation rates paid more than two years later.

Aon Hewitt has been informed that the SFY 2014 capitation rates are currently under review by CMS, with DMS and CMS finalization pending.

Subsection AA.2: Base Year Utilization and Cost Data

AA.2.0 Based Only Upon Services Covered Under the State Plan

CMS Checklist: The State must document that payment rates are based only upon services covered under the State Plan or costs directly related to providing these services.

Aon Hewitt developed actuarially sound capitation rate ranges for only services covered under the State plan and the costs related to providing these services.

The base period expenditure data used in the rate development reflects the incurred period April 1, 2013 to March 31, 2014, paid through June 30, 2014. The data covered all members during the period. Data samples were not used in rate development. Aon Hewitt obtained the following data from DMS and the participating MCOs and from this data selected the base data used in the rate development:

- Detailed inpatient, outpatient, professional, dental, and pharmacy claim data with dates of service from January 1, 2013 through June 30, 2014, paid through June 30, 2014;
- Summaries of aggregated non-system payments (non-claims), such as capitation expense, incurred for the period January 1, 2013 through June 30, 2014, paid through June 30, 2014;
- Detailed eligibility data for the enrollees from January 1, 2013 through June 30, 2014; and
- MCO financial data from MRT reports from January 1, 2013 through June 30, 2014. The MRT reports include claims data as well as capitated medical service payments, lump sum payments and administrative costs.

From the detailed claim, capitation and eligibility data sets, Aon Hewitt summarized the data by eligibility group and service category to compute the relative per member per month costs.

Refer to Appendix A, Exhibits 1A-1H for the completed claims data.

Service Categories

The data book summarizes each of the rate cells by major categories of service. Data for claims was received from all contracted MCOs present in each region. The data was then mapped into the following major service categories based on file types in conjunction with medical coding fields, such as bill type and place of service.

The major service categories used in rate development include: Inpatient Hospital, Outpatient Hospital, Professional Services and Home Health Care & Hospice, Dental, Pharmacy, and Federally Qualified Health Centers (FQHC).

Inpatient Hospital

The data was formatted by Aon Hewitt into admission episodes and run through the Medicare Severity (MS)-DRG Grouper version 31 for all hospital admission claims. Admission data received did not contain a consistent grouped DRG.

The resulting DRGs were summarized and grouped into the following service categories: Medical/Surgical, Maternity, Complex Newborn, Normal Newborn, Mental Health, and Other. Admission claims for Psychiatric Residential Treatment Facilities (PRTF), which were identified using place of service, bill type and/or procedure codes, were classified under the inpatient PRTF service category.

Since many of the provider agreements are not DRG based, the data split within the subcategories. The variance between the actual allocation and the estimated allocation achieved through this methodology is expected to be minimal.

Outpatient Hospital

Outpatient procedures are prioritized for a claim based on the revenue and procedure codes included on the total claim record. A hierarchy is used to determine the main reason for the outpatient visit. Once determined, the data was summarized into six categories: emergency room, laboratory, radiology, surgery, mental health, and other. Table 1 shows the hierarchy values and descriptions, with lower values taking precedent over higher values.

Table 1. Outpatient Hierarchy

Hierarchy	Description	Aon Hewitt Service Category
0	Federally Qualified Health Center	FQHC & RHC
1	Emergency Room	OP - Emergency Room
2	Surgery	OP - Surgery
3	Cardiac Catheter	OP - Surgery
4	Cardiovascular	OP - Other
5	Observation	OP - Other
6	Dialysis	OP - Other
7	Office Visits	OP - Other
8	Mental Health/Substance Abuse	OP - Mental Health
9	Therapeutic Radiology/Chemotherapy	OP - Radiology
10	Diagnostic Radiology	OP - Radiology
11	Pathology/Lab	OP - Laboratory
12	Physical Medicine	OP - Other
13	Pulmonary	OP - Other
14	Prosthetics	OP - Other
15	DME/Supplies	OP - Other
16	Drugs	OP - Other
17	Injections	OP - Other
18	Home Health	Home Health Care & Hospice
19	Gastroenterology	OP - Other
20	Other Medicine	OP - Other
21	Transplant	OP - Other
22	Ambulance/Transportation	OP - Other
23	Sleep Study	OP - Other
24	Other Outpatient	OP - Other

Home Health (Includes Private Duty Nursing) and Hospice

Home health and Hospice services are identified by place of service, bill type and/or procedure codes and summarized under the Home Health Care & Hospice category.

Federally Qualified Health Centers (FQHC)

FQHC services are identified by place of service, bill type and/or procedure codes and summarized under the FQHC & RHC category.

Dental

Distinct dental claims files were submitted by each MCO. The data is summarized under the Dental category.

Pharmacy

Distinct pharmacy claims files were submitted by each MCO. The data is summarized under the Pharmacy category.

Professional

The professional services, includes all physical healthcare services not addressed above. This is primarily physician services; but, it may also include a variety of other miscellaneous services, including "J-codes." The data is summarized by service categories assigned to each procedure code. There are nine service categories in all including: evaluation and management, maternity, surgery, DME/Supplies, Lab, Radiology, Transportation, Mental Health, and Other.

Determination of Units

MCO claims records were used and classified into the detailed service categories discussed above. After grouping and categorizing the claims, the final stage involved linking the claims data to the eligibility data. This data was then further summarized into the rate cells.

In this summarization process, unit counts were made for each service category.

- "Days" refer to inpatient units, and represent the inpatient length of stay for inpatient care;
- "Claims" refer to a count of "1" for each claim record in the historical database for outpatient care; and,
- "Services" refer to the count of paid lines that were recorded on each claim for all other major categories of care including professional, dental, FQHC & RHC, Home Health & Hospice, and pharmacy. Units will be defined by the service. Units of services for pharmacy, for example, refers to prescriptions.

Claim Completion

MCO claims data was completed for incurred but not paid claims (IBNR) through actuarial completion factors. The claims data was also supplemented with other data sources because some services are paid through other aggregated payment methods. These are described as "non-system expenses" and these are expenses that are not included in the claims data.

Appendix A, Exhibit 1A-1H shows completed claims data after adjusting for non-system expenses for the period April 1, 2013 through March 31, 2014, paid through June 30, 2012 for each rate cell.

A summary list of the non-system expenses that were identified in the MRTs, and how these expenses were allocated, is provided below. These non-system expenses were added to the base period data to complete the data. Expenses were allocated to the appropriate service categories and rate cells. Applicable utilizations are added in such a way that the unit costs for the impacted service categories and rate cells remain unchanged before and after adding the non-system expenses.

- Graduate Medical Education (GME). Statewide expenses were allocated based upon inpatient utilization distribution. No utilization was added.
- Commission for Children with Special Health Care Needs (CCSHCN). Statewide expenses were allocated based on claim distribution.

- Other. Expenses were allocated based on claim distribution.
- Risk-sharing expenses. Region 3 and non-region 3 expenses reported by MCOs were allocated based on claim distribution.
- Pharmacy rebate. Statewide expenses were allocated based on claims distribution. No utilization was added.
- Sub-capitation. Region 3 and non-region 3 expenses were allocated based on claim distribution.
- Supplemental provider payments. Region 3 and non-region 3 expenses were allocated based on membership distribution. No utilization was added.
- TPL (recoveries). MCO claims data was net of TPL; therefore, no adjustment was necessary.

AA.2.1 Provided Under the Contract to Medicaid-Eligible Individuals

CMS Checklist: The State must document that payment rates are only for Medicaid-eligible individuals included under the managed care contract.

Payment rates are only for Medicaid-eligible individuals included under the managed care contract. Aon relied upon the MCO capitation file provided by DMS to ensure that only Medicaid-eligible included under the managed-care contract were counted. Aon Hewitt received from DMS data for the period January 2013 through June 2014.

Aon Hewitt calculated member months of eligibility from this data, stratified by aid category, demographic group, region, health plan, and month.

AA.2.2 Data Sources

CMS Checklist: Base utilization and cost data must be derived from the Medicaid population.

Base utilization and cost data was derived from the Medicaid population.

Subsection AA.3: Adjustments to the Base Year Data

AA.3.0 Adjustments to the Base Year Data

CMS Checklist: Base utilization and cost data must be derived from the Medicaid population. Adjustments to the base year data may be made to ensure that rates are predictable for, comparable to, the Medicaid population.

The base utilization and cost data was derived from the Medicaid population.

Base period data was adjusted to ensure the actuarial soundness of each component. All the adjustments are mutually exclusive and have not been taken twice. Adjustments were made to the base year data for the Non-ACA populations; and, then for the ACA populations.

- Non-ACA Adjustments. Based on the completed base year data, additional adjustments were made for the Non-ACA populations to account for differences in risk among MCOs (between Spirit and other MCOs). Other adjustments applied to the base year data reflect IBNR development, non system expenses, MCO risk selection, and Medicaid copayments. The data was not adjusted for the effects of managed care, because the data was provided by the MCOs and managed care effects were presumed to be reflected in the MCO data.
- ACA Adjustments. The ACA adjustments were made to account for risk selection differences between the Non-ACA and ACA populations with assumed lower rates of morbidity and pent-up demand.

AA.3.1 Benefit Differences

CMS Checklist: Actuarially sound capitation rate payments must be based upon on services covered under the State Plan.

Aon Hewitt adjusted the base year data for the Non-ACA population to account for several benefit changes that took effect on January 1, 2014. Adjustments were applied at the rate cell level for each affected service category.

Several benefit changes took effect on January 1, 2014, which were not fully reflected in the base period data, including: (1) the expansion of mental health and substance abuse services, (2) expansion of private duty nursing services, (3) expansion of therapy benefit, allergy services, and finally, (4) the addition of BRCA gene testing.

The pharmacy cap limit was eliminated on January 1, 2014 but this was determined to already be reflected in the base data.

The ACA base year data was adjusted to exclude maternity payments to reflect that upon pregnancy, DMS moves pregnant women that were in ACA rate cells to Non-ACA rate cells.

AA.3.2 Administrative Cost Allowance Calculations

CMS Checklist: State must document that an adjustment was made to the rate for MCO, PIHP, or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates.

Three Components: General Administration, Care Coordination and Margin

Aon Hewitt calculating the administrative cost allowance based on three components to reflect only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid eligible members. The three components include: (1) a fixed PMPM amount for administrative costs; (2) care coordination; and; (3) a margin of 1 percent for risk and profit. Refer to Appendix A, Exhibit 5 to examine the administrative cost allowance.

Aon Hewitt calculated the administrative allowance for the period April 1, 2013 through March 31, 2014, allocating 75 percent of the administrative expenses by MCOs to general administration and 25 percent to care coordination.

The general administrative PMPM amount was trended to SFY 2016. The aggregate statewide administrative costs including general administration and care coordination component of 1.0% to 3.0% are estimated to be 7% to 8.9% for Non-ACA rates.

Health Insurance Fee

Aon Hewitt also calculated the actuarially sound rate ranges for the Health Insurance Fee (HIF). Pre-tax, Aon Hewitt calculated the HIF “add-on” rate range to be between 0 and 3 percent. The income tax was estimated to be between 0 and 34.4 percent for this rate period. The HIF range including the income tax component is calculated to be between 0 and 4.6 percent.

ACA establishes a fee that applies to all health insurers and applies to Medicaid risk revenue. Aon calculated a separate actuarial rate range for the HIF, in keeping with DMS plan to pay this to the MCOs as an “add-on” amount to the capitation rates.

The calculation of a separate “add-on” amount also aligns well with Kentucky’s goal of transparency in two ways. First, this approach will streamline the process of calculating the final settlement amount for HIF.

Second, this approach aligns well with DMS plans to implement a new program of incentives. The total potential incentive amount for participating MCOs will be calculated based on the capitation rate premium revenue without the HIF. A separate amount of the HIF provides MCOs with total transparency as to the total value of the incentive program.

AA.3.3 Special Populations’ Adjustment

CMS Checklist: State may make specific health needs adjustments to make the populations more comparable.

Medicaid MCOs currently serve individuals covered under both Medicaid and Medicare, who are known as the Personal Care Home Population. These individuals have high medical costs and reside in a personal care home. Medicaid MCOs do not currently serve individuals who are part of the Personal Care Home Population who have only Medicaid coverage, and therefore do not benefit from the care coordination that Medicaid MCOs can offer.

Starting July 1, 2015, DMS will contract with Medicaid MCOs to serve individuals who comprise the Personal Care Home Population who have Medicaid-only coverage. This will afford the entire Personal Care Home population the benefit of the care and coordination that Medicaid MCOs can offer this high cost population. Medicaid-only members stand about 1,200 in number.

The base period data provided by the MCOs reflects the populations enrolled during the period April 1, 2013 through March 31, 2014. MCO claims data does not reflect the Medicaid-only Personal Care Home Population. Data provided by DMS for the period April 1, 2013 through March 31, 2014 paid through June 30, 2014 was used to develop an actuarially sound adjustment to the PMPM base period data at the appropriate rate cell level to reflect the Medicaid-only population's move to managed care.

AA.3.4 Eligibility Adjustment

CMS Checklist: Actuary analyzed the covered months in the base period to ensure that member months are parallel to the covered months for which the entities are taking risk.

The claims and financial data used for this analysis reflects the expected costs of the population enrolled in the program during the contract period.

AA.3.5 Third Party Liability

CMS Checklist: Contract must specify any activities the entity must perform related to TPL including who will retain the TPL collections. Rates must reflect the appropriate adjustment.

Actuarially sound rate ranges are net of all TPL. In accordance with federal requirements and the Commonwealth of Kentucky's contract requirements, the MCOs have primary responsibility for TPL recoveries.

AA.3.6 Indian Health Care Provider Payments

CMS Checklist: Not Applicable.

AA.3.7 DSH Payments

CMS Checklist: Capitation rates may not include DSH payments.

DSH payments are not included in the capitation rate ranges.

AA.3.8 FQHC and RHC Reimbursement

CMS Checklist: State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs.

No FQHC/RHC encounter rates, cost-settlements, or prospective payments are included in these rates.

AA.3.9 Graduate Medical Education

CMS Checklist: State may include GME costs in the capitation rates, as an option, or not.

The cost of Graduate Medical Education is included in the actuarially sound rate ranges.

AA.3.10 Copayments, Coinsurance and Deductibles in Capitated Rates

CMS Checklist: State must calculate the capitated payments to the organization as if those cost sharing charges were collected at 100 percent.

Certain Medicaid members have copayments for services. The copays are collected by the MCOs. MCOs do not collect all required copayments, however, As a result, Aon Hewitt adjusted the base period data in a downward manner to account for copayments that are not collected by MCOs.

AA.3.11 Medical Cost/Trend Inflation

CMS Checklist: All trend factors must be explained and documented. Medical cost and utilization trend inflation factors are based on historical medical State-specific costs or a national/regional medical market basket applicable to the state and population.

Trend rates are comprised of changes in cost per unit of service as well as changes in the volume of services used per person over time.

For the base period data, the trend was applied for 27 months. This extends the midpoint of base period April 1, 2013 through March 31, 2014 to the midpoint of the contract period July 1, 2015 through June 30, 2016.

- Medical trends were developed based upon the following sources: trends projected by the MCOs, historical trends calculated from the MRTs, trends from other states, and national trends based on CMS projected Medicaid expenditure per enrollee.
- Pharmacy trends were developed based upon the following sources: trends for pharmacy benefit management, and the projected trend for the treatment of Hepatitis C. Industry trends were considered as well as data that was requested and collected contracted MCOs.

Weighted average calculations were made for both medical and pharmacy for PMPMs and utilization. Unit cost trends were calculated based on PMPMs and utilization.

AA.3.12 Utilization Adjustments

CMS Checklist: Utilization adjustment differences between base data and Medicaid managed care population and changes in Medicaid utilization over time are possible.

The capitation rate ranges reflect a low and high degree of managed care adjustments to account for expected increased health care medical management year over year.

AA.3.13 Utilization and Cost Assumptions

CMS Checklist: State must document that utilization and cost data assumptions are appropriate.

Capitation rates are based on claims data and aggregate financial expenditure data previously mentioned for the covered population. The program is mandatory and no further adjustments need to be made to utilization and cost. The assumptions are appropriate to the data used for projecting the rate ranges.

As discussed in AA.3.11, cost assumptions were derived from the projected trends for PMPMs and utilization.

AA.3.14 Post-Eligibility Treatment of Income

CMS Checklist: State must document that an adjustment was made to the rate for MCO, PIHP, or PAHP administration. Only administrative costs directly related to the provision of Medicaid State Plan approved services to Medicaid-eligible members are built into the rates.

Post-eligibility treatment of income is not applicable for the population covered under these capitation rates.

AA.3.15 Incomplete Data Adjustment

CMS Checklist: State must adjust base period data to account for incomplete data.

The completion patterns of the claim data were examined and, using an IBNR model, factors have been developed and applied to estimate the value of incurred but not reported claims. The factors in Exhibit 1 were applied to complete the claims for the incurred period of April 1, 2013 to March 31, 2014 with run-out through June 30, 2014.

AA.3.16 Primary Care Rate Enhancement

CMS Checklist: State must adjust the base period data to account for any changes in payment rates to primary care providers.

PCP enhanced payments were not included in the expenditures used for rate setting.

AA.3.17 Health Homes

CMS Checklist: State should adjust rates in a manner consistent with state plan amendment, if the State has created health homes. The Commonwealth of Kentucky has not created health homes.

Subsection AA.4: Rate Category Groupings

AA.4.0 Establish Rate Category Groupings

CMS Checklist: State must create rate cells specific to the enrolled population by eligibility category, age, gender, and locality/region; and, risk adjustments based on diagnosis or health status, if used.

Table 2 below provides a summary of the capitation rate cells by eligibility group, by gender and by age for SFY 2016. All rate cells will be further broken down by each of the 8 regions.

Table 2. Rating Groups by Age and Gender for ACA and Non-ACA Populations.

Kentucky Rate Cell Structure			
Non-ACA Populations			
Families and Children	**SSI Adults without Medicare**	**Dual Eligible**	**SSI Child**
Infant - Age Under 1	Age 19 to 24 Female	Female	Age Under 1
Child - Age 1 to 5	Age 19 to 24 Male	Male	Age 1 to 5
Child - Age 6 to 12	Age 25 to 44 Female		Age 6 to 18
Child - Age 13 to 18 Female	Age 25 to 44 Male		**Foster Care**
Child - Age 13 to 18 Male	Age 45 or Older Female		Infant - Age Under 1
Adult - Age 19 to 24 Female	Age 45 or Older Male		Age 1 to 5
Adult - Age 19 to 24 Male			Age 6 to 12
Adult - Age 25 to 39 Female			Age 13 or Older Female
Adult - Age 25 to 39 Male			Age 13 or Older Male
Adult - Age 40 or Older Female			
Adult - Age 40 or Older Male			

ACA Populations	
Former Foster Care Child	**MAGI**
Age 18 through 20 - Female	Age through 18 - Female
Age 18 through 20 - Male	Age through 18 - Male
Age 21 through 25 - Female	Age 19 through 24 – Female
Age 21 through 25 - Male	Age 19 through 24 - Male
	Age 25 through 39 – Female
	Age 25 through 39 - Male
	Age 40 or Older - Female
	Age 40 or Older - Male

AA.4.1 Eligibility Categories

CMS Checklist: Define eligibility categories.

Rate ranges were established to reflect the cost patterns for particular eligibility categories.

Refer to AA. 4.0 for a summary of the Non-ACA and ACA eligibility groups covered under the MCO program.

AA.4.2 Age

CMS Checklist: Define age categories.

The rate ranges have been established for adults and children by age ranges that most appropriately reflect medical care consumption by age. These splits are used to recognize differences in the health care uses and costs for certain services among population groups. Refer to AA.4.0 to see how each eligibility group splits by age group. Some eligibility groups do no split by age.

AA.4.3 Gender

CMS Checklist: Define gender categories.

The rate ranges differentiate between genders to reflect cost differences where appropriate. Refer to AA. 4.0 to see how each eligibility group splits by gender. Certain rate cells for children do not split by gender, because there are no actuarially significant differences in their costs by gender.

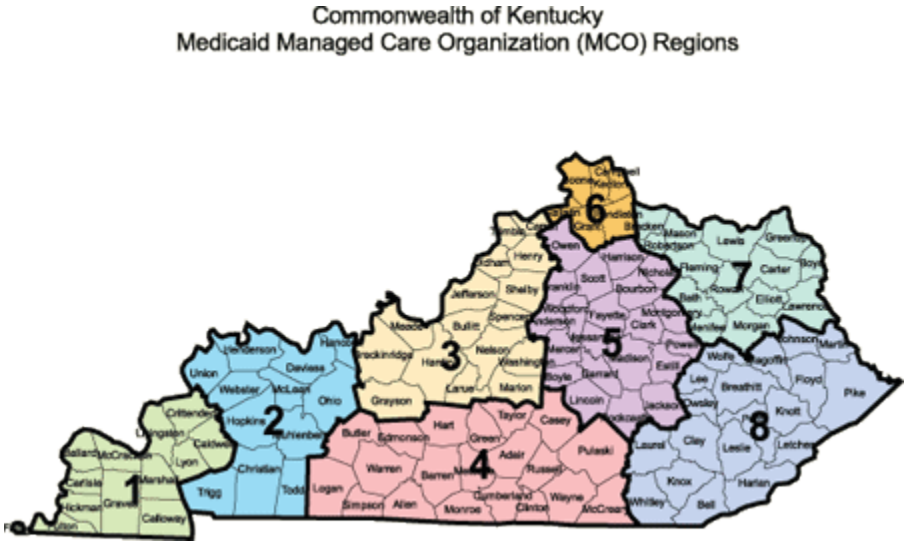
AA.4.4 Locality/Region

CMS Checklist: Define locality/region categories.

The rate ranges were established for eight regions to reflect regional differences in claim costs, access and managed care in the State of Kentucky. All actuarially sound rate ranges were calculated by region.

Table 3 below shows the map for Kentucky and its regions and the counties within each region.

Table 3. Summary of Regions and Counties.



Region	Counties
Region 1	Ballard, Calloway, Caldwell, Carlisle, Crittenden, Fulton, Graves, Hickman, Livingston, Lyon, McCracke, Marshall
Region 2	Christian, Daviess, Hancock, Henderson, Hopkins, McLean, Muhlenberg, Ohio, Todd, Trigg, Union, Webster
Region 3	Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, Washington
Region 4	Adair, Allen, Barren, Butler, Casey, Clinton, Cumberland, Edmonson, Green, Hart, Logan, McCreary, Metcalfe, Monroe, Pulaski, Russell, Simpson, Taylor, Warren, Wayne
Region 5	Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jackson, Jessamine, Lincoln, Madison, Mercer, Montgomery, Nicholas, Owen, Powell, Rockcastle, Scott, Woodford
Region 6	Boone, Campbell, Gallatin, Grant, Kenton, Pendleton
Region 7	Bath, Boyd, Bracken, Carter, Elliott, Fleming, Greenup, Lawrence, Lewis, Mason, Menifee, Morgan, Robertson, Rowan
Region 8	Bell, Breathitt, Clay, Floyd, Harlan, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Whitley, Wolfe

AA.4.5 Risk Adjustments

CMS Checklist: Define risk adjustments based on diagnosis or health status.

In partnership with the Commonwealth of Kentucky, Aon Hewitt provides support for the development of risk adjusted capitation rates.

Under Kentucky's model of risk adjustment, MCO capitation rates will be adjusted based on the risk profile of the MCO-enrolled population. The process of calculating risk adjustment rates is based on the assignment of risk scores to each individual enrolled in the MCO program. Individual risk scores will be attributed to each MCO based on the MCO in which the person is enrolled as of a specific point in time. Raw risk scores and member months will be aggregated by rate cell, region, and attributed MCO, and relative risk adjustment scores will be calculated.

Risk scores for the Kentucky Medicaid population, excluding Dual populations, are calculated on a semi-annual basis using 12 months of recent, reasonably complete data and the most recent month of membership enrollment available. These calculated risk scores are applied to the capitation rates each quarter.

It important to note that since risk scores are calculated at the rate cell level, there may be instances when the numbers are small and lose credibility at the rate cell and region level. When this occurs, risk scores are aggregated to the rate group level within each region for application to the contracted MCO rates. As a result, each rate cell within a rate group and region will receive the same risk adjustment factor for a given MCO. (DMS will include this provision in its contract with the Medicaid MCOs starting July 1, 2015.)

DMS plans risk adjust capitation rates for the ACA populations in SFY 2016 on a semi-annual basis.

Key features of Kentucky's risk adjustment model include:

- Diagnosis-based risk adjustment model. MCO capitation rates will be risk adjusted using the combined Chronic Illness & Disability Payment System (CDPS) and pharmacy based risk adjustment model, or CDPS + Rx. CDPS is a diagnosis-based risk adjustment model that uses ICD-9 codes to assess risk. An ICD-10 based risk model will be used when ICD-10 diagnosis codes are available in the claims data.
- Concurrent model. Kentucky's model of risk adjustment is considered to be a concurrent model, in that the risk profile of MCO enrollees is based upon same year data.
- Use of Kentucky Medicaid data. Risk scores will be calculated using twelve months of data from fee-for-service claims and managed care encounter data. Lab and x-ray services are excluded. Months of Medicaid eligibility during the 12-month analysis period are also calculated.
- Model weights. The model's weights are used to assign the relative cost differences among CDPS diagnostic categories. Kentucky's model current uses national weights. In the future, Kentucky plans to re-calibrate the model using data that is specific to Kentucky as soon as sufficient managed care data is available.
- Assignment of risk score. The model is designed to assign all MCO enrollees a risk score, as long as they meet a minimum eligibility threshold. (The minimum length of eligibility is not necessarily continuous.) During the risk analysis period, MCO enrollee must meet the following threshold in order to be assigned a risk score and to be considered in the MCO risk adjustment calculations. Thresholds are: (1) one month for infants and pregnant women; and, (2) three months for all other rate cells. Members who do not receive a risk score will be assigned the average risk score for their MCO within their rate cell and region.

- Applied to MCO contracted rates. Risk adjustment is applied to the contracted rates, exclusive of HIF payments and provider settlements. MCO provider settlement obligations are a fixed amount each month for the Non-ACA populations and are a fixed PMPM for the ACA populations. The per capita value of the settlement obligations are removed from each MCO's contracted rates prior to applying risk adjustment, and are added back in after applying risk adjustment. The MCO provider settlement obligations will be recalculated each time the MCO capitation rates are adjusted.

Subsection AA.5: Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0 Data Smoothing

CMS Checklist: State has examined the data for any distortions and adjusted in a cost-neutral manner.

Data smoothing issues are largely addressed by ensuring the rate cells used to develop the per capita costs have sufficient population size. The data was examined for distortions resulting from smaller populations, access problems, or extremely high cost catastrophic claims. Most capitation rate cells were determined to be credible on their own.

One adjustment was made, however, based upon the large observed variations in rate changes after comparing the projected rates to current base rates. The comparisons are shown in Exhibit 8 for non-ACA rates and Exhibit 14 for ACA rates. A cost-neutral smoothing adjustment was made to the projected rates. This was performed by calculating the aggregate rate change for each rate group and region. All rate cells for a given rate group and region received the same rate change that was equal to the aggregate rate change for that rate group and region.

The resulting rate ranges are shown in Exhibit 9 for the non-ACA population and Exhibit 15 for the ACA population; these ranges do not include the HIF.

AA.5.1 Cost Neutral Data Smoothing Adjustment

CMS Checklist: State supplies an explanation of the smoothing adjustment.

Refer to section AA.5.0.

AA.5.2 Data Distortion Assessment

CMS Checklist: State must employ appropriate data smoothing techniques, as necessary.

See section AA.5.0.

AA.5.3 Data Smoothing Techniques

CMS Checklist: State must employ one of the suggested options for data smoothing in a cost neutral manner.

See section AA.5.0.

AA.5.4 Risk Adjustment

CMS Checklist: State may employ a risk adjustment methodology based upon enrollees' health status, diagnosis, and/or pharmacy usage to set its capitated rates. Risk adjustment must be cost neutral.

Risk adjustment to the capitation rates is applied on a cost neutral basis within each rate group and region, such that MCOs with higher than average member risk scores receive capitation payments above their negotiated rates and MCOs with lower than average member risk scores receive capitation payments below their negotiated rates. For a given rate group and region, the total capitation payments are equivalent to the amount that would have been paid to all the MCOs, if risk adjustment was not applied. In addition, refer to section AA.4.5.

Subsection AA.6: Risk Sharing: Stoploss Limits, Reinsurance

AA.6.0 Stop Loss, Reinsurance, or Risk-Sharing Arrangements

CMS Checklist: Stop Loss, Reinsurance, or Risk-sharing arrangements (State Optional Policy) - If the State chooses to offer one of these options, the State must submit an explanation of state's reinsurance, stop loss, or other risk-sharing methodologies. These methodologies must be computed on an actuarially sound basis.

State may offer stop loss, reinsurance or risk sharing and compute options on an actuarially sound basis.

The Kentucky Medicaid MCO Program does not require that entities purchase commercial insurance, nor does the State offer stoploss or reinsurance. The State was, however, required to establish a risk sharing arrangement to cover the ACA populations.

AA.6.1 Commercial Reinsurance

CMS Checklist: State may require entities to purchase commercial reinsurance and must be demonstrate that the reinsurance was computed on an actuarially sound basis.

The State does not require entities to purchase commercial reinsurance.

AA.6.2 Stoploss Program

CMS Checklist: State will provide stop-loss protection by writing into the contract limits on the entity's liability for costs incurred by an individual enrollee over the course of a year. Costs beyond the limits are either entirely or partially assumed by the state. Capitation rates are reduced for the state's assumption for a portion of the risk for enrollees.

DMS does not have a stop-loss protection on the entity's liability for costs.

AA.6.3 Risk Corridor Program

CMS Checklist: State may share in both the aggregate profits and losses of an entity. To the extent that FFP is involved, CMS will also share in the profits and losses of the entity. The State and CMS must agree upon the benchmark point up to which federal match will be provided.

DMS has a program of risk corridors, based on the CMS requirement to include a risk corridor for the ACA expansion population. This risk corridor applies to MCO enrollees for whom DMS receives 100 percent federal reimbursement. This risk corridor is included in the contract between DMS and contracted MCOs.

Subsection AA.7: Incentive Arrangements

AA.7.0 Incentive Arrangements

CMS Checklist: State must include an explanation of the State's incentive program.

At present, Kentucky's Medicaid Managed Care Organization Program does not have an incentive program.

DMS is looking to implement a new incentive program in SFY 2016.

This new program, which is currently in the early stages of development, may be called the HEDIS Measure Incentive Program (MIP), or called MIP. The State is currently working on the design of the program, which would then be included in its Request for Proposal as it re-procures its new MCO program, and incorporated into its contract with managed care entities. Under this proposed program, the total incentive amount will not exceed more than 3 percent of the total premiums paid for the months in the Incentive Period. The incentive program would apply to all rating categories except for dual eligible individuals.

The first incentive period will be based upon fiscal year; incentive periods two through five will be based upon calendar years.

The proposed implementation schedule for ramping up to 3 percent is as follows:

- Incentive Period 1: Percentage of premium for the Incentive Period 7/1/15-12/31/15 = 1%
- Incentive Period 2: Percentage of premium for the Incentive Period 1/1/16-12/31/16 = 1.5%
- Incentive Period 3: Percentage of premium for the Incentive Period 1/1/17-12/31/17 = 2%
- Incentive Period 4: Percentage of premium for the Incentive Period 1/1/18-12/31/18 = 2.5%
- Incentive Period 5: Percentage of premium for the Incentive Period 1/1/19-12/31/19 = 3%

AA.7.1 Electronic Health Records (EHR) Incentive Payments

CMS Checklist: States must have a process and methodology in place to verify incentive payments including EHR does not exceed 105 percent of the capitation rate.

DMS has a process and methodology for verifying that EHR incentive payments do not exceed 105 percent of the capitation rate, based on the MCO utilization counts by provider.

APPENDIX A

Actuarially-Sound Rate Ranges for the Non-ACA Populations

APPENDIX B

Actuarially-Sound Rate Ranges for the ACA Populations

APPENDIX C

Statewide Rate Comparisons and Total Expenditure Projections for the Non-ACA and ACA Populations