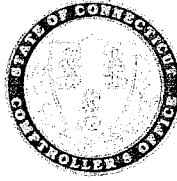


State of Connecticut

NANCY WYMAN
COMPTROLLER



MARK E. OJAKIAN
DEPUTY COMPTROLLER

Hartford

May 27, 2009

The Honorable Christopher Donovan
Speaker of the House of Representatives
Legislative Office Building
Hartford, CT 06106

Dear Representative ^{Chris} Donovan:

Attached is a final copy of the rate setting review for the Husky A program conducted by Milliman consulting actuaries under the auspices of the Comptroller's Office. The major findings are encapsulated within the Executive Summary, which also contains additional observations by my office.

The most significant budgetary finding by Milliman is that an actuarially-sound basis exists to reduce the capitation rate paid to the Husky A managed care organizations by between \$41 million and \$49 million—a 5 to 6 percent rate reduction.

The findings and summary have been reviewed by the Department of Social Services (DSS) and Mercer consulting actuaries, which is the firm used by DSS in the Husky A rate setting process. The response provided to my office by DSS is attached to this report.

Within their response, DSS acknowledges that the "the rates recommended within the Milliman report fall within the rate range developed by Mercer and would have met Mercer's actuarial soundness requirements." The points of conflict relate to adjustments that moved Milliman to a lower number within the rate range.

Specifically, Milliman found that the inflation factor or trend used by DSS was higher than those observed for similar Medicaid populations in other states. In addition, Milliman found that DSS had made no net downward adjustment in the rate for improvements in utilization and outcomes that are normally associated with the active management of care. That is the managed care companies were not held accountable to specific performance standards designed to lower costs. Finally, Milliman noted that DSS negotiated to a rate above the Milliman mid-point range. It was assumed that this was the product of the negotiation process.

In addition to these findings, I am recommending that the legislature consider appropriating the Medicaid budget by component part rather than as one lump-sum line

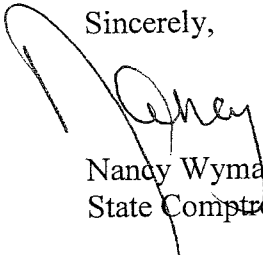
May 27, 2009
page 2

item. This will enable the General Assembly to see and analyze in greater detail how the state's Medicaid funds are expended. The Massachusetts' Medicaid budget contains a dozen Medicaid account appropriation items. I am also recommending that work begin with DSS to bring Medicaid accounting detail into the state-wide Core-CT financial system.

In these financial times it is necessary that every effort be made to reduce existing budget costs and enhance fiscal transparency. This report provides a foundation to achieve these goals within the Medicaid program administered by DSS.

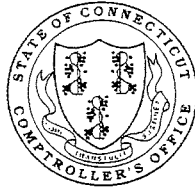
I would be pleased to work with you and DSS as we move forward in seeking lower costs, greater efficiency and enhanced transparency in the state's Medicaid program.

Sincerely,



Nancy Wyman
State Comptroller

CC: Chairman Appropriations, Public Health and Human Services



NANCY WYMAN
COMPTROLLER

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
55 ELM STREET
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EXECUTIVE SUMMARY

The attached report is the product of a request from leadership of the General Assembly to the State Comptroller for an assessment of areas that could produce budget savings within the Department of Social Services (DSS).

From the outset, the legislature expressed particular interest in the Husky A health insurance program for low-income families as a vital area of review for the following reasons:

- Its annual cost of approximately \$800 million makes it one of the state's largest budget expenditures.
- A 24 percent increase in the rate paid to participating managed care organizations (MCOs) that followed a major administrative restructuring of the program.
- Unexpended budgeted funds of nearly \$100 million were moved forward from Fiscal Year 2008 to Fiscal Year 2009 without a clear understanding of the sources that comprised this carry-forward funding.

A review of Husky A and the rate-setting mechanism utilized by DSS and its consulting actuaries to justify a 24-percent increase to the MCOs required expertise in actuarial science and health care modeling. The Comptroller's office contracted with Medicaid actuarial specialists at the firm of Milliman for this purpose.

The state's contracted payments to MCOs are a significant component of its total contracted services statewide. The findings below should be viewed in light of the current budgetary imperative to generate substantial savings in outside contracted services, i.e. Public Act 09-2 requires savings of \$50 million in contracted services in Fiscal Year 2009 and additional savings requirement over the upcoming biennium are anticipated.

The major findings and policy implications of Milliman's study are as follows:

Finding #1

There is an actuarially-sound basis to reduce the capitation rate paid to the MCOs in the Husky A program by between \$41 and \$49 million annually - representing a five percent to six percent rate reduction.

Policy Implication

Prospects for negotiated rate reductions and budgeted savings should be aggressively pursued by DSS in light of this finding. All state agencies are under pressure to reset contracted service arrangements to obtain maximum budget savings. Presumably, changes to the Husky program contained in the Governor's budget would have required a reevaluation of capitation rates.

The three factors that explain the variance in the capitation rate used by DSS and the rate developed by Milliman are: 1) the negotiated rate adjustment; 2) data rebasing or adjusting past claims data to the new period using a combination of actual encounter data, financial reports and other program changes and relevant data; and, 3) annual trend or inflation adjustments. In each case Milliman's calculation yielded a lower rate adjustment than that used by DSS.

Detail

1) With respect to the negotiated rate adjustment used by DSS, Milliman did not provide an adjustment to the MCOs in excess of the mid-point actuarially sound capitation rate.

Removing this adjustment lowers the rate by one percent (\$7.8 million). The Comptroller's office is sensitive to the fact that DSS made a policy decision to return to an MCO model and to use a negotiated bid strategy. We are also aware that the MCO model is the most common delivery system utilized by states in the Medicaid program.

However, there are other administrative options and delivery systems. For example, the state of Oklahoma decided that MCO rate demands were too high and opted for a state-wide Primary Care Case Management System, which according to state documents has saved over \$20 million.

It is also important to note that due to cash flow considerations and other factors, the state budget would not be adversely impacted by a return to the pre-MCO system in Fiscal Year 2010.

The state should not be held fiscal hostage to the existing policy preference. While the potential that lower rates could compromise MCO participation exists, any short-term dislocations to clients may provide long-term advantages to both clients and the state.

2) Regarding data rebasing. Milliman calculated a 2.2 percent rate reduction where DSS had no adjustment.

There was concern that the MCO financial reports utilized in rebasing did not reconcile to the MCO statutory statements provided to regulators. While some variance is expected, the degree of variance observed was significant. To the extent that the financial reports are overstated the capitation rate range would also be overstated.

In addition, it is typical for states to incorporate within the capitation rates targets for managed care improvements in utilization and outcomes. Omitting this adjustment implies that the program has met or exceeded all utilization targets and no improvement is expected between the base year and the capitation rate period.

This is not believed to be the case. There was little documentation or explanation of the restated values used by DSS.

3) The annual trend or inflation factor of 6.8 percent used by DSS was found to be higher than those typically observed by Milliman for similar Medicaid managed care populations.

Milliman used a rate of 5 percent. This difference is compounded over two years. In addition, the Fiscal Year 2009 fee schedule increases allotted to the program adjustments should have put additional downward pressure on the inflation trend.

The Comptroller's office cannot determine if the fee schedule adjustment could have been implicitly double-counted in both program and trend. The federal CMS guidance explicitly indicates that the inflation trend and any program changes to the fee schedule should not be double-counted.

Finding #2

In the course of meeting with legislators and staff relative to the Medicaid budget, concern was expressed that insufficient transparency existed with respect to the transfer of dollars within the Medicaid line-item. In addition, almost \$100 million of Medicaid funding was unexpended in Fiscal Year 2008 and brought forward to Fiscal Year 2009.

Concern was expressed that the source of this carry-forward funding was not well documented. The General Fund Medicaid appropriation occupies a single budget line-item/SID (special identification code) that is quickly approaching \$4 billion. While Medicaid is a single line-item it contains multiple component programs.

Policy Implication

Greater budget control could be attained by the legislature if Medicaid was appropriated by individual program area rather than as a single line-item. Husky A would be one such line-item appropriation.

Detail

Under existing state statutes, the transfer and carry-forward of budgeted General Fund dollars are largely controlled by appropriation line-item or SID. For example, any material transfer of dollars between appropriation line-items in the General Fund requires the approval of the legislative and executive Finance Advisory Committee (FAC).

However, dollars appropriated within a single line-item can be moved between programs within that line-item with no legislative oversight or control. This is the case in Medicaid. To lump all of Medicaid into a single line-item abrogates a degree of legislative control. There are other states that separate their Medicaid appropriations into component parts for budget control purposes.

Finding # 3

The way in which Medicaid expenditures are recorded within the state-wide financial and human resources system known as Core-CT, does not provide sufficient transparency with respect to payment detail.

Policy Implication

The Comptroller will work with DSS to create an interface from the DSS client system used for Medicaid to Core-CT. This interface will be designed to ensure the security of DSS's client information.

Detail

Currently, only the dollars that are drawn down into DSS's checking account for Medicaid payments are posted in the state-wide Core-CT financial system. Medicaid is too large a program to be exempted from the reporting requirements of Core-CT.

Medicaid payment detail must be enhanced within the Core-CT system if DSS is to retain its independent check writing authority which was granted by the Comptroller and Treasurer more than a decade ago in accordance with the provisions of Connecticut General Statutes, Section 4-33. While DSS currently prepares numerous financial reports and detailed program expenditure information required by the legislature, the information available on Core-CT for consolidated state-wide reporting purposes is clearly not sufficient.

This review could not have been completed without the cooperation of DSS and its consulting actuaries. The Comptroller's office recognizes the many hours of work devoted to this review by the DSS staff and expresses our thanks.

Sincerely,

Nancy Wyman
State Comptroller



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May 20, 2009

Mr. John Clark
Office of the State Comptroller
State of Connecticut
55 Elm Street
Hartford, CT 06106

RE: HUSKY CAPITATION RATE REVIEW – SFY2009 – FINAL

Dear John:

Milliman Inc. (Milliman) has been engaged by the State of Connecticut, Office of the State Comptroller (State), to provide actuarial and consulting services with respect to a review of the State Fiscal Year (SFY) 2009 risk based managed care capitation rates for the HUSKY A population. This letter contains the results of our analysis.

LIMITATIONS

The information contained in this report has been prepared for the State of Connecticut, Office of the State Comptroller and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for the State by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the results contained herein.

Milliman received various data and information related to the history of the Husky A program and development of the SFY 2009 capitation rates. However, the scope of this assignment was such that a full and complete understanding of all facets of the program and development were not feasible. As such,

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Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for the State by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information contained in this document.

certain information or comments included may be indicative of the level of detail employed for the review.

The nature of this assignment was such that Milliman was requested to provide a review and discussion with respect to the negotiated capitation rates for the Husky A program for SFY 2009. This report does not contain any information that should be interpreted or characterized as a statement by Milliman regarding the actuarial soundness of the capitation rates developed and documented by the Connecticut Department of Social Services (DSS) or its Actuary, Mercer Government Human Services Consulting (Mercer). Actuarial soundness requirements do not prescribe the specific assumptions and rates to be employed; rather, the definition of actuarial soundness prescribes that rates are to be calculated in accordance with generally accepted actuarial practice, are appropriate for the populations and services covered, and are developed by an actuary meeting the qualification standards established by the American Academy of Actuaries.

SUMMARY OF RESULTS

Milliman has been engaged by the State to review the SFY 2009 risk based managed care capitation rates negotiated with participating managed care organizations (MCO) for the HUSKY A population. The capitation rates include provision for all medical services to Husky A population enrolled members with the exception of pharmacy, dental, and behavioral health benefits which are “carved-out” of the risk based capitation rates.

The review consisted of an assessment of three primary components: (1) Overall level of the SFY 2009 capitation rates, (2) Actuarial rating assumptions and calculations, and (3) Reporting and transparency. Each component is described below including the summary comments from Milliman.

- **Overall level of capitation rates for the population to be covered, the benefits to be provided, and the cost of services included**

Milliman summary comments: The overall potential for reduced capitation rates is estimated to be in the range of 5% to 6% (approximately \$41 to \$49 million in combined State and Federal dollars).

The overall level of the negotiated capitation rates represents an approximate 1% increase over the midpoint actuarially sound capitation rate developed by Mercer on behalf of DSS. The actuarially sound capitation rate range was not provided to Milliman for purposes of this assignment; however, Milliman believes that the negotiated rates would likely fall within the capitation rate range.

The midpoint of the actuarially sound rate range contains certain assumptions that appear to be generally reasonable; however, the midpoint values are towards the upper end of the values Milliman would likely have applied given the limited information available for this review.

The potential for savings to the program as compared with the final negotiated capitation rates relies entirely on the ability to negotiate more aggressively to a lower position within the actuarially sound rate range. This result is dependent on the specific circumstances surrounding the bid process. For example, who are the potential bidders and what is their minimum acceptable capitation level? Is the State willing to risk lower MCO participation by not accepting certain bids? Does the resulting bid position provide enough MCO participation to allow adequate coverage of the program and not limit future competition by allowing one or two plans to dominate the market?

Milliman calculated an alternative midpoint capitation rate using modified assumptions for certain rating parameters. The overall potential for reduced capitation rates is estimated to be in the range of 5% to 6% provided the State was able to negotiate to this lower midpoint capitation rate level. The State would have to dictate the maximum capitation rate level it is willing to accept, and force the negotiations to achieve the desired values.

- **Actuarial rating assumptions and calculations employed to develop the final capitation rates**

Milliman summary comments: The calculations and assumptions reviewed by Milliman are generally reasonable; however, as stated above, certain specific assumptions appear to be on the higher end of our anticipated range.

Specifically, the annual trend and rebased data for SFY 2007 were higher than our anticipated ranges. Additionally, Milliman typically includes an assessment of the base data managed care utilization and reimbursement levels to determine if an adjustment is necessary to reflect continued managed care improvements in the program.

The annual trend assumptions are, in aggregate, higher than those that Milliman typically observes for similar Medicaid managed care populations (i.e. Temporary Assistance for Needy Families (TANF) populations). Additionally, the increase in fee schedules allotted in the SFY 2009 program adjustments provides further downward pressure on the level of required inflation trend.

The base data included a significant increase compared to the SFY 2007 adjusted target claim cost included in the SFY 2007 capitation rates. This increase appears to have allowed the full increase of observed base data to impact the capitation rates without offset for continued managed care improvements or documentation and explanation of the restated values.

The base data did not include explicit adjustments reflecting continued managed care improvements for utilization of services. Omitting this adjustment implies that the program is meeting or exceeding utilization targets and is not expected to improve between the base year and the capitation rate period. Milliman would typically consider this adjustment omission at the high capitation rate value as opposed to the midpoint level. Milliman understands there are circumstances in Connecticut that may complicate additional utilization efficiencies in the short term such as replacing historical MCOs with new entrants for SFY 2009. However, with the

significant re-basing impact of the historical data, Milliman believes some level of adjustment may be warranted for the midpoint value.

The SFY 2009 capitation rates were developed using historical MCO encounter and financial report experience. This data inherently contains the composite level of provider contracting for the MCOs. While capitation rates are required to include reasonable cost data expected in the managed care program, Milliman often observes that certain MCO reimbursement rates are above the levels the State would consider a reasonable target in terms of the percentage of the Fee-for-Service (FFS) Medicaid fee levels. This adjustment appears to have been omitted from the SFY 2009 midpoint capitation rate calculations.

The administrative cost and profit assumptions are reasonable in aggregate for the Husky A program. However, the development of the administrative cost components contained several methodology and assumption differences that were largely offsetting and ultimately resulted in consistent composite values.

- **Reporting and transparency**

Milliman summary comments: Milliman was also requested to comment on the reporting and transparency of the rate-setting process. Milliman understands that a competitive bid methodology requires certain confidentiality to protect the integrity of the process; however, Milliman believes that additional disclosure of key elements would foster enhanced confidence in prospective bidders and State stakeholders.

Specifically, the bidders may have been more confident to bid aggressively with additional information regarding the development of the base data and large program adjustments included in the SFY 2009 capitation rates.

Milliman developed a summary progression of the SFY 2007 capitation rates to the negotiated SFY 2009 capitation rates (Table 1). The information contained in this exhibit is intended to allow the State to observe the primary items impacting the change in capitation rates from the previous capitation period.

The information contained in Table 1 was estimated by Milliman using data and information provided by DSS and Mercer. All values stated as expenditures are in millions and represent State and Federal combined amounts.

Table 1

STATE OF CONNECTICUT
 OFFICE OF THE STATE COMPTROLLER
 Husky A Capitation Rate Progression – SFY 2007 to SFY 2009¹

	Per Member Per Month (PMPM)	Total Expenditures (\$ Millions)	Percentage of SFY 2007
SFY 2007 (Capitation Rate)	\$ 183.91	\$ 767.8	100.0%
Removal of Admin/Profit (Display Only)	\$ (19.22)	\$ (80.2)	(10.5%)
Removal of Pharmacy ²	\$ (32.04)	\$ (133.8)	(17.4%)
Removal of Dental ²	\$ (8.07)	\$ (33.7)	(4.4%)
Age/Gender Adjusted to SFY 2009 Base ³	\$ 2.54	\$ 10.6	1.4%
SFY 2007 (Adjusted Claim Cost to SFY 2009 Base)	\$ 127.12	\$ 530.7	
Rebasing Impact of SFY 2009 Rates ⁴	\$ 7.19	\$ 30.0	3.9%
SFY 2007 (Base Claims Data for SFY 2009 Rates)	\$ 134.31	\$ 560.7	
Medical Inflation ⁵	\$ 18.79	\$ 78.5	10.2%
Program Adjustments ⁶	\$ 20.20	\$ 84.3	11.0%
SFY 2009 Claim Cost	\$ 173.30	\$ 723.5	
Administrative Cost	\$ 19.19	\$ 80.1	10.4%
Profit and Risk	\$ 1.94	\$ 8.1	1.1%
SFY 2009 Mid-point Capitation Rate	\$ 194.43	\$ 811.7	
Negotiation Adjustment ⁷	\$ 1.88	\$ 7.8	1.0%
SFY 2009 Negotiated Capitation Rate	\$ 196.31	\$ 819.5	106.7%
Milliman Estimated Alternative Midpoint	\$ 184.83	\$ 771.6	100.5%
Potential for Reduced SFY 2009 Capitation Rates	(\$ 11.48)	(\$ 47.9)	(6.2%)

1. Source of information: SFY 2007 and 2009 CMS rate certification letters.
2. Represents carve-out of specific service categories from capitation rates.
3. Represents adjustment for changes in demographic mix of individuals from SFY 2007 to SFY 2009.
4. Represents the difference between SFY 2007 projected claims and SFY 2007 actual claims.
5. Represents the adjustment needed to progress claims from SFY 2007 to SFY 2009.
6. Represents the adjustments for fee changes, population changes, and service changes from SFY 2007 to SFY 2009.
7. Represents the impact of negotiating rates higher than the midpoint values.

The values contained in Table 1 illustrate the progression of the capitation rates from SFY 2007 to SFY 2009. Milliman understands that there are certain documents that also illustrate the progression of the capitation rates from SFY 2008 to SFY 2009. The base SFY 2008 capitation rates were not used in this analysis due to the discontinuation of risk-based managed care in this period. However, Milliman

believes the primary assumptions described in Table 1 serve to explain the “24%” adjustments identified in other documents provided by DSS and Mercer.

Enclosure 1 summarizes the SFY 2009 midpoint capitation rate and corresponding negotiated capitation rate composited by Milliman from the rate cell specific calculations provided in the SFY 2009 capitation rate documentation from DSS and Mercer.

Enclosure 2 summarizes the SFY 2009 midpoint capitation rate using Milliman alternative assumptions for base data managed care adjustments, medical inflation trend adjustments, and administrative cost adjustments.

DETAILED REVIEW ELEMENTS

The following sections identify the review elements and discussion regarding the assumptions and methods employed to develop the SFY 2009 capitation rates. At the beginning of each section the applicable CMS guidance is listed for reference. The guidance is taken directly from Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Rate-setting (Edit Date: 7/22/03) (CMS Rate-Setting Checklist). The referenced document is used by the CMS Regional Offices (RO) in their review of proposed risk-based managed care capitation rates for all state managed Medicaid programs.

1. Rate Setting Methodology

CMS allows for two primary rate-setting methodologies in the development of actuarially sound capitation rates for Medicaid managed care contracts (Section AA.1.3 of CMS Rate-Setting Checklist):

***Option 1: State set rates** - The rates are developed using a set of assumptions meeting federal regulations that results in a set of rates. Open cooperative contracting occurs when the State signs a contract with any entity meeting the technical programmatic requirements of the State and willing to be reimbursed the actuarially-sound, State-determined rate. Sole source contracting occurs where the state contracts with a single entity to provide a set of services must be documented as meeting the requirements of 42 CFR 438.6(c) under this option.*

***Option 2: Competitive Procurement** - The rates are developed using a set of assumptions meeting federal regulations that results in a range of acceptable bids to determine a bid range for rates. Competitive procurement occurs when entities submit bids and the State negotiates rates within the range of acceptable bids. A State could also disclose a maximum or minimum acceptable payment and encourage bids below or above that amount.*

The rate-setting process employed for the development of the SFY 2009 capitation rates for the Husky A Medicaid population can be characterized as a competitive procurement (option 2 above).

Additionally, the SFY 2009 capitation rate range was developed using base year cost and utilization data. This means that the capitation rates were developed by re-basing the claim experience to a new period. The previous rates were developed using SFY 2005 adjusted claims experience for the SFY 2007 period whereas the SFY 2009 capitation rates were developed using adjusted SFY 2007 claims experience. This practice is very common and most states re-base the capitation rates every one to three years. States may develop multi-year capitation rates or use a trend and program adjustments methodology in years that a re-basing is not performed to reduce the resource requirements of rate-setting or to better align with biennium budget cycles.

The base data selected for the development of the SFY 2009 capitation rates employed a combination of historical MCO encounter data and MCO financial reports for the managed care enrolled population. Use of this type of information is very common and appears to be the most comparable to the population to be enrolled in managed care in SFY 2009. Certain states supplement the base data with cost or utilization from applicable Fee-for-Service (FFS) populations; however, since the State is a mandatory managed care program, there is not a credible data source for the FFS population. Additionally, certain states supplement the encounter data with FFS cost information from FFS data or fee schedules if cost information is omitted or invalid on the encounter data.

2. Selection of Base Data

CMS provides the following guidance for the selection of base data in the development of actuarially sound capitation rates for Medicaid managed care contracts (Section AA.1.3 of CMS Rate-Setting Checklist):

Base Year Utilization and Cost Data - The State must provide documentation and an assurance that all payment rates are:

- Based only upon services covered under the State Plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration)
- Provided under the contract to Medicaid-eligible individuals.

**In setting actuarially sound capitation rates, the State must apply the following element or explain why it is not applicable: Base utilization and cost data that are derived from the Medicaid population or if not, are adjusted to make them comparable to the Medicaid population. The base data used were recent and are free from material omission.*

Base data for both utilization and cost are defined and relevant to the Medicaid population (i.e., the database is appropriate for setting rates for the given Medicaid population). States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval.

Examples of acceptable databases on which to base utilization assumptions are: Medicaid FFS databases, Medicaid managed care encounter data, State employees health insurance databases, and low-income health insurance program databases. Note: Some states have implemented financial reporting requirements of the health plans which can be used as a data source in conjunction with encounter data and would improve on some of the shortcomings of these other specific databases used for utilization purposes. For example, some states now require the submission of financial reports to supplement encounter data by providing cost data. It would also be permissible for the State to supplement the encounter data by using FFS cost data. The State could use the cost and utilization data from a Medicaid FFS database and would not need to supplement the data with plan financial information.

The base data selected for the development of the SFY 2009 capitation rates included MCO encounter experience from July 2005 to June 2007 and MCO financial reports from January 2005 to June 2007. This data selection period is reasonable and appropriate for purposes of the SFY 2009 capitation rates. The base data period is current enough to allow for more accurate projections to SFY 2009 and sufficiently mature to allow for a reasonable claims completion run-out period. Adjustments were performed to align the base data and adjust for historical programmatic changes impacting the program.

The use of both the MCO encounter data and MCO financial reports allows for a reasonable composite between an encounter only dataset (which has potential to be under-reported) and a financial report only dataset (which has potential to be over-reported).

Milliman reviewed the financial reports compared to the statutory Annual and Quarterly Statements for three of the four historical MCOs. Annual and Quarterly Statements were not available for CHN. Milliman retrieved the statutory statements from the Highline Data (Insurance Analyst Pro) software through a licensing agreement maintained by Milliman. Table 2 summarizes the comparison between the MCO financial reports and the MCO statutory financial statements.

Table 2

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
Comparison of Claims Cost – MCO Financial Reports and Statutory Financial Statements

(\$ Millions)

	MCO Financial Reports	MCO Statutory Statement ^{1,3}	Percentage Difference
Anthem - CY 2005	\$281.6	\$301.0	(6.4%)
WellCare - CY 2005	\$58.6	\$60.8	(3.6%)
HealthNet - CY 2005	\$186.7	\$176.4	5.9%
Composite CY 2005	\$526.9	\$538.2	(2.1%)
Anthem - CY 2006	\$271.2	\$263.0	3.1%
WellCare - CY 2006	\$60.2	\$62.0	(2.9%)
HealthNet - CY 2006	\$169.8	\$161.3	5.2%
Composite CY 2006	\$501.2	\$486.3	3.1%
Anthem - CY 2007 (YTD June 2007) ²	\$150.0	\$166.1	(9.7%)
WellCare - CY 2007 (YTD June 2007) ²	\$31.1	\$33.8	(8.0%)
HealthNet - CY 2007 (YTD June 2007) ²	\$92.0	\$91.9	0.1%
Composite CY 2007 (YTD June 2007) ²	\$273.1	\$291.8	(6.4%)

1. Milliman calculated the MCO statutory statement values for CY 2005 and 2006 on a restated basis using information contained on subsequent years Underwriting and Investment Exhibit, Schedule 2B reports.
2. The restatement information was not available for YTD CY 2007, and as such is not incorporated into the statutory values for YTD CY 2007.
3. Milliman understands the MCO Statutory Statements to include Husky A and Husky B experience.

As observed in Table 2, the experience reported in the MCO financial reports is higher in certain instances than the restated MCO statutory statements filed with the regulator. Milliman recognizes that there are valid reasons for the observed discrepancies such as timing differences and reserve value differences. However, the results for CY 2006 are concerning as the removal of Husky B experience from the statutory statements would only serve to exacerbate the differences. To the extent the MCO financial reports are over-stated, the resulting capitation rate range would be overstated as well.

The information in Table 2 is intended to highlight the necessity of documenting and reporting the validity of the base data amounts. Additionally, it emphasizes the need for MCP audit and confirmation of reported financial statement values.

3. Adjustments to Base Data

CMS provides the following guidance related to base period adjustments in the development of actuarially sound capitation rates for Medicaid managed care contracts (Section AA.3.0 of CMS Rate-Setting Checklist):

Adjustments to the Base Year Data - The State made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population.

All regulator referenced adjustments are listed in 3.1 through 3.14.

Adjustments must be mutually exclusive and may not be taken twice. States must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. The RO should check to ensure that the State has contract clauses (or State Plan Amendments), where appropriate, for each adjustment.

Sample Adjustments to the Base Year that may increase the Base Year:

- *Administration (Step AA.3.2)*
- *Benefit, Programmatic and Policy change in FFS made after the claims data tape was cut (Step AA.3.1)*
- *Claims completion factors (Step AA.3.2)*
- *Medical service cost trend inflation (Step AA.3.3)*
- *Utilization due to changes in FFS utilization between the Base Year and the contract period. Changes in utilization of medical procedures over time is taken into account (Step AA.3.11)*
- *Certified Match provided by public providers in FFS*
- *Cost-sharing in FFS is not in the managed care program*
- *FFS benefit additions occurring after the extraction of the data from the MMIS are taken into account*
- *One-time only adjustment for historically low utilization in FFS program of a State Plan Approved benefit (i.e., dental)*
- *Patient liability for institutional care will be charged under this program*
- *Payments not processed through the MMIS*
- *Price increase in FFS made after the claims data tape was cut*

Sample Adjustments to the Base Year that may adjust the Base Year downward:

- *Benefit deletions in the FFS Program occurring after the extraction of the data from the MMIS are taken into account (Step AA.3.1)*
- *Cost-sharing in managed care in excess of FFS cost-sharing*
- *Disproportionate Share Hospital Payments (Step AA.3.5)*
- *Financial Experience Adjustment*
- *FQHC/RHC payments*
- *Graduate Medical Education (Step AA.3.8)*
- *Income Investment Factor*
- *Indirect Medical Education Payments (Step AA.3.8)*
- *Managed Care Adjustment*
- *PCCM Case Management Fee*



The SFY 2009 rate-setting process included several modifications to the base data to normalize and adjust the historical experience to be appropriate for projecting forward to SFY 2009. The adjustments included: claim reserves and risk sharing, third party liability recoveries, service category reclassifications, encounter omissions, reinsurance recoveries, and trend to SFY 2007.

Milliman received information related to base data adjustments applied in the development of the SFY 2009 midpoint capitation rates. Table 3a illustrates the adjustments as interpreted by the documentation.

Table 3a

**STATE OF CONNECTICUT
 OFFICE OF THE STATE COMPTROLLER
 MCO Encounter and Financial Reports Base Data Adjustments
 State Fiscal Years 2006 / 2007**

Adjustment	Encounter Data		Financial Reports	
	SFY 2006	SFY 2007	SFY 2006	SFY 2007
IBNR	0.0%	1.4%	N/A	N/A
Shared Risk	0.4%	0.8%	N/A	N/A
IBNR/Shared Risk	N/A	N/A	2.2%	1.6%
Third Party Liability	(1.0%)	(1.0%)	0.0%	0.0%
Omissions	2.1%	1.8%	0.0%	0.0%
Reinsurance	0.8%	(1.0%)	0.9%	(1.0%)
Trend to SFY 2007	6.6%	0.0%	6.3%	0.0%
Composite Adjustments	9.0%	2.0%	9.4%	0.5%

Note: Values have been rounded.

The results illustrated in Table 3a indicate several adjustments applied to the base encounter and financial report data in the capitation rate calculation. Milliman did not independently estimate the value of each item listed above; however, following discussion with DSS and Mercer as well as general reasonableness checking, the values listed appear reasonable and appropriate.

Milliman observed a significant increase in the re-based SFY 2007 data as compared to the adjusted SFY 2007 target claim cost contained in the SFY 2007 capitation rate documentation. This increase resulted in a PMPM percentage increase of approximately 5.7% between the rate-setting time periods. While this does occur, especially when MCO experience is inflating at rates higher than the assumptions used in the rate-setting process, Milliman anticipated that this increase would be explained in greater detail or adjusted somewhat for the midpoint capitation rates. That is, Milliman would anticipate that a full adjustment for substandard MCO experience and no adjustment for enhanced managed care would be at the high end of the rate range as opposed to the midpoint. Table 3b illustrates the change in PMPM

between the SFY 2007 midpoint claims costs included in the SFY 2007 capitation rates and the SFY 2007 base claims cost included in the development of the SFY 2009 capitation rates.

Table 3b

**STATE OF CONNECTICUT
 OFFICE OF THE STATE COMPTROLLER
 SFY 2007 Claims Cost PMPM Comparison**

	SFY 2007 Claims Cost as Observed in:		
	SFY 2007 Capitation Rate Documentation ¹	SFY 2009 Capitation Rate Documentation	Percentage Difference
Inpatient	\$ 37.15	\$ 38.95	4.8%
Outpatient	38.91	42.46	9.1%
Physician	40.65	40.34	(0.8%)
Transportation	3.35	3.32	(0.8%)
All Other	7.06	9.24	30.9%
Total Medical	\$ 127.12	\$ 134.31	5.7%

1. The values listed for SFY 2007 Capitation Rate Documentation were adjusted to remove pharmacy and dental costs as well as adjusted for the estimated age/gender differences between the time periods.

Additionally, Milliman did not observe an adjustment or documentation of the cost per unit calculations taking into consideration the actual MCO fee amounts as compared to the state Medicaid fee amounts. The base data was developed using the aggregate of the MCO negotiated fees and may contain reimbursement levels that are greater than a reasonable target level stated as a percentage of the state Medicaid fee schedule. For example, one MCO may have reimbursement rates for facility equal to 120% of the Medicaid fee amounts while other MCOs may have reimbursement levels of 110%. The base data contains the composite values, while a reasonable assumption may be to adjust the higher MCO fees to reflect the more aggressive negotiated rates.

4. Program Adjustments

The SFY 2009 midpoint capitation rates include several program adjustments which reflect different benefits, fee schedules, and populations to be covered between the base period (SFY 2007) and the capitation rate effective period (SFY 2009). Table 4 summarizes the primary impacts affecting the development of the SFY 2009 capitation rates. Milliman has also included independent estimates of the impacts of the program changes derived from information provided by the State, information internally available to Milliman, and public sources of information.

Table 4

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
Program Adjustments – SFY 2009 Capitation Rates

Program Change	Program Adjustments SFY 2009 Rates	Program Adjustments Milliman Estimates
Provider Fees	7.9%	8.0%
Population Expansions	1.3%	1.9%
FQHC Wrap Payment	2.8%	2.4%
Dental Exams by PCPs	0.6%	0.6%
Composite ¹	13.1%	13.4%

1. The composite value reflects that the program changes were developed as multiplicative factors.

a. Provider Fee Increases

CMS provides the following guidance for the interaction of medical cost/trend inflation and fee or price schedule increases (Section AA.3.10 of CMS Rate-Setting Checklist):

Note: This [Inflation] also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State “inflates” the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.

The CMS guidance indicates that the inflation trends and any program changes legislated to increase the fee schedules should not be double-counted. Generally, Milliman accounts for this requirement by developing the trend rates after normalizing for historical fee changes over the time period from which the trend is calculated.

The SFY 2009 capitation rates include provision for fee increases to Medicaid providers. Milliman understands that the legislature appropriated \$ 53.3 million of additional (State and Federal) funds for the HUSKY A Program which were specifically allocated for the managed care capitation rates. The amounts are listed below:

- Inpatient Hospital: \$ 24.0 million
- Outpatient Hospital: \$ 8.0 million
- Physician: \$ 16.0 million

- Clinics: \$ 3.0 million
- Vision: \$ 0.4 million
- Family Planning: \$ 0.8 million
- Emergent Transportation: \$ 0.6 million
- Non-emergent Transportation: \$ 0.5 million

Milliman estimated the total expenditures for SFY 2009 before and after the appropriated fee schedule changes using the SFY 2009 projected member months and PMPM cost amounts. Milliman concluded that the 7.9% adjustment included in the SFY 2009 capitation rates equated to an approximate increase in expenditures of \$53.3 million for SFY 2009 as intended by the State.

Milliman was unable to validate that the resulting FFS Medicaid fee schedules represent the intended increases due to insufficient data. Milliman received the physician fee schedules both before and after the fee changes; however, the detail included on the encounter utilization files did not allow for appropriate mapping to the fee schedule categories. Further, Milliman did not receive hospital fee schedule tables to allow for a review of the respective fee changes.

b. Population Eligibility Expansions

CMS provides the following guidance related to adjustments for population differences between the base period and the capitation rate period (Section AA.3.3 of CMS Rate-Setting Checklist):

Special populations' adjustments - Specific health needs adjustments are made to make the populations more comparable. The State may make this adjustment only if the population has changed since the utilization data tape was produced (e.g., the FFS population has significantly more high-cost refugees) or the base population is different than the current Medicaid population (e.g., the State is using the State employees health insurance data). The State should use adjustments such as these to develop rates for new populations (e.g., SCHIP eligibles or 1115 expansion eligibles). The State should document why they believe the rates are adequate for these particular new populations.

The SFY 2009 capitation rates were adjusted to reflect the eligibility expansion of Parents and Caregivers to 185% of the Federal Poverty Level (FPL) and Pregnant Women to 250% of the FPL.

Milliman estimated the impact of the Parents and Caregivers eligibility expansion to be insignificant and the impact of the Pregnant Women eligibility expansion to be 1.9% (Table 4 above) of the total adjusted claims cost. Milliman estimated the impact of the Pregnant Women eligibility expansion using the historical encounter data and US Census Bureau population estimates by FPL for females in the "15 to 39" and "40+" age range.

The difference between the actual included impact and the Milliman estimate should not be considered material. The data sources and assumptions used can vary greatly and our results may have been derived with less specific information than was available to DSS and Mercer.

c. FQHC Wrap Payments

CMS defines the allowable FQHC and RHC expenses to be included with the actuarially sound capitation rates for Medicaid managed care contracts (Section AA.3.9 of CMS Rate-Setting Checklist):

***FQHC and RHC reimbursement** – The State may build in only the FFS rate schedule or an actuarially equivalent rate for services rendered by FQHCs and RHCs. The State may NOT include the FQHC/RHC encounter rate, cost-settlement, or prospective payment amounts. The entity must pay FQHCs and RHCs no less than it pays non-FQHC and RHCs for similar services. In the absence of a specific 1115 waiver, the entity cannot pay the annual cost-settlement or prospective payment.*

Milliman understands that an adjustment was performed within the SFY 2009 capitation rate development to include the full encounter rate for FQHCs. The guidance from CMS cited above, as interpreted by Milliman, would suggest that the full encounter rates may not be included. Additionally, there is guidance with respect to annual cost-settlement and prospective payments for states using an 1115 waiver; however, the guidance is silent with respect to the encounter rates for these states and the Connecticut managed care program has used a 1915(b) waiver methodology.

It would appear that special permission from CMS would have had to be obtained to include this adjustment. Milliman received documentation that the Husky A FQHC impact was intended to be \$13.7 million for SFY 2007. This amount divided into the estimated SFY 2007 claims cost of \$560.7 million equates to a percentage impact of approximately 2.4%. The discrepancy between this amount and the documented 2.8% may be due to the information available for purposes of our review. It may also be the case that the intended allotment to Husky B of \$1.3 million was not realized.

d. Dental Exams by PCPs

CMS provides the following guidance with respect to benefit differences between the base period and the capitation rate period (Section AA.3.1 of CMS Rate-Setting Checklist):

***Benefit Differences** - Actuarially sound capitation rates are appropriate for the services to be furnished under the contract. The State must document that actuarially sound capitation rates payments are based only upon services covered under the State Plan. Differences in the service package for the Base Period data and the Medicaid managed care covered service package are adjusted in the rates. Documentation of assumptions and estimates is required for this adjustment.*

The SFY 2009 capitation rates include a program adjustment to provide routine dental examinations by primary care physicians. Milliman did not obtain sufficient details surrounding this program change. However, a quick reasonableness check produced a value of 0.6% composite claims impact which is

consistent with the assumptions identified in the capitation rate documentation letter for SFY 2009 from DSS and Mercer. Milliman's analysis assumed that children ages 1 to 15 would increase PCP visits by 10% which yields a total increase to PCP visits of approximately 4%. The 4% increase in PCP visits translates to an approximate 0.6% composite increase to claims cost.

5. Medical Inflation (Trend)

CMS provides the following guidance for the application of medical cost/trend inflation to be included within the actuarially sound capitation rates for Medicaid managed care contracts (Section AA.3.10 of CMS Rate-Setting Checklist):

***Medical Cost/Trend Inflation** – 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. All trend factors and assumptions are explained and documented.*

Note: This also includes price increases not accounted for in inflation (i.e., price increases in the fee-for-service or managed care programs made after the claims data tape was cut). This adjustment is made if price increases are legislated by the Legislature. The RO must ensure that the State "inflates" the rate only once and does not double count inflation and legislative price increases. The State must document that program price increases since the rates were originally set are appropriately made.

Table 5 summarizes the inflation trends applied to the adjusted base data to progress the SFY 2007 base data forward to the SFY 2009 capitation rate period. The amounts are stated on an annualized basis. There are 24 months from the midpoint of the base period to the midpoint of the capitation rate period, and as such the annual rates listed in Table 5 would compounded over 2 years.

Table 5

**STATE OF CONNECTICUT
 OFFICE OF THE STATE COMPTROLLER
 Comparison of Annual Trend Values**

Service Category	Trend SFY 2009 Midpoint Rates	Trend Encounter Data	Trend Milliman Range
Inpatient	6.5%	13% to 17%	4% to 6%
Outpatient	8.8%	12% to 13%	5% to 7%
Emergency Care	9.5%	14% to 15%	5% to 7%
Professional	5.4%	0% to 4%	3% to 5%
Transportation	2.5%	4% to 6%	2% to 4%
Ancillary Lab/Rad	6.2%	12% to 13%	6% to 8%
DME	3.5%	4% to 6%	2% to 4%
Vision	3.4%	4% to 6%	2% to 4%
Other	3.8%	4% to 6%	2% to 4%
Composite	6.8%	10% to 11%	4% to 6%

The CMS guidance indicates that the inflation trends and any program changes legislated to increase the fee schedules should not be double-counted. Generally, Milliman accounts for this requirement by developing the trend rates after normalizing for historical fee changes over the time period from which the trend is calculated.

The Milliman trend range listed above is exclusive of periodic fee adjustments and is based on our experience with other similar Medicaid managed care populations. As observed in the table above and the alternative Milliman midpoint calculations in Enclosure 2, our midpoint trend assumption is approximately 1.8% lower than the SFY 2009 rate-setting assumed trend which would result in an approximate 3.6% decrease to the midpoint capitation rate due to the compounding impacts of medical trend.

Milliman's trend estimate assumes that the majority of unit cost increases required from the SFY 2007 base period to the SFY 2009 capitation rate period are reflected in the fee schedule increases appropriated by the legislature and included as a separate program adjustment in the rate-setting calculation. The appropriateness of this assumption depends on the CT provider marketplace, a complete understanding of the rationale of the appropriated fee increases, and the implications to beneficiary access to providers; all of which were beyond the scope of our analysis.

6. Administrative Cost Components

CMS provides the following guidance for the administration cost allowance calculations to be included within the actuarially sound capitation rates for Medicaid managed care contracts (Section AA.3.2 of CMS Rate-Setting Checklist):

Administrative cost allowance calculations - The State must document that an adjustment was made to the rate to account 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. Documentation of assumptions and estimates is required.

Note: CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates.

The SFY 2009 capitation rates include provision for administration and profit as shown in Table 6a. Additionally, Table 6a includes Milliman's estimated range, the range observed for the specific Connecticut MCOs, and the range observed by Milliman for all Medicaid MCOs nationwide.

Table 6a

**STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
Administrative Cost Components – Percentage of Capitation Rate**

Administrative Costs	Administration SFY 2009 Rates	Milliman Range	CT MCO Observed	Nationwide Medicaid MCOs
Administration	9.9%	8.0% to 10.0%	7.0% to 16.0%	9.0% to 15.0%
Contribution to Surplus	0.0%	1.0%	N/A	N/A
Profit and Risk	1.0%	1.0%	N/A	N/A
Total Administration	10.9%	10.0% to 12.0%	N/A	N/A

As observed in Table 6a, the midpoint administration component contained in the SFY 2009 capitation rates developed by DSS and Mercer are generally consistent with the midpoint administration component estimated by Milliman. While the results are consistent, the development of the amounts contained several variations that were offsetting in nature.

Milliman estimated the administrative cost using three primary components: (1) Administration expense; (2) Contribution to Surplus; and (3) Profit and Risk contingency. The administrative expense includes operational or organization administrative costs such as salaries, office costs, and claim payment functions. The contribution to surplus component recognizes that as capitation revenue increases, the required risk based capital (RBC) also increases. The profit and contingency margin reflects the target

amount of profit included within the capitation rates to reflect that the MCO is assuming the total risk of claim cost fluctuations in the capitation rate period.

The administration expense developed by Milliman resulted from a projection of the SFY 2007 administration component increased for inflation and decreased for changes in the capitation covered benefits. Rather than estimate the administration as a percentage of capitation, Milliman inflated the PMPM administration from SFY 2007 using a trend rate of 3.5%. This methodology reflects that administration costs generally do not increase at the same rate as medical costs. Additionally, Milliman decreased the SFY 2007 base administration costs to reflect the removal of claim administration for pharmacy and dental benefits. It should be noted that Milliman did not increase the PMPM administration costs to reflect the addition of the program changes. The program changes were primarily fee changes and would not generally require additional administration functions on a PMPM basis.

Milliman estimated the profit and risk contingency and the contribution to surplus components as a percentage of the SFY 2009 capitation rate. These items are generally considered a function of the capitation revenue, and as such were adjusted at the same rate as the capitation payments.

Table 6b illustrates the development of the Milliman estimated midpoint administrative component.

Table 6b

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
Administrative Cost Components – Illustrative Development

Administrative Component Development	PMPM
SFY 2007 Administration Expense PMPM	\$17.38
Removal of Pharmacy and Dental Administration	(\$1.50)
Adjusted SFY 2007 Administration Expense PMPM	\$15.88
Inflation to SFY 2009 (3.5% Annualized)	\$1.13
SFY 2009 Administration Expense PMPM	\$17.01
SFY 2009 Surplus Contribution PMPM	\$1.85
SFY 2009 Profit and Risk PMPM	\$1.85
Total Administrative Cost PMPM – Alternative Calculation	\$20.71
Mercer Midpoint Administrative Cost PMPM	\$21.13

7. Reporting and Disclosure

Milliman reviewed the SFY 2009 capitation rate documentation letter as well as all corresponding data and information provided in the Prospective Bidders Library. The following discussion summarizes the general comments related to documentation and transparency of the SFY 2009 rate-setting process.

a. Databook

Milliman reviewed the Data Book and supporting material located on the CT DSS website (Prospective Bidders Library). The resources provide a significant amount of information for prospective bidders.

The general practice with respect to the level of information to provide to MCOs relates to the methodology of capitation rate-setting.

For State determined capitation rates, more information is usually provided as there is no negotiation or competitive bidding. This type of process generally provides enough information to quantify the capitation rates from base data through to the capitation rate, including the values of all adjustments assumed.

For Competitively bid capitation rates, there is a need to maintain a certain level of confidentiality of information, and as such generally less information is provided. With respect to the SFY 2009 capitation rates, Milliman believes that additional disclosure of key elements would foster enhanced confidence in prospective bidders which may have influenced the bidders to propose capitation rates with more confidence and aggressiveness. Specifically, Milliman believes that additional information related to the following items would have been beneficial to the process:

- Documentation and analysis of program adjustments.
- Detail with respect to adjustments to the base encounter data.
- Detail with respect to the base data cost per unit as stated as a percentage of the Medicaid fee schedule.

The base encounter data required significant adjustment to be usable for capitation rate setting purposes. Milliman did not observe sufficient documentation to allow for an independent adjustment of this data for rate-setting purposes. Prospective bidders may have benefited from additional data fields such as provider type, place of service, and sub-capitation indicator.

Prospective bidders may have benefited from information with respect to the underlying cost data represented by the encounter and financial report information. For example, a prospective bidder may have been more aggressive if they knew the underlying data represented 105% of Medicaid fees and their contracts represent approximately 103% of Medicaid fees.

b. CMS Certification Documentation

The SFY 2009 capitation rate documentation provided to Milliman by DSS and Mercer for purposes of this review represents the documentation provided to CMS for approval of the capitation rates. Milliman considers the information provided a “minimum necessary” level of transparency which lacks significant details regarding adjustment factors and documentation of primary assumptions.

The SFY 2009 capitation rate documentation letter does, however, follow the general direction and format of the CMS Rate-Setting Checklist.

DATA RELIANCE

Milliman has relied upon information provided by the CT Office of the Comptroller, CT Department of Social Services, and Mercer in the development of the information presented in this report. To the extent that the information contains errors or omissions, the results presented may be impacted.

Specifically, Milliman relied on the following information from the above parties:

1. Managed Care Rate Ranges for SFY 2009 Husky A Program – CMS Certification Letter (Mercer – June 18, 2008);
2. Managed Care Rate Ranges for SFY 2007 Husky A Program – CMS Certification Letter (Mercer – November 30, 2006);
3. Managed Care Rate Ranges for SFY 2006 Husky A Program – CMS Certification Letter (Mercer – June 22, 2005);
4. 1915(b) Waiver Filings;
5. Bidders Databook (Mercer – March 28, 2008);
6. Encounter data – SFY 2005 to SFY 2007;
7. Husky A IS Summary (MCO Financials CY 2005 to YTD CY 2007);
8. Response to Milliman Request for Information (Mercer – March 20, 2009) including all supporting attachments and follow up information; and,
9. Oral discussions during conference calls on October 20, 2008, November 20, 2008, and April 2, 2009.



Mr. John Clark
May 20, 2009
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If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

A handwritten signature in cursive script that reads "Robert M. Damler".

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/sds
Enclosures



ENCLOSURE 1

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Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for the State by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information contained in this document.

**State of Connecticut
SFY 2009 Medicaid Capitation Rate Review - Husky A
Mercer Estimate - Midpoint Capitation Rate**

Population Member Months	Composite 4,174,723	SFY 07		SFY 07		Base and SFY08		Midpoint		SFY09	
		Encounter PMPM	Credibility Adjustment	Financial PMPM	Credibility Adjustment	Blended SFY 07 PMPM	Program Changes	Annualized Trend	SFY09 Program Changes	Midpoint Rate	
Inpatient	\$ 38.92	50%	\$ 38.98	50%	\$ 38.95	0.0%	6.5%	15.7%	\$ 51.13		
Outpatient	\$ 27.07	50%	\$ 26.33	50%	\$ 26.70	2.8%	8.8%	7.2%	\$ 34.83		
Emergency Care	\$ 15.83	50%	\$ 15.68	50%	\$ 15.76	0.0%	9.5%	0.4%	\$ 18.97		
PCP	\$ 15.11	50%	\$ 18.95	50%	\$ 17.03	18.2%	5.4%	13.9%	\$ 25.42		
SCP	\$ 20.15	50%	\$ 26.47	50%	\$ 23.31	0.0%	5.4%	11.4%	\$ 28.84		
Emergency Trans	\$ 1.44	50%	\$ 1.58	50%	\$ 1.51	0.0%	2.5%	9.9%	\$ 1.74		
Nonemergency Trans	\$ 1.59	50%	\$ 2.03	50%	\$ 1.81	0.0%	2.5%	6.4%	\$ 2.03		
Ancillary Lab/Rad	\$ 7.38	50%	\$ 3.82	50%	\$ 5.60	0.0%	6.2%	0.5%	\$ 6.35		
DME	\$ 1.66	50%	\$ 0.74	50%	\$ 1.20	0.0%	3.5%	0.0%	\$ 1.29		
Vision	\$ 1.72	50%	\$ 1.08	50%	\$ 1.40	0.0%	3.4%	6.3%	\$ 1.59		
Other	\$ 1.38	50%	\$ 0.69	50%	\$ 1.04	0.0%	3.8%	0.1%	\$ 1.12		
Total	\$ 132.26		\$ 136.36		\$ 134.31	2.9%	6.8%	10.1%	\$ 173.30		

Admin: \$ 19.19
 Profit/Risk: \$ 1.94
 Total Capitation: \$ 194.43
 Negotiated Capitation: \$ 196.31



ENCLOSURE 2

**State of Connecticut
SFY 2009 Medicaid Capitation Rate Review - Husky A
Milliman Estimate - Midpoint Capitation Rate**

Population Composite
Member Months 4,174,723

	SFY 07		SFY 07		Illustrative Base Data	Base and SFY08 Program Changes	Annualized Trend	SFY09 Program Changes	SFY09 Midpoint Rate
	Encounter PMPM	Credibility Adjustment	Financial PMPM	Credibility Adjustment					
Inpatient	\$ 38.92	50%	\$ 38.98	50%	\$ 38.95	0.0%	5.0%	15.7%	\$ 48.46
Outpatient	\$ 27.07	50%	\$ 26.33	50%	\$ 26.70	2.8%	6.0%	7.2%	\$ 32.24
Emergency Care	\$ 15.83	50%	\$ 15.68	50%	\$ 15.76	0.0%	6.0%	0.4%	\$ 16.88
PCP	\$ 15.11	50%	\$ 18.95	50%	\$ 17.03	18.2%	4.0%	13.9%	\$ 24.78
SCP	\$ 20.15	50%	\$ 26.47	50%	\$ 23.31	0.0%	4.0%	11.4%	\$ 28.08
Emergency Trans	\$ 1.44	50%	\$ 1.58	50%	\$ 1.51	0.0%	3.0%	9.9%	\$ 1.76
Nonemergent Trans	\$ 1.59	50%	\$ 2.03	50%	\$ 1.81	0.0%	3.0%	6.4%	\$ 2.05
Ancillary Lab/Rad	\$ 7.38	50%	\$ 3.82	50%	\$ 5.60	0.0%	7.0%	0.5%	\$ 6.12
DME	\$ 1.66	50%	\$ 0.74	50%	\$ 1.20	0.0%	3.0%	0.0%	\$ 1.21
Vision	\$ 1.72	50%	\$ 1.08	50%	\$ 1.40	0.0%	3.0%	6.3%	\$ 1.50
Other	\$ 1.38	50%	\$ 0.69	50%	\$ 1.04	0.0%	3.0%	0.1%	\$ 1.04
Total	\$ 132.26		\$ 136.36		\$ 134.31	2.9%	5.0%	10.1%	\$ 164.12

Admin: \$ 17.01
 Profit/Risk: \$ 1.85
 Surplus Contribution: \$ 1.85
 Total Capitation: \$ 184.83



MICHAEL P. STARKOWSKI
Commissioner

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER
May 19, 2009

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The Honorable Nancy Wyman
Comptroller
State of Connecticut
55 Elm Street
Hartford, CT

Dear Ms. Wyman:

The Department of Social Services (DSS) is providing the attached detailed response to your office's May 1, 2009 draft Executive Summary and your contracted actuaries' draft report relative to the review requested by the General Assembly of the HUSKY A health insurance program. As noted in John Clark's email transmitting the draft reports, we appreciate that you will be including our response in the final report.

As stated in our May 2, 2009 letter we take great exception to the conclusions reached by Milliman and again ask you to reconsider releasing a report that is misleading and inaccurate. Specifically, conclusions reached by Milliman were based on assumptions concerning premium or base payments to the MCO's, calculated rate reductions, and annual trend and/or inflation factors that are either not supported in the report and/or are simply incorrect.

In addition, even Milliman prefaces their conclusions several times in the report with disclaimers and/or scope limitations that call into question the validity of their conclusions and their understanding of the Connecticut rate setting process. Based on that, it is misleading to use such conclusions to project major budget savings where in reality they most likely do not exist.

As noted in our previous correspondence, we are willing to meet with your staff and actuaries to determine if there are any real savings that can be for the State of Connecticut while maintaining high quality health care for Connecticut's children.

Sincerely,

A handwritten signature in black ink, appearing to read "Claudette Beaulieu".

Claudette Beaulieu, Deputy Commissioner

A handwritten signature in black ink, appearing to read "Fran Freer".

Fran Freer, Acting Deputy Commissioner

CB:FF:JW

Cc: Michael P. Starkowski, Commissioner

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EXECUTIVE SUMMARY

- The Comptroller incorrectly assumes “savings” by subtracting costs that Connecticut does not in fact pay for in its MCO rates.
 - Milliman assumed that if “bonus” or “premium” payments were subtracted, the state could save \$7.8 million.
 - **DSS DOES NOT provide a “bonus” or “premium” to its MCO’s.**
 - Milliman assumed that the rates DSS pays are over the midpoint of an actuarially sound payment range.
 - **The rates used by DSS are actually BELOW the midpoint of an actuarially sound payment range.**
- The Comptroller’s finding that substantial savings could be achieved if Milliman’s calculations were accepted is speculative at best, and assumes that Milliman’s calculations are grounded on a thorough analysis of Connecticut’s circumstances. This is certainly not supported by Milliman’s own cautionary comments and disclaimers in the draft report.
 - **“Milliman received various data and information related to the history of the HUSKY A program and development of the SFY capitation rates. However, the scope of this assignment was such that a full and complete understanding of all facts of the program and development were not feasible.”**
 - **Milliman itself admits their trend estimates are speculative at best. “The appropriateness of this assumption [trend] depends on the CT provider marketplace, a complete understanding of the rationale of the appropriated fee increases, and the implications to beneficiary access to providers; ALL OF WHICH WERE BEYOND THE SCOPE OF OUR ANALYSIS. (emphasis added)”**
- The Comptroller assumes significant savings would be achieved by a harder negotiating stance in MCO contract negotiations.
 - **The department negotiated long and hard after the initial MCO bids were submitted. In fact, the actuarially certified bids originally submitted by each of the MCO’s in response to the RFP, were above the top of the Mercer rate range. It took multiple negotiations and resubmissions over the course of three months in order to get the three bidding health plans into the Mercer rate range. Through this experience, the Department can state with confidence that lower**

capitation rates would have resulted in fewer MCO's agreeing to participate in the HUSKY managed care program.

- The Comptroller assumes that substantial savings could be achieved without reducing payments to medical providers and without reducing services to clients.
 - **This assumes savings could come out of other areas – perhaps “MCO profits.” Unfortunately, early experience indicates that 2 of the 3 new MCO's are showing losses for this year, and “profits” for the third are nearly non-existent (less than 1%).**
- The Comptroller claims that DSS use of a 6.8% inflation factor was higher than those typically observed (by Milliman) in other states for similar Medicaid managed care populations. This is completely unsupported and undocumented.
 - **DSS has provided background on its use of HUSKY-specific, Connecticut-specific data. Healthcare is local and so are costs and trends! What Milliman is (observing) in other state may not represent Connecticut's healthcare environment.**
 - **Milliman provides no clear evidence how its trend range of 4 to 6 percent was developed.**

DSS RESPONSE TO COMPTROLLER'S DRAFT REPORT RELATIVE TO THE
HUSKY A HEALTH CARE PROGRAM

Comptroller's Finding #1:

There is an actuarially-sound basis to reduce the capitation rate paid to the Managed Care Organization's (MCO's) in the Husky A program by between \$41 and \$49 million annually - representing a five percent to six percent rate reduction.

DSS Response:

This statement is purely speculative and misleading.

This finding by the Comptroller assumes (1) that if the factors detailed in the Milliman report were accepted, the State would be able to realize reductions to the MCO capitation rates that would generate the \$41 to \$49 million annually, (2) that the targeted reductions to the current MCO reimbursement structure can be negotiated and (3) that the reductions would not negatively impact the current HUSKY delivery model.

The finding is, however, based only on Milliman's review of the calculations and assumptions employed by the Department's actuaries to develop the final capitation rates and without a clear and complete understanding of the origination of and migration to the current HUSKY A program. Milliman concedes this fact within their report, "*Milliman received various data and information related to the history of the HUSKY A program and development of the SFY capitation rates. However, the scope of this assignment was such that a full and complete understanding of all facets of the program and development were not feasible.*"¹

While this response will address the detail provided in the Comptroller's executive summary and underlying Milliman report for the three factors used to explain the variance in the capitation rate used by DSS and the rate developed by Milliman, first it will address the feasibility of negotiating a reduction to the rate structure and the impact of such a negotiation on the current HUSKY delivery model.

The Milliman report appropriately identifies the potential risks and implications of dictating lower MCO capitation rates for State Fiscal Year 2009 (SFY09). They state, "*The potential for savings to the program as compared with the final negotiated capitation rates relies entirely on the ability to negotiate more aggressively to a lower position within the actuarially sound rate range. This result is dependent on the specific circumstances surrounding the bid process. For example, who are the potential bidders and what is their minimum acceptable capitation level? Is the State willing to risk lower MCO participation by not accepting certain bids? Does the resulting bid position provide*

¹ Damler, Robert M., HUSKY CAPITATION RATE REVIEW - SFY 2009 (4/24/09 - DRAFT AND CONFIDENTIAL) p. 2

enough MCO participation to allow adequate coverage of the program and not limit future competition by allowing one or two plans to dominate the market?"²

In light of the Department's actual experience with the MCO's during the competitive bid and the SFY09 payment rate negotiation process, it is unlikely that the current MCO's would agree to comply with the contractual requirements required by the State for the operation of the HUSKY A program in return for the targeted capitation rates recommended in the Milliman report.

The rates recommended in the Milliman report fall within the rate range developed by Mercer and would have met Mercer's actuarial soundness requirements. However, the actuarially certified bids originally submitted by each of the MCO's in response to the RFP were above the top of the Mercer rate range. It took multiple negotiations and resubmissions over the course of three months in order to get the three bidding health plans into the Mercer rate range. Through this experience, the Department can state with confidence that lower capitation rates would have resulted in fewer MCO's agreeing to participate in the HUSKY managed care program.

Even if, however, the MCO's would agree to lower capitation rates, we are of the strong opinion that lower capitation rates would be counterproductive to the State's ability to attract and adequately compensate providers. Lower capitation rates could translate into lower reimbursements for medical providers which would negatively impact a providers' decision to join the MCO's' provider network. This would jeopardize the ability for MCO's to contract with an adequate number of providers, compromising the MCO's' ability to maintain an adequate provider network and negatively impacting client choice and access to services for HUSKY members.

If the MCO's were not to agree to lower capitation rates and exit the program, then a different delivery model would be required to provide healthcare services for the HUSKY population. Currently, there is no analysis or empirical evidence in Connecticut that a FFS, PCCM or hybrid delivery model would be able to achieve lower costs or better quality of care than the current managed care model.

In order to appropriately assess the efficacy of different health care delivery models in Connecticut, the State will conduct an analysis of the preliminary results for the PCCM pilot program in 2010.

The Comptroller's Executive Summary identifies and provides detail to three factors that explain the variance in the capitation rate used by the Department and the rate developed by Milliman. The "Milliman rate" is the basis for Comptroller's Finding #1 and the

² Damler, Robert M., HUSKY CAPITATION RATE REVIEW - SFY 2009 (4/24/09 - DRAFT AND CONFIDENTIAL) p. 3

assumption that the utilization of the "Milliman rate" would reduce the HUSKY A program by between \$41 and \$49 million annually. DSS provides the following response to each of the three detail factors:

Comptroller's Finding #1: Detail 1 - "With respect to the negotiated rate adjustment used by DSS, Milliman did not provide a premium or bonus payment to the MCO's in excess of the mid-point actuarially sound capitation rate. Removing this bonus payment lowers the rate by one percent (\$7.8 million)."

DSS Response to Detail 1: The Comptroller and Milliman assume not only that DSS provides a premium or bonus payment to the MCO's but also that the weighted average payment rates used by DSS are in excess of the midpoint of the actuarially sound rate range. These are not accurate statements.

- a. **DSS DOES NOT provide a bonus payment or pay a premium to the MCO's.** CMS requires the disclosure of bonus payments or premiums. A thorough review of the copies of the rate certification letters provided to Milliman, cited by Milliman throughout its report, provides evidence that there was no bonus payment or premium. Further, Milliman does not cite the use of any bonus payment in its report.
- b. **The weighted average payment rates used by DSS are actually BELOW the midpoint of the actuarially sound rate range.** Using current FY09 HUSKY A enrollment by MCO, a more appropriate value for the actual overall weighted average payment rate is \$192.70 PMPM, a rate that is 0.9 percent below the midpoint. The difference from the initial assumption of a negotiated weighted average payment rate 1 percent above the midpoint to a more recent value that is 0.9 percent below the midpoint is already realized and captured in terms of budget savings.

Comptroller's Finding #1: Detail 2 - "Regarding data rebasing. Milliman calculated a 2.2 percent rate reduction where DSS had no adjustment."

DSS Response to Detail 2: Milliman did not "calculate" a 2.2 percent rate reduction.

- a. Milliman made arbitrary and unsupported assumptions about "illustrative base data adjustments" that are not based on HUSKY data and thus have no basis in reality. Specifically, Milliman provides no basis for its assumed reduction in hospital inpatient, outpatient, emergency care, lab/radiology, or vision and other services.
- b. If there were some basis for Milliman's reductions in these services, it is not actuarially appropriate to only assume downward reductions in service. It is a recognized and well-documented fact that to achieve such reductions, there will be corresponding increases in services such physician visits, transportation

services, or pharmacy utilization. Milliman makes no such balancing adjustments, making their assumptions both misleading and inaccurate.

Comptroller's Finding #1: Detail 3 – “The annual trend or inflation factor of 6.8 percent used by DSS was found to be higher than those typically observed by Milliman for similar Medicaid managed care populations.”

DSS Response to Detail 3: The Milliman trend figures are completely unsupported and undocumented. While DSS has provided the background on its use of HUSKY-specific trend figures, Milliman provides no such documentation for its “observed” trend figures. Healthcare is local and so are costs and trends. What Milliman may be observing in other states may not be representative of the healthcare environment in Connecticut.

- a. It is unclear exactly how Milliman developed its trend range of 4 percent to 6 percent. More than half of Milliman’s purported savings come from an assumption that even Milliman admits is speculative at best. They state, “The appropriateness of this assumption [trend] depends on the CT provider marketplace, a complete understanding of the rationale of the appropriated fee increases, and the implications to beneficiary access to providers; ALL OF WHICH WERE BEYOND THE SCOPE OF OUR ANALYSIS (emphasis added).”³
- b. “The Comptroller’s office cannot determine if the fee schedule adjustment could have been implicitly double counted in both program and trend.”⁴ The resulting trends are reasonable and do not double count. While any inflation on unit pricing will be suppressed, price inflation represents just one component of the overall trend increases. There may still be unit cost increases with changes in service case mix and medical technology, as evidenced in years where there are no provider fee increases, yet there is still a unit cost trend. In addition, with improved provider fee increases, more providers may be willing to participate in Medicaid, resulting in increased utilization. This is currently being observed in the Connecticut HUSKY program with dental services.
- c. The best way to validate the trends is to review emerging experience. Milliman did have the benefit of being able to view the trends one additional year into the future. However, recently reported HUSKY A financial experience for the first quarter from the new managed care contractors are showing losses for two of the managed care contractors, and modest profits (less than 1 percent) for one of the plans. While this experience is preliminary and likely to change, it does not suggest that the trends were overstated resulting in payment rates well in excess of actual claims experience.

³ Damler, Robert M., HUSKY CAPITATION RATE REVIEW ~ SFY 2009 (4/24/09 – DRAFT AND CONFIDENTIAL) p. 17

⁴ Comptroller’s Executive Summary p.3

Comptroller's Finding #2:

In the course of meeting with legislators and staff relative to the Medicaid budget, concern was expressed that insufficient transparency existed with respect to the transfer of dollars within the Medicaid line-item. In addition, almost \$100 million of Medicaid funding was unexpended in Fiscal Year 2008 and brought forward to Fiscal Year 2009.

Concern was expressed that the source of this carry-forward funding was not well documented. The General Fund Medicaid appropriation occupies a single budget line-item/SID (special identification code) that is quickly approaching \$4 billion. While Medicaid is a single line-item it contains multiple component programs.

DSS Response:

DSS was taken aback by the inclusion of this finding as it is neither within the stated scope of the Milliman review nor is it referenced or discussed in the Milliman report. The Milliman report states the scope of its review as pertaining to the "...State Fiscal Year (SFY) 2009 risk based managed care capitation rates for the HUSKY A population. Further since neither the Comptroller's Office nor Milliman ever raised the inclusion of this issue during the course of this review DSS was not afforded the opportunity to provide factually based information and documentation to support the budgeting process. It is completely inappropriate to publish this finding and associated recommendations without first seeking input from DSS. It is also misleading to include this finding in an executive summary to an underlying report that fails to address the detail of the findings and include the analysis conducted to reach the stated findings.

While DSS would expect to be granted the opportunity to review and conduct an in-depth analysis of these findings we have completed a cursory review in order to provide our response in accordance with the Comptroller's deadline. While our analysis is not complete, we can unequivocally state that we firmly disagree with the assertions made in this finding.

- a. Health care financing for a package of services such as those provided under Medicaid clearly calls for a level of flexibility that is generally inherent in all major health care coverage. As the Office of the State Comptroller can attest, health care benefits for State employees and retirees are not budgeted at a category of service level. Changes in utilization of services, compounded by other variations in estimates versus actuals, can alter the level of funding necessary in any given service category. To constrict funding by service area through a direct appropriation of funds runs the potential to disrupt service provision, while creating significant inefficiencies in service funding. It was our understanding that the purpose of this study was as a tool to find efficiencies, not to create unnecessary and inefficient bureaucracy.

- b. There appears to be less than a handful of states, and none in our region, which appropriate by service line-item. The vast majority use a single appropriation approach, as Connecticut does recognizing the extreme confines the detailed appropriation approach would involve.
- c. While the Department utilizes a single appropriation approach for the Medicaid area, expenditures are reported at the line-item level. Timely monthly reports on the Medicaid account are currently provided by service category. It is inaccurate to say that the utilization of a single line-item appropriation translates into the absence of legislative oversight and control.
- d. The comments on carryforward indicate legislative concerns existed regarding documentation for the \$100 million that was ultimately provided to the Legislature. What the Comptroller's office and Milliman describe as a lack of transparency in the process would be more accurately described as a complex series of estimates that, if needed or requested could be explained or documented by DSS. The breakout of the source of the carryforward requests are now and have been available. They were not, however, requested nor was this issue discussed with DSS. DSS did not then, nor would it now, withhold any available documentation. DSS has, and will continue to be, forthcoming in providing documentation in response to legislative requests.

Comptroller's Finding # 3:

The way in which Medicaid expenditures are recorded within the state-wide financial and human resources system known as Core-CT, does not provide sufficient transparency with respect to payment detail.

DSS Response:

As with Finding #2, never during the course of this review, spanning almost seven (7) months, did the Comptroller's Office or Milliman raise this issue and/or seek comment, documentation, or justification from DSS on this issue. Just as with Finding #2, it is completely inappropriate to forward this finding and associated recommendations without first seeking input from DSS. However, notwithstanding the Comptroller's Office and Milliman's failure to obtain and consider the Department's input on this issue we provide the following:

- a. DSS has and will continue to provide expenditure data to both the Legislature and the Office of Fiscal Analysis. However, it is the Department's opinion that expanding Core-CT's role would be duplicative. The Department produces a monthly Comprehensive Financial Status Report (CFSR) on all expenditures for each month which details all Department expenses, for both General Funds and all other funding sources. Medicaid specific data is compiled into a report which includes detailed expenses by service category. This report is a part of

the CFSR report but is also forwarded separately as an individual report to the Office of Fiscal Analysis.

- b. It is unclear what problem the Comptroller's office is attempting to solve. Efforts to duplicate payment data or processing that is already occurring in the Department's Medicaid payment processing system seems to once again be contrary to the Comptroller's call for enhancing efficiencies. The development of redundant processing activities would only add further bureaucracy in a process that is operating efficiently.
- c. The Department is open to discussing efforts to share payment information on providers, however, we can only support such efforts if they did not include client level data and that such efforts do not involve unnecessary duplication of efforts and inefficiencies.

Conclusion

The Department remains committed to cooperating with the Comptroller's Office and the Legislature as we examine those areas that could produce budgets savings within the Department. However, it is imperative that reports of possible savings be developed through the application of logical and supported assumptions to facts. After a careful review of the Comptroller's summary and the underlying Milliman report we are confident that is not the case in this instance.