HEALTH WEALTH CAREER

MANAGED CARE RATE DEVELOPMENT MAY 1, 2017 THROUGH JUNE 30, 2018

STATE OF MISSOURI
MO HEALTHNET DIVISION

JUNE 1, 2016

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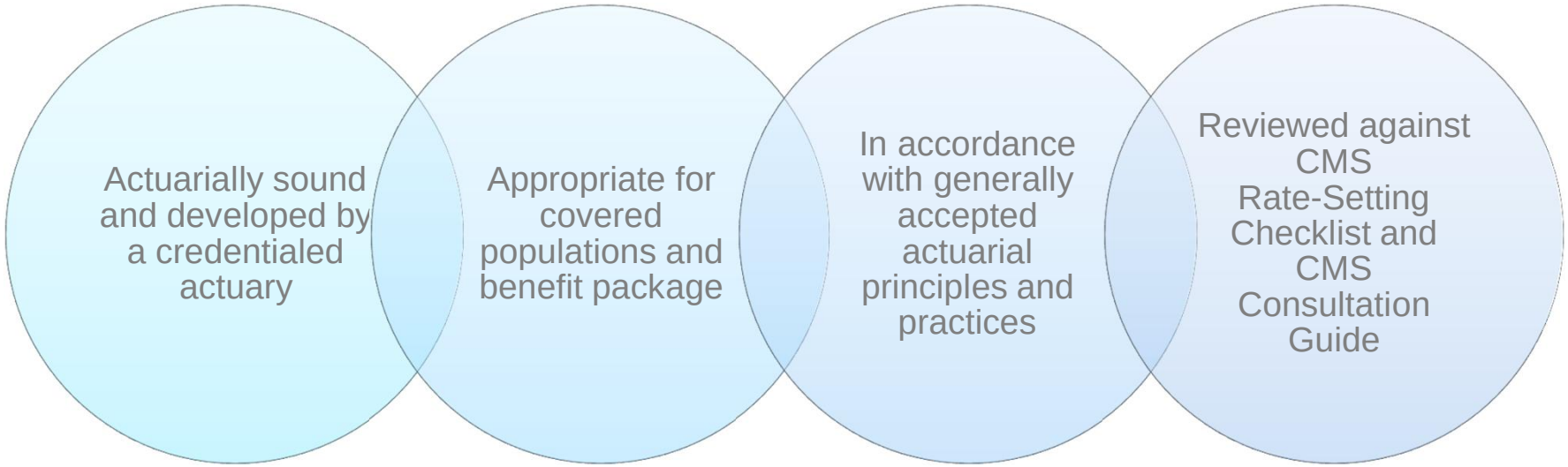
GOALS

- Recognize federal rate-setting requirements
- Review materials provided related to capitation rate development
- Understand covered services and populations
- Highlight steps taken to develop the rate ranges:
  - Base data development
  - Managed care rate range development
  - Medicaid Expansion population
- Review other payment considerations:
  - Risk adjustment
  - Performance withhold
- Questions

FEDERAL RATE-SETTING REQUIREMENTS

In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations (42 CFR 438.6(c)), rates must be:



"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs."

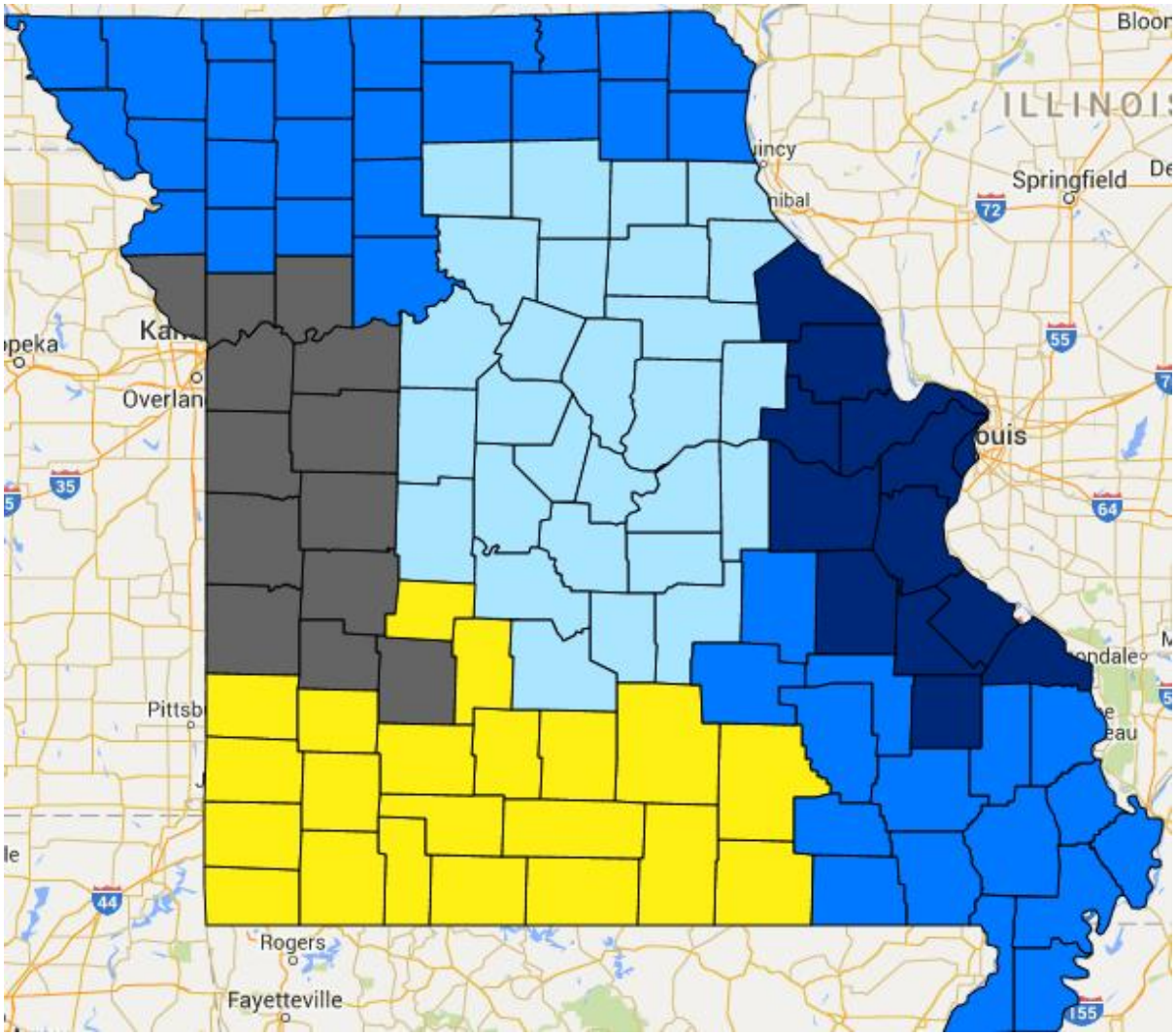
March 2015 Actuarial Standard of Practice No. 49, "Medicaid Managed Care Capitation Rate Development and Certification"

CAPITATION RATE DEVELOPMENT MATERIALS

- Health Plan (HP) Financial Data
- Encounter Data
- Fee-for-Service (FFS) Data
- Rate Development
- Medicaid Expansion Option
- Rate Build-Up Summaries

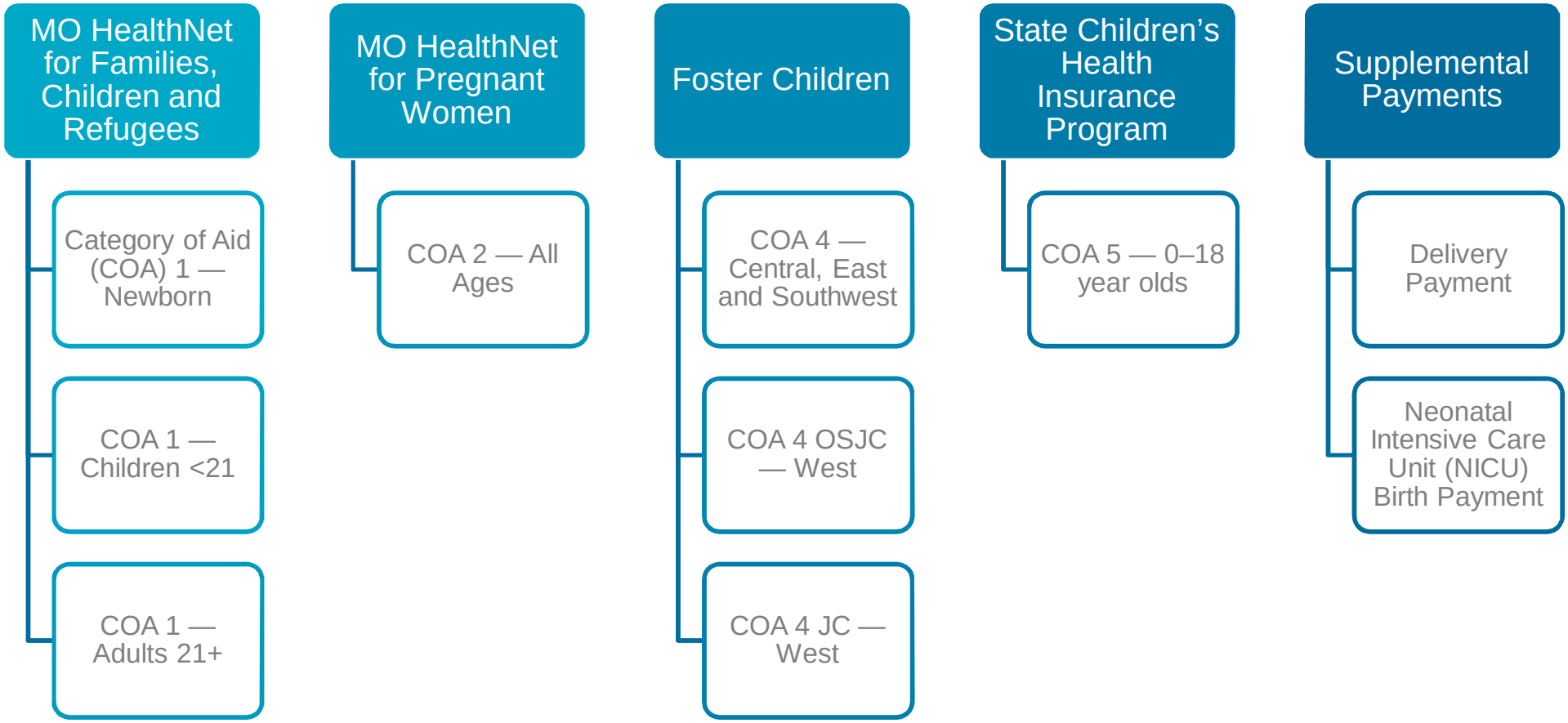
PROGRAM OVERVIEW

PROGRAM OVERVIEW
SERVICE AREA



- The extension of managed care on a statewide basis includes the addition of 61 counties
- New regional definitions:
  - Eastern Region
  - Western Region
  - Central Region — Current
  - Central Region — Extension
  - Southwest Region

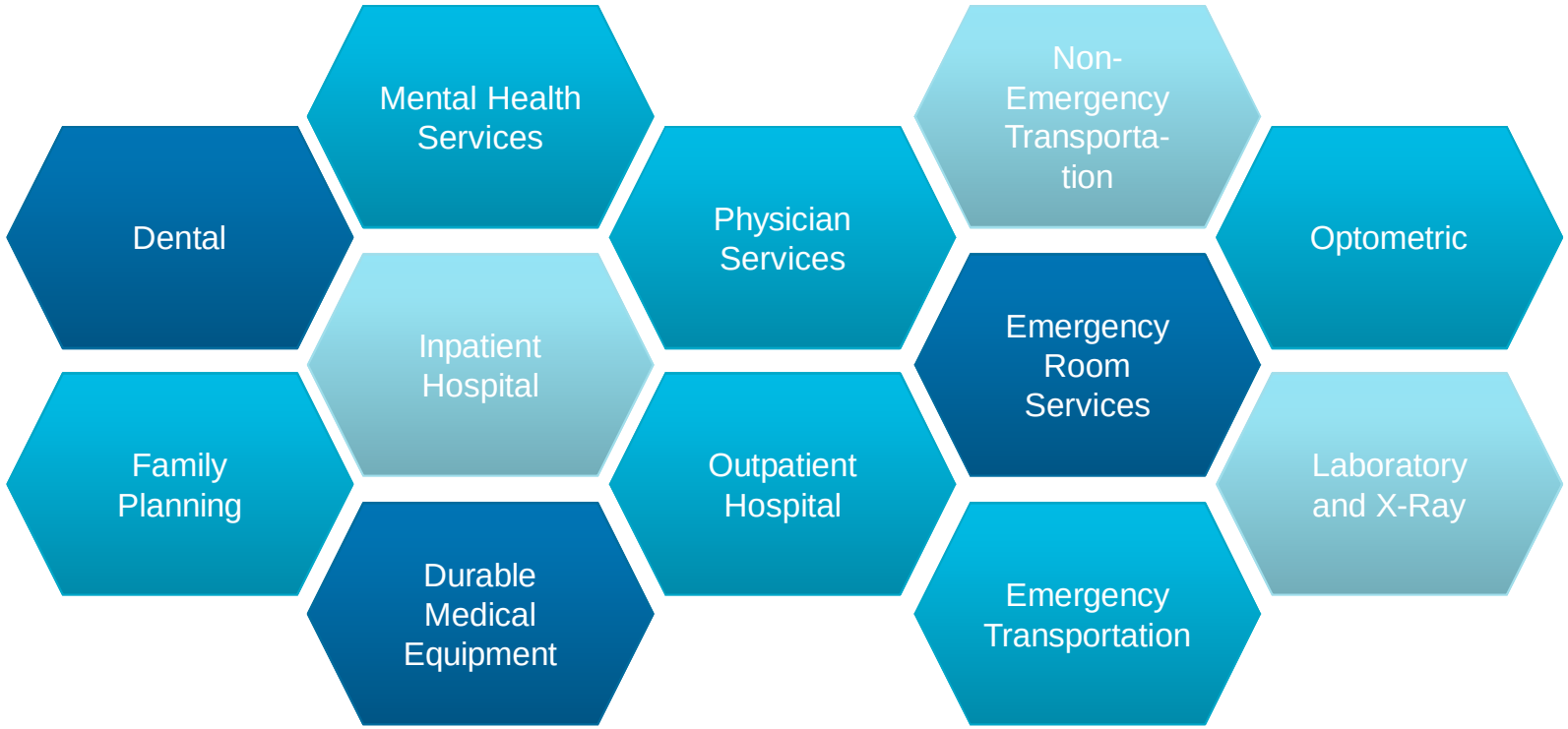
PROGRAM OVERVIEW
COVERED POPULATIONS



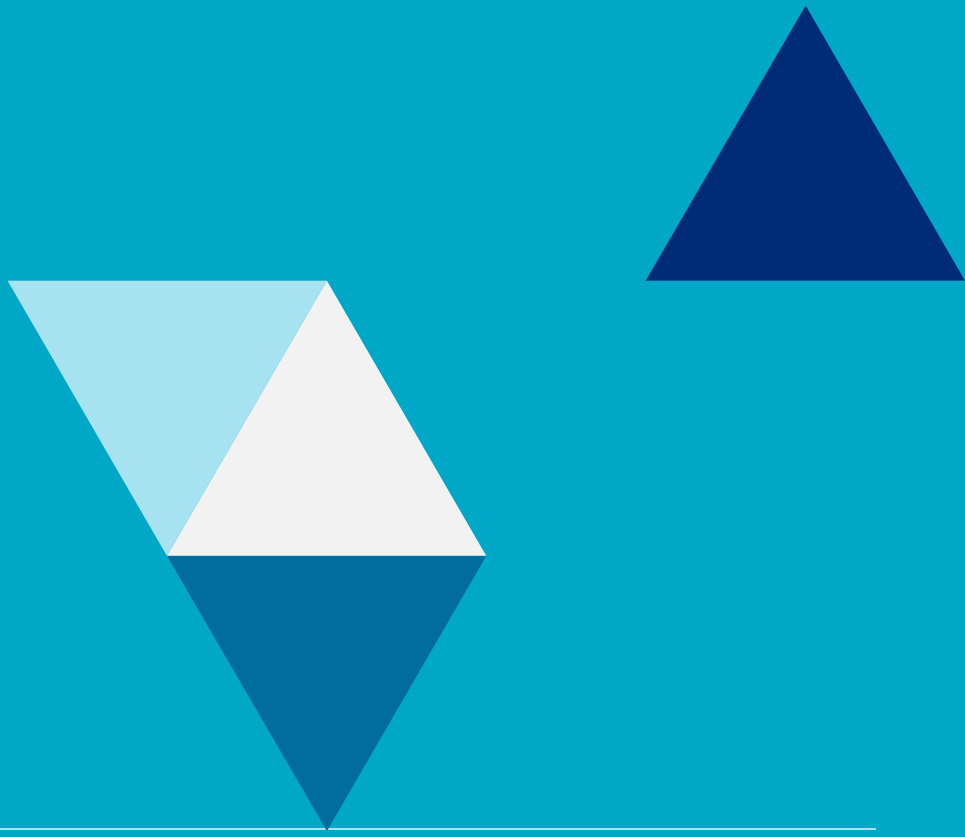
- RFP provides flexibility to include ACA Medicaid Expansion population if obtain appropriate authority

PROGRAM OVERVIEW
COVERED SERVICES

- Services provided through the MO HealthNet Division (MHD) managed care program are summarized into broader categories of service (COS) outlined in Section 3 of the Data Book
- The HP Financial Reporting Form includes a description of the COS reporting requirements for the HPs effective May 1, 2017



BASE DATA DEVELOPMENT



BASE DATA DEVELOPMENT
OVERVIEW OF DATA SOURCES

- Mercer utilized three data sources to summarize the demographic, cost and utilization information for each region:

HP Financial Data

- Calendar Year (CY) 2013 and CY 2014 non-delivery and delivery data for the Central — Current, Eastern and Western Regions

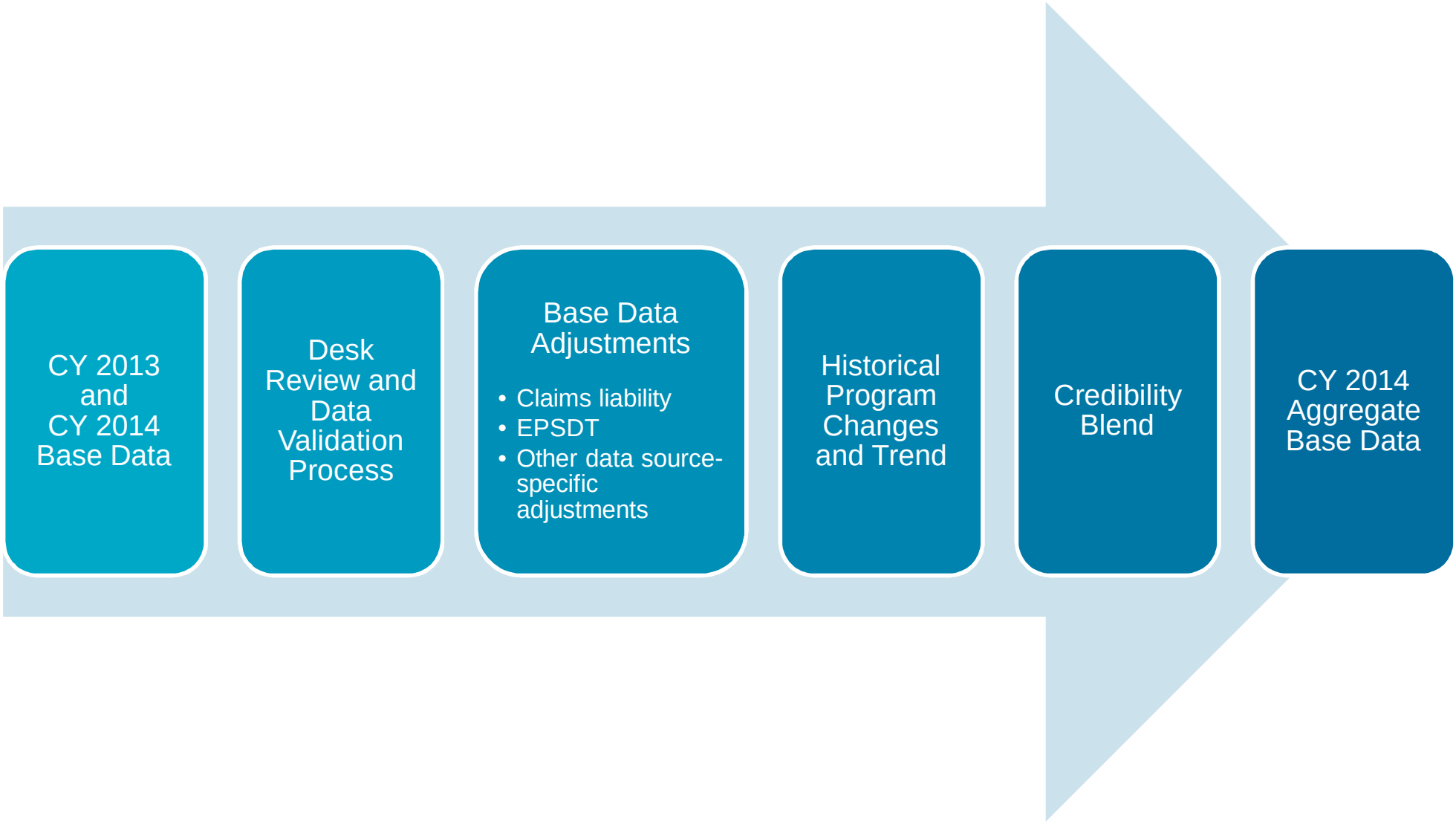
HP Encounter Data

- CY 2013 and CY 2014 non-delivery and delivery data for the Central — Current, Eastern and Western Regions

FFS Data

- CY 2013 and CY 2014 non-delivery and delivery data for the Central — Extension and Southwest Regions

BASE DATA DEVELOPMENT
GENERAL METHODOLOGY



BASE DATA DEVELOPMENT
GENERAL METHODOLOGY

- Desk review and data validation:
  - Check for completeness and accuracy
  - Review for reasonability of the utilization and unit cost information
  - Compare data to other available data sources
- Claims completion factor
- Adjustment to reflect 80% EPSDT presentation rate goal
- Other adjustments:
  - Encounter data adjustment based on comparison to HP financial data
  - FFS base data adjustments
- Historical trend
- Historical program changes
- Credibility blending of the CY 2013 (20%) and CY 2014 (80%) adjusted data

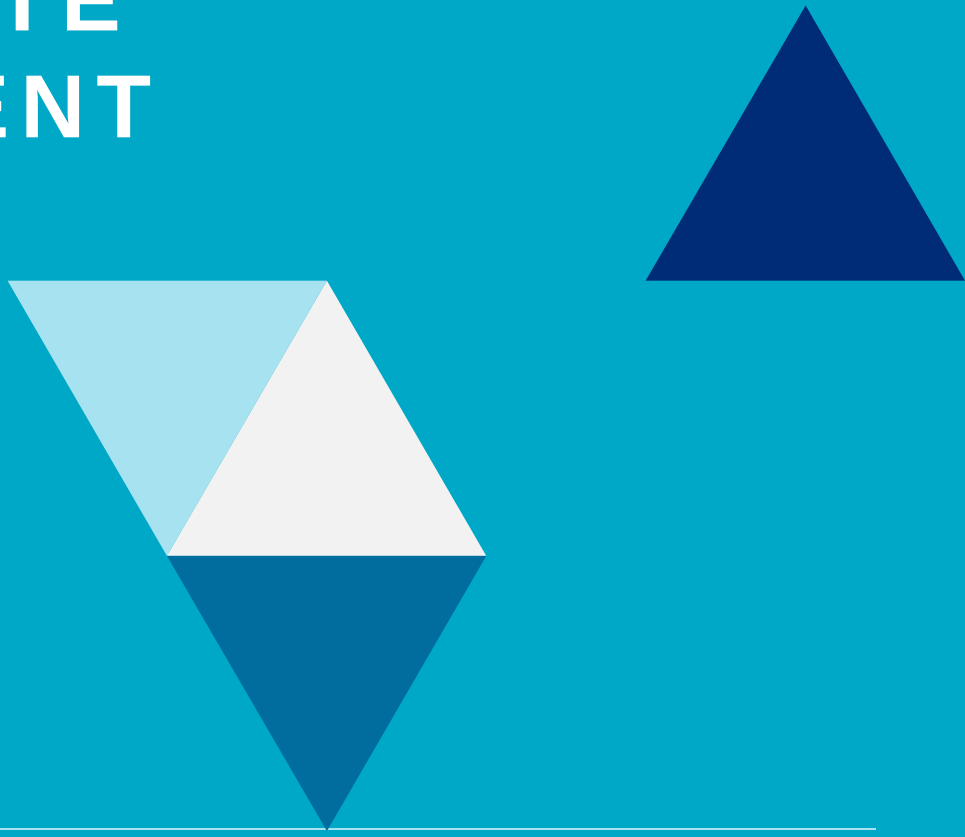
BASE DATA DEVELOPMENT
FFS DATA ADJUSTMENTS

- There are a number of adjustments made to the FFS data to account for differences in covered services and populations between the current FFS and managed care program

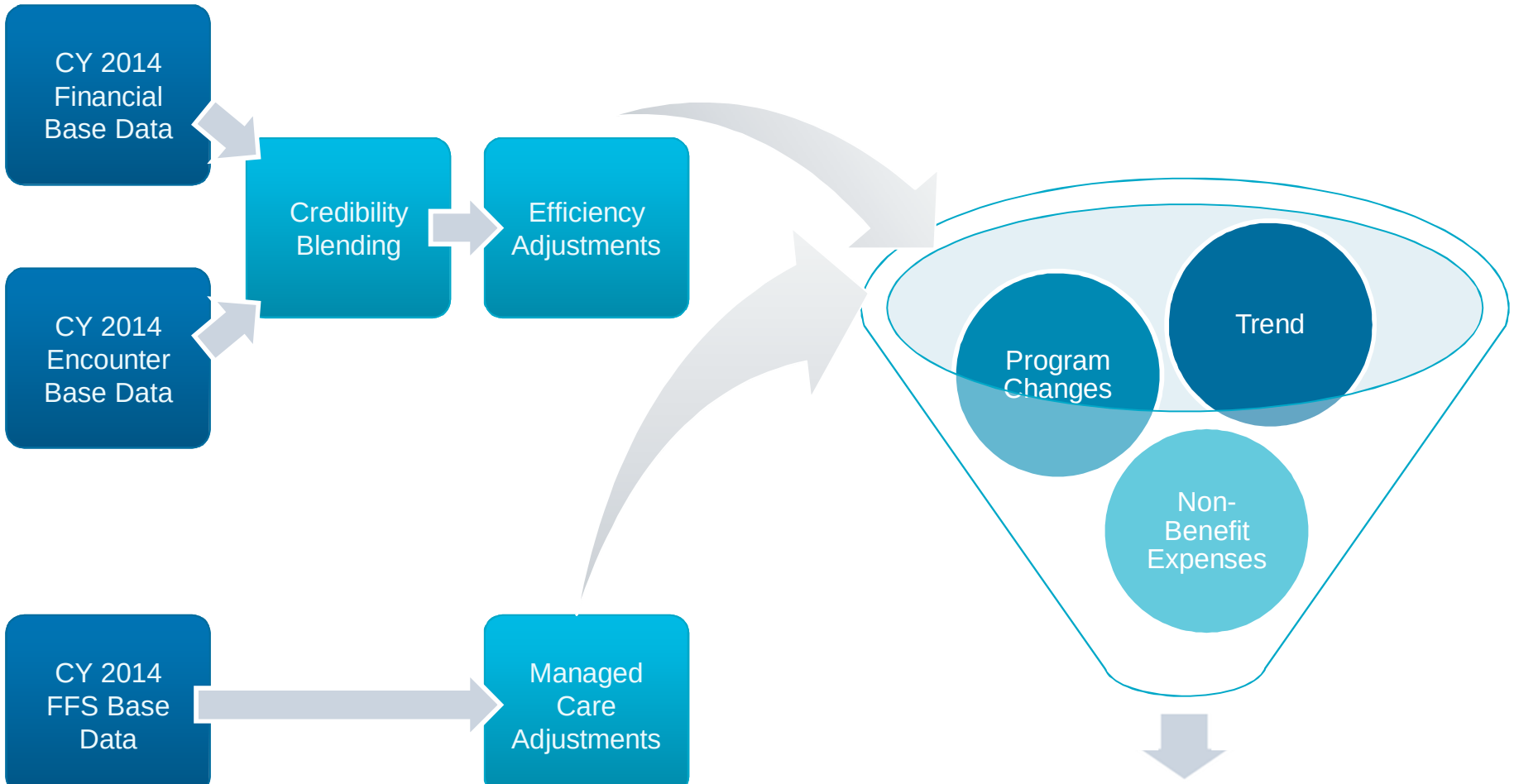
Adjustment	CY 2013	CY 2014
Carve Out Services	-16.2%	-17.4%
Gross Adjustments	-0.7%	-1.2%
Copayments	+0.2%	+0.2%
FFS Window	-1.8%	-1.6%
Opt-Out Population	-3.9%	-3.7%
NEMT	+0.4%	+0.4%
Third Party Liability	0.0%	0.0%
Graduate Medical Education	not applicable	not applicable
Disproportionate Share Hospital	not applicable	not applicable

*Initial FFS Per Member Per Month (PMPM) for CY 2013 is $222.66 and for CY 2014 is $216.22

MANAGED CARE RATE RANGE DEVELOPMENT



MANAGED CARE RATE RANGE DEVELOPMENT
METHODOLOGY OVERVIEW



MANAGED CARE RATE RANGE DEVELOPMENT
CREDIBILITY BLENDING

- Blending considerations include CMS requirements on detailed data source, HP reported data reliability and encounter data limitations

COS	Central Current & Eastern	Western (COA 1 — Adults)	Western (All Other COA)	Central and Southwest - Extension
Data Source	Financial/ Encounter	Financial/ Encounter	Financial/ Encounter	FFS
Inpatient — Physical Health	75%/25%	75%/25%	100%/0%	100%
ER	75%/25%	75%/25%	100%/0%	100%
Outpatient — Physical Health	75%/25%	75%/25%	100%/0%	100%
Physician Services	75%/25%	75%/25%	100%/0%	100%
Family Planning Services	50%/50%	50%/50%	100%/0%	100%
All Other Services	100%/0%	100%/0%	100%/0%	100%

MANAGED CARE RATE RANGE DEVELOPMENT
NICU PAYMENT

- The State pays a supplemental NICU payment to HPs for costs experienced in the first year of life for MHD managed care eligibles that meet a low birth weight criterion
- Payment assumptions were developed from historical HP and FFS data:
  - Prevalence of NICU births
  - Relativity of additional first year costs for NICU births compared to the COA 1 newborn rate cell for the non-NICU births

Region	Prevalence Factor	NICU Relative Cost Factor
Central — Current	1.121%	1959%
Central — Extension	0.878%	1576%
East	1.789%	2112%
West	1.216%	1623%
Southwest	0.878%	1576%

MANAGED CARE RATE RANGE DEVELOPMENT
PREGNANT WOMEN

- COA 2 Pregnant Women Medical Eligibility (ME) codes include 18, 43, 44, 45 and 61:
  - For current managed care regions used CY 2014 HP financial experience to develop payment assumptions
  - For managed care extension regions used Pregnant Women ME Codes to summarize FFS base data

Region	Pre-adjustment MMs	Pre-adjustment PMPM	Post-adjustment MMs	Post-adjustment PMPM
COA 1 — Children <21	3,604,872	$131.45	3,581,418	$129.59
COA 1 — Adults 21+	726,217	$289.73	589,836	$260.01
COA 2 — Pregnant Women	n/a	n/a	159,835	$417.73
Weighted Average	4,331,089	$157.99	4,331,089	$157.99

- Overall, this is a cost neutral adjustment

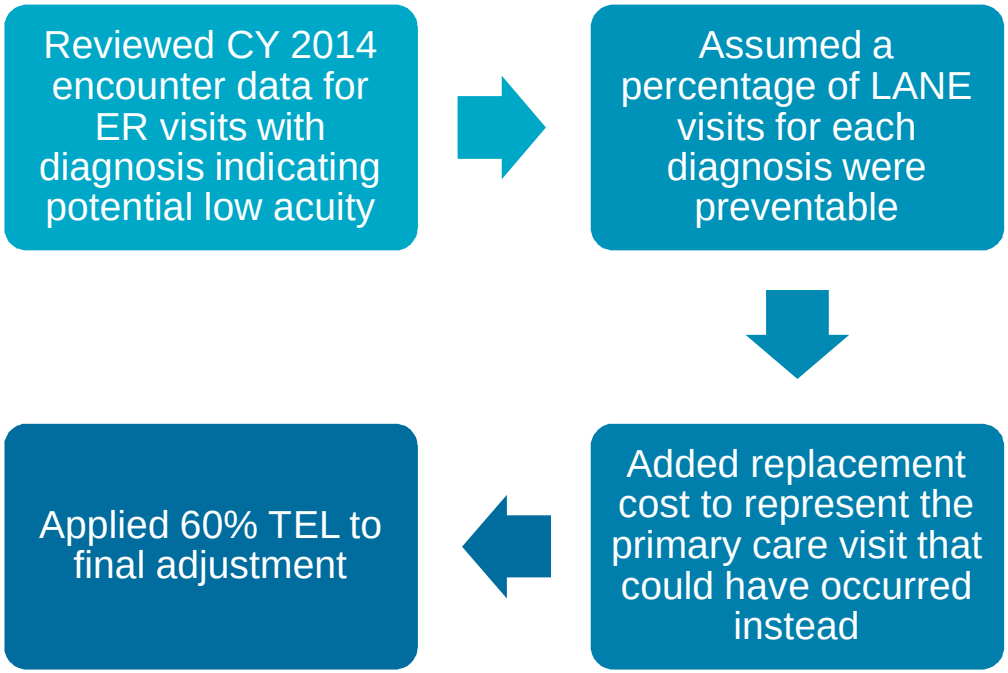
MANAGED CARE RATE RANGE DEVELOPMENT
EFFICIENCY ADJUSTMENTS

- Effective cost-containment strategies to reduce health care inefficiencies and support the State's strategy for value-based purchasing
- Successful management can reduce overall health care costs and improve patients' quality of medical care
- First implemented for rates effective July 1, 2010
- Apply a targeted efficiency level (TEL) to each adjustment to recognize that HPs may need time to incorporate best practices and to account for State-specific environment
- Efficiency adjustments include:
  - Low-Acuity Non-Emergency (LANE)
  - Potentially Preventable Hospital Admissions (PPA)
  - Risk-Adjusted Efficiency (RAE)

MANAGED CARE RATE RANGE DEVELOPMENT
EFFICIENCY ADJUSTMENTS — LANE

- HPs are expected to manage a portion of low-acuity ER visits in a less acute setting
- Observations:
  - LANE visits accounted for 50% of total financial ER costs
  - 24% of LANE visits removed (99284 and 99285 CPT codes were not removed)

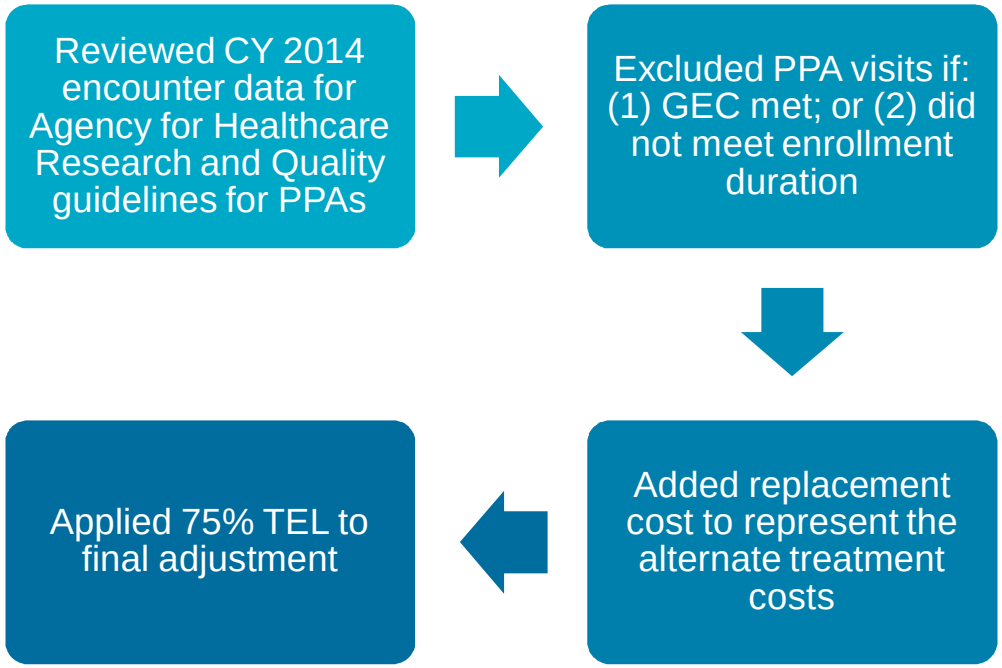
Region	Impact
Central — Current	-1.0%
East	-1.5%
West	-1.3%



MANAGED CARE RATE RANGE DEVELOPMENT
EFFICIENCY ADJUSTMENTS — PPA

- Certain Inpatient admissions may have been avoided or reduced in duration through alternative services and high-quality care management
- Observations:
  - Child/adult PPA dollars accounted for 0.6%/0.8% of total medical costs
  - 65% of identified PPA visits removed after global exclusion criteria (GEC) and/or duration criteria

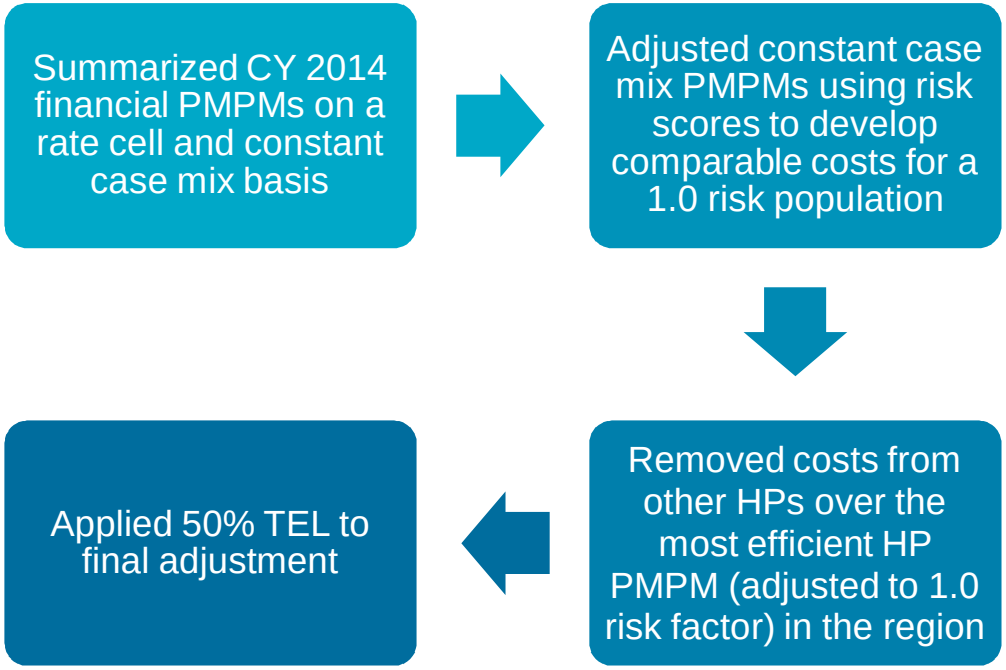
Region	Impact
Central — Current	-0.2%
East	-0.5%
West	-0.4%



MANAGED CARE RATE RANGE DEVELOPMENT
EFFICIENCY ADJUSTMENTS — RAE

- Addresses differences in claim levels among HPs within a region after adjusting for the underlying risk level of their enrolled population
- Considerations:
  - Most efficient HP must account for a minimum of 1/3 of the regional member months
  - Impact calculated after accounting for LANE and PPA adjustments

Region	Impact
Central — Current	-0.4%
East	-2.0%
West	-4.0%

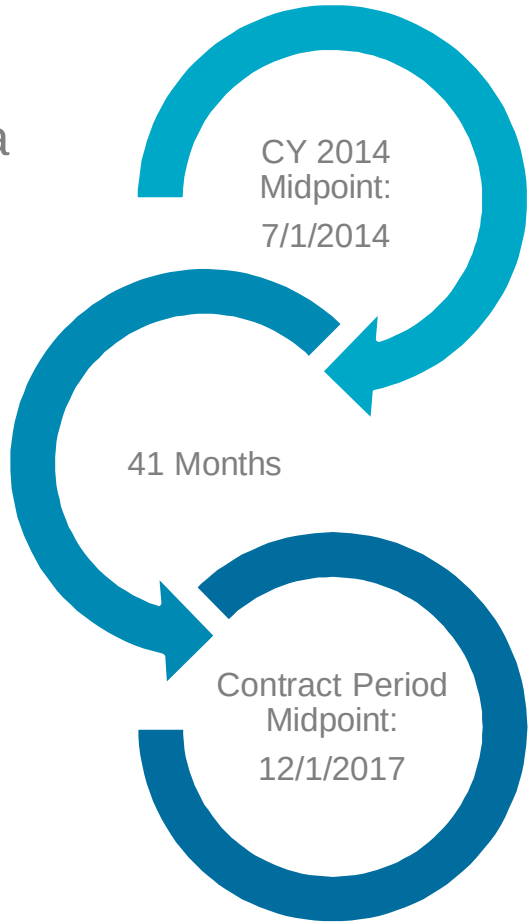


MANAGED CARE RATE RANGE DEVELOPMENT
FFS MANAGED CARE ADJUSTMENT

- Managed care assumptions reflect a shift in costs from a FFS environment to a managed care delivery model
- HPs are generally expected to provide care coordination, reduce utilization and redirect care to the most appropriate and cost effective setting
- Methodology:
  - Compare FFS metrics to current managed care experience
  - Current Central region data primarily leveraged due to geographic similarities
  - Consideration made for feasibility of care management impacts in initial 14 months of operations
- Results:
  - Decrease in projected utilization largely for Inpatient and ER services
  - Impact to Physician services based on tighter utilization management expectations
    - PMPMs higher than current Central region experience; driven by utilization

MANAGED CARE RATE RANGE DEVELOPMENT TREND

- Medical trend is the projection of utilization and unit cost changes over time
- Base data is trended from the midpoint of the base year data period to the midpoint of the contract period
- Trend sources:
  - Primary sources:
    - HP-reported financial data
    - HP responses to financial data desk review questions
  - Secondary sources:
    - Other state Medicaid programs
    - National trend indices
- Total annual trend, variable by COS and region:
  - Unit Cost: 0.3%–0.8%
  - Utilization/1000: 0.5%–2.0%



MANAGED CARE RATE RANGE DEVELOPMENT
PROSPECTIVE PROGRAM CHANGES

- Program changes implemented that occurred after the base period

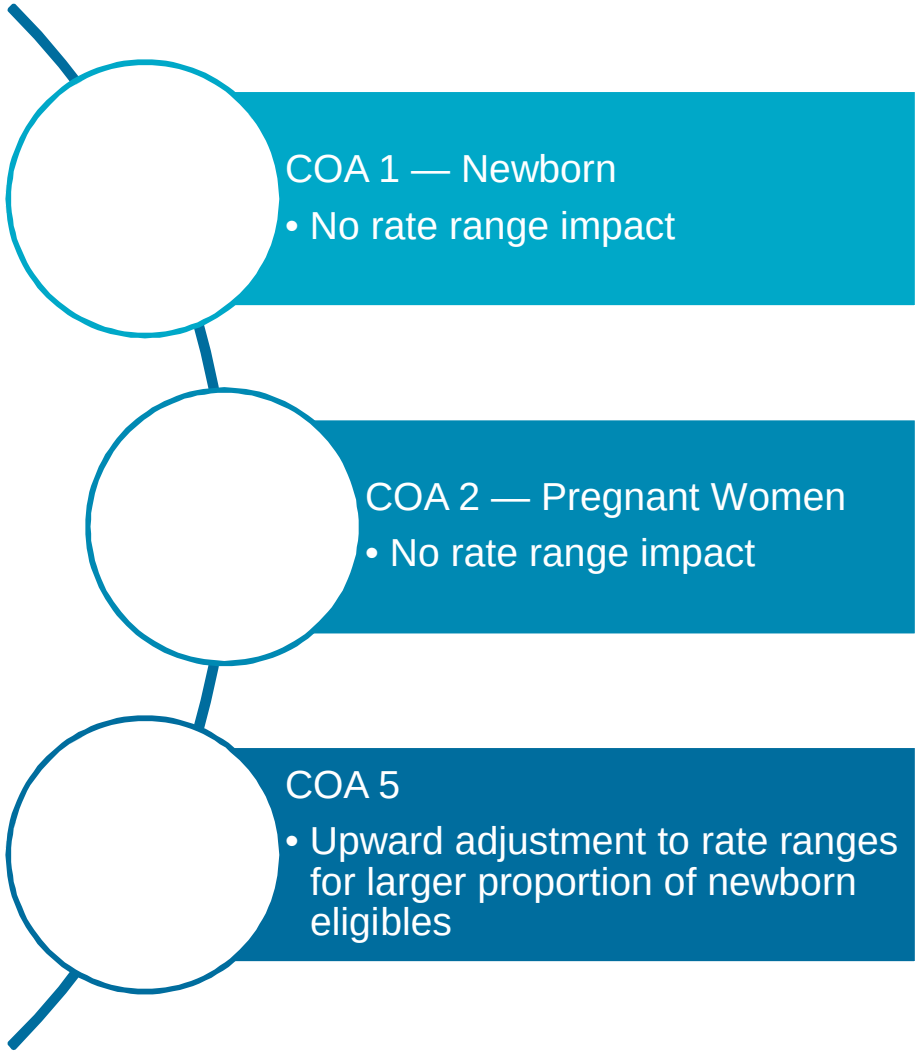
Adjustment	Effective Date	Overall Impact
Enhanced PCP payments as required by the ACA	January 1, 2015	-2.3%
Community Mental Health Center reimbursement changes	July 1, 2015	0.7%
Federally Qualified Health Center/Rural Health Clinic reimbursement changes	July 1, 2015	3.2%
Home Health rate increases	July 1, 2015	0.0%
Complex Rehab rate increases	July 1, 2015	0.0%
Revised billing instructions for Health and Behavior Assessment/Intervention and Screening, Brief Intervention, and Referral to Treatment	July 1, 2015	0.0%
Bariatric Surgery benefit change	September 1, 2015	0.0%
Hospice rate increases	January 1, 2016	0.0%
Provider rate increases	January 1, 2016	0.3%
Show Me Healthy Babies (SMHB) coverage	January 1, 2016	2.4%
Adult Dental coverage	July 1, 2017	0.8%
Full Medicaid Pricing	May 1, 2017	38.8%

MANAGED CARE RATE RANGE DEVELOPMENT
PROGRAM CHANGE — SMHB COVERAGE

- Effective January 1, 2016, SMHB initiative added as a separate program for low income unborn children
- Mercer relied on State estimates and census data to estimate the number of newly eligible

Rate Cell	Total
COA 1 — Newborns	770
COA 2 — Pregnant Women	3,114
COA 5	2,344

- Assessed the impact of both the mothers and newborns eligible through the SMHB program on the current rate ranges



MANAGED CARE RATE RANGE DEVELOPMENT
PROGRAM CHANGE — ADULT DENTAL

- Prior to May 1, 2017 and after the base data period, MHD added an adult Dental benefit for non-pregnant women eligibles
- To estimate the cost of the additional Tier 1 through 6 Dental services for the non-pregnant women adult population, Mercer reviewed Tier 1 through 6 Dental costs for the pregnant women adult population
- Based on the cost relativity of Tier 1 through 6 Dental benefits to total Dental benefits for the pregnant women adult population, Mercer developed an adjustment to include the Tier 1 through 6 Dental service costs into the rate ranges for non-pregnant women adults
- In total, this program change resulted in a $14.36 PMPM increase to the COA 1 — Adults Dental COS on a statewide average basis

MANAGED CARE RATE RANGE DEVELOPMENT
PROGRAM CHANGE — FULL MEDICAID PRICING

- Effective May 1, 2017, MHD will implement a program change to ensure sustainable pricing in the Medicaid program for hospital services. This change requires the use of Full Medicaid Pricing for reimbursement of Inpatient and Outpatient Hospital services
- Mercer and MHD reviewed the aggregate funding levels for Hospital services between the base period and the contract period and determined that an addition to the historical data was necessary in order to ensure that the capitation rate ranges reflect Full Medicaid Pricing
- This adjustment reflects the impact of moving the base data unit costs summarized in Appendix A, B and C of the Data Book to the Full Medicaid Pricing reimbursement methodology reflected in the rates outlined in the RFP pricing pages
- Section 8 and Appendix J of the Data Book provide detailed impacts of the Full Medicaid Pricing adjustment

MANAGED CARE RATE RANGE DEVELOPMENT
NON-BENEFIT EXPENSES

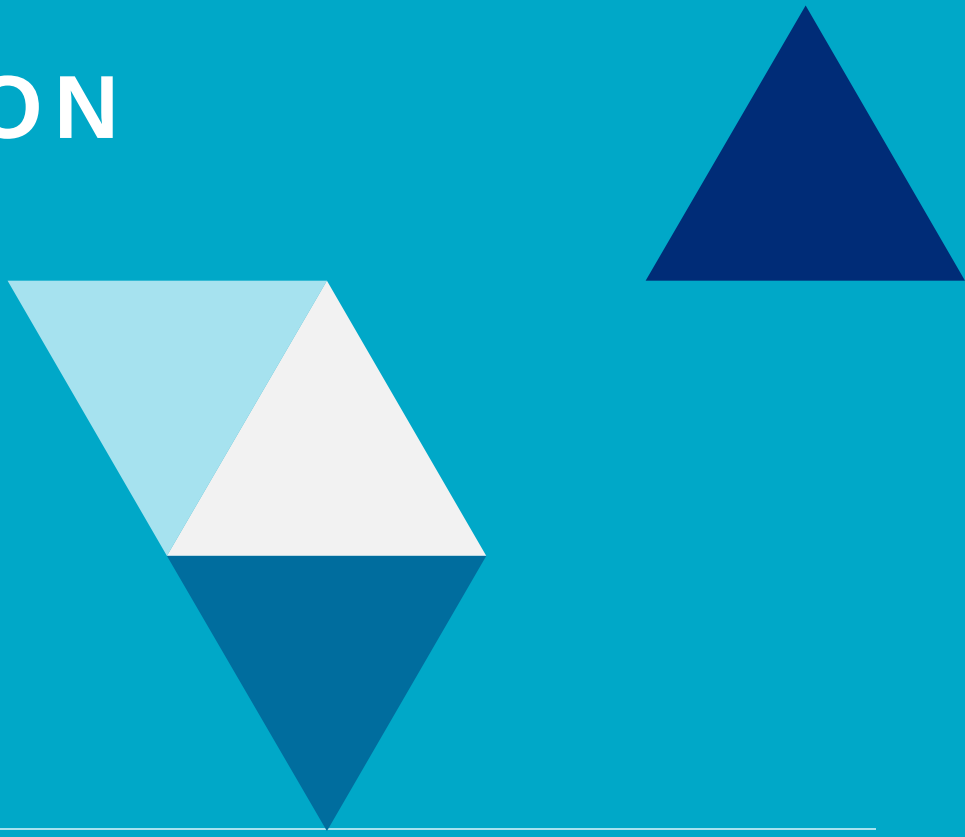
- Administration:
  - Reviewed components of administrative allowances
  - Evaluated administration across the entire managed care region on PMPM basis
  - Adjusted for additional enrollment for the statewide extension of managed care
  - Final administrative PMPM for the statewide managed care rates for the current managed care population $25.25
- Underwriting Gain of 2.0% (including 0.5% for risk margin)
- Health Insurance Provider Fee (HIPF) of 0.0%:
  - 2017 moratorium on HIPF
  - Will amend rate ranges to include future HIPF considerations
- Minimum Loss Ratio (MLR) requirement of 85%

MANAGED CARE RATE RANGE DEVELOPMENT
RATE BUILD-UP

	Central	East	West	Southwest
(R1) Base Data	$199.52	$200.49	$222.41	$158.98
(R2) FFS Managed Care Adjustments	-5.31%	n/a	n/a	-8.67%
(R3) Efficiency Adjustments	-0.77%	-3.88%	-5.54%	n/a
(R4) Annual Trend (applied for 41 months)	1.77%	2.49%	2.53%	0.80%
(R5) Program Changes	53.46%	43.75%	30.92%	63.01%
SMHB Coverage	*2.31%*	*2.99%*	*2.03%*	*1.62%*
Adult Dental	*0.70%*	*0.67%*	*0.50%*	*0.56%*
Full Medicaid Pricing	*48.20%*	*34.59%*	*25.87%*	*59.61%*
All Other Program Changes	*0.51%*	*3.01%*	*1.44%*	*-0.06%*
(R6) Admin/Underwriting Gain	9.40%	9.43%	9.54%	11.15%
(R7) HIPF	0.00%	0.00%	0.00%	0.00%
(R8) May 2017–June 2018 Contract Rate	$337.18	$332.64	$331.17	$273.68

*Rate Development Formula: [**R8**] = ((**R1***(1+**R2**)*(1+**R3**)*((1+**R4**)^(41/12))*(1+**R5**)) / (1-**R6**)) / (1-**R7**)

MEDICAID EXPANSION



MEDICAID EXPANSION
OVERVIEW

- RFP provides flexibility to include ACA Medicaid Expansion population if authorized
- Medicaid Expansion would increase the FPL income level for coverage of the non-disabled adults
- HP reimbursement for new eligibles
  - Adult expansion population will be paid a separate capitation rate
  - Risk adjustment will not apply to the rate cell until sufficient data is available
- Rate development
  - Base data: non-delivery service component of the current COA 1 – Adult 21+ population rate for each region
  - Adjustments: developed largely by leveraging other expansion state experience
  - Non-Benefit Expenses: include additional risk add-on for new population

MEDICAID EXPANSION ADJUSTMENTS

Initial Managed Care

- Managed care effects may take longer to mature with newly covered expansion population
- To reflect mix of base experience, applied upward adjustments to the current managed care region experience and a dampened downward managed care assumption for the current FFS regions
- Overall +2.2% for impact of initial managed care

Acuity Adjustment

- Evaluated expected health status, especially for initial enrollment, for newly eligible enrollees relative to existing non-disabled adults
- Expansion adults expected to be somewhat higher acuity than COA 1 — Adults 21+
- Assumed +15.0% combined effect of underlying acuity difference and first year enrollment patterns

Pent-Up Demand

- Newly covered adults assumed to have higher initial health care costs relative to the expected ultimate average cost , as they catch up on care delayed while uninsured
- After a period of coverage, pent-up demand effect wears off
- Assumed +5.5% for pent-up demand

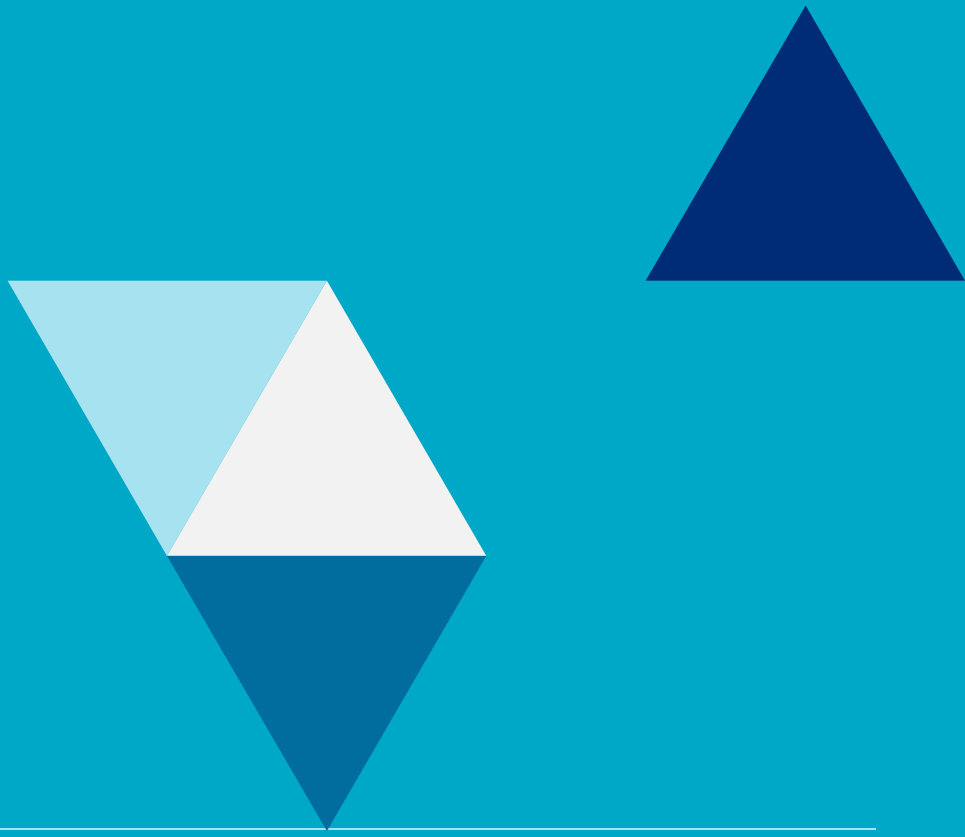
MEDICAID EXPANSION
THERAPY BENEFITS

- ACA requires that Medicaid expansion populations receive coverage actuarially equivalent to a benchmark plan, across the 10 Essential Health Benefits (EHB)
- Evaluation of State Plan benefits against EHB requirements identified the need to add Therapy benefits for both Rehabilitative and Habilitative services
- Coverage of these benefits are expected to apply to both the current adult and expansion population
- State does not anticipate applying visit limits or cost sharing to the new Physical Therapy, Occupational Therapy and Speech Therapy services
- Built in a $2.32 medical PMPM for Therapy benefits for both the COA 1 — Adult 21+ rate cell and Medicaid Expansion COA

MEDICAID EXPANSION
NON-BENEFIT EXPENSES

- Administration:
  - Re-evaluated administration projection to adjust for additional expansion enrollment
  - Final administrative PMPM for statewide managed care rates, including coverage of the adult expansion population, is $24.12
- Underwriting Gain of 3.0%:
  - Base assumption of 2.0% for current population (including 0.5% for risk margin)
  - Additional 1.0% risk contingency load factor for the adult expansion population:
    - Temporary consideration until sufficient program population experience is available
    - Paired with 85% MLR requirement
- HIPF of 0.0%

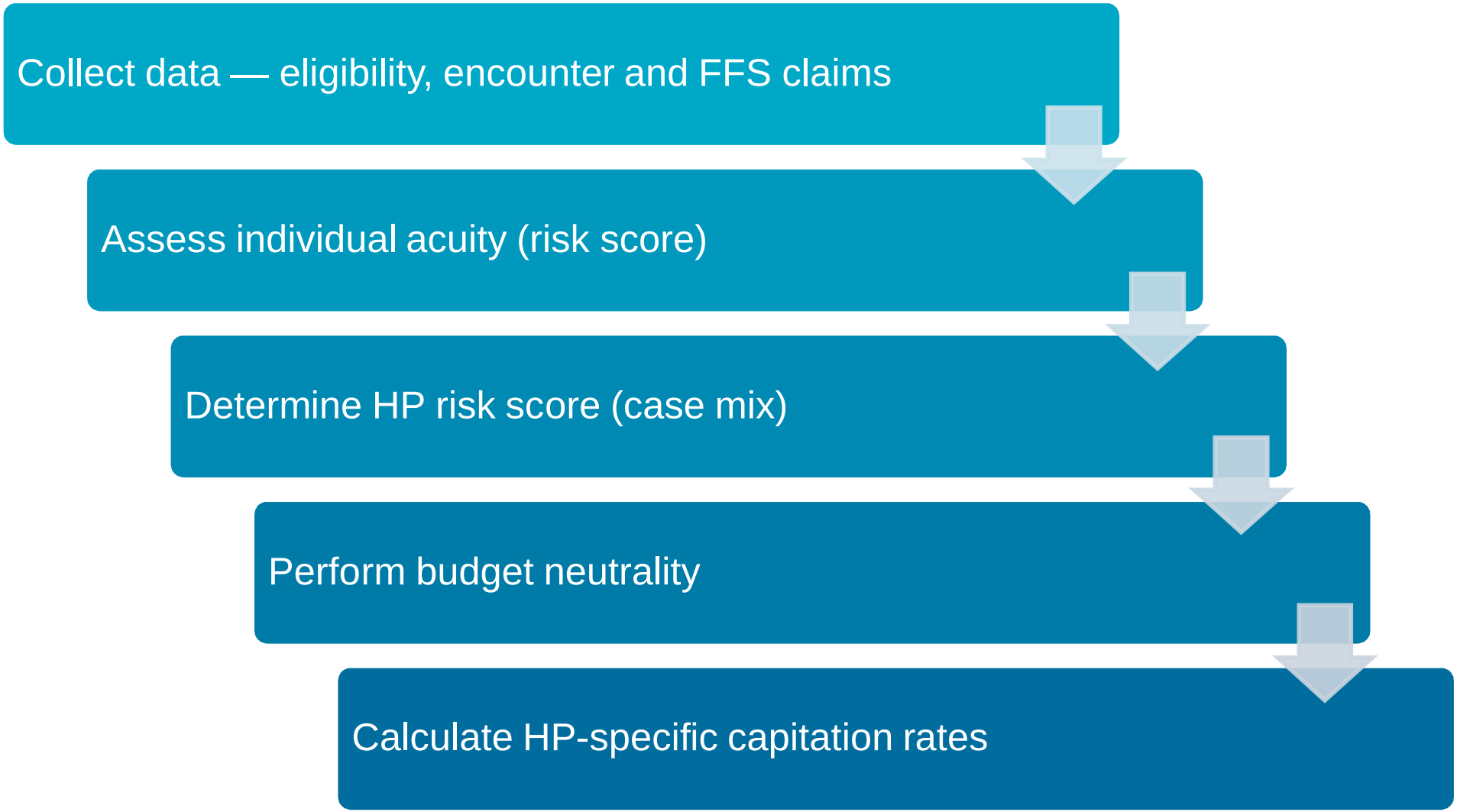
OTHER PAYMENT CONSIDERATIONS



RISK ADJUSTMENT
BACKGROUND

- Risk adjustment helps match payment to risk by estimating health care expenses based on the disease conditions attributed to the population
- This is a budget neutral procedure such that it is a “rate allocation”
- Chronic Illness and Disability, and Pharmacy Payment System (CDPS+Rx) model used for risk adjustment process:
  - Relies mainly on diagnosis information taken from HP-reported encounter data and NDCs from FFS claims data
- Twelve months of data are used to classify recipients into CDPS categories
  - Anticipated study period for risk scores effective May 1, 2017 is anticipated to be February 2015 through January 2016
- Risk scores communicated at least 30 days in advance of effective period:
  - Initial May 1, 2017 risk scores will be delayed due to timing of HP initial enrollment period
- Applicable rate cells risk adjusted quarterly

RISK ADJUSTMENT METHODOLOGY



RISK ADJUSTMENT
RATE CELL IMPLICATIONS

- Budget neutrality will be calculated for each region separately
- Anticipated rate structure and associated model

COA	Model
COA 1 — Newborns	Not risk adjusted
COA 1 — Child < 21	Child cost weights
COA 1 — Adults 21+	Adult cost weights
COA 2 — Pregnant Women	Not risk adjusted
COA 4	Child cost weights
COA 5	Child cost weights
Maternity delivery payments NICU payments	Not risk adjusted
COA — Medicaid Expansion — Adults	Not risk adjusted

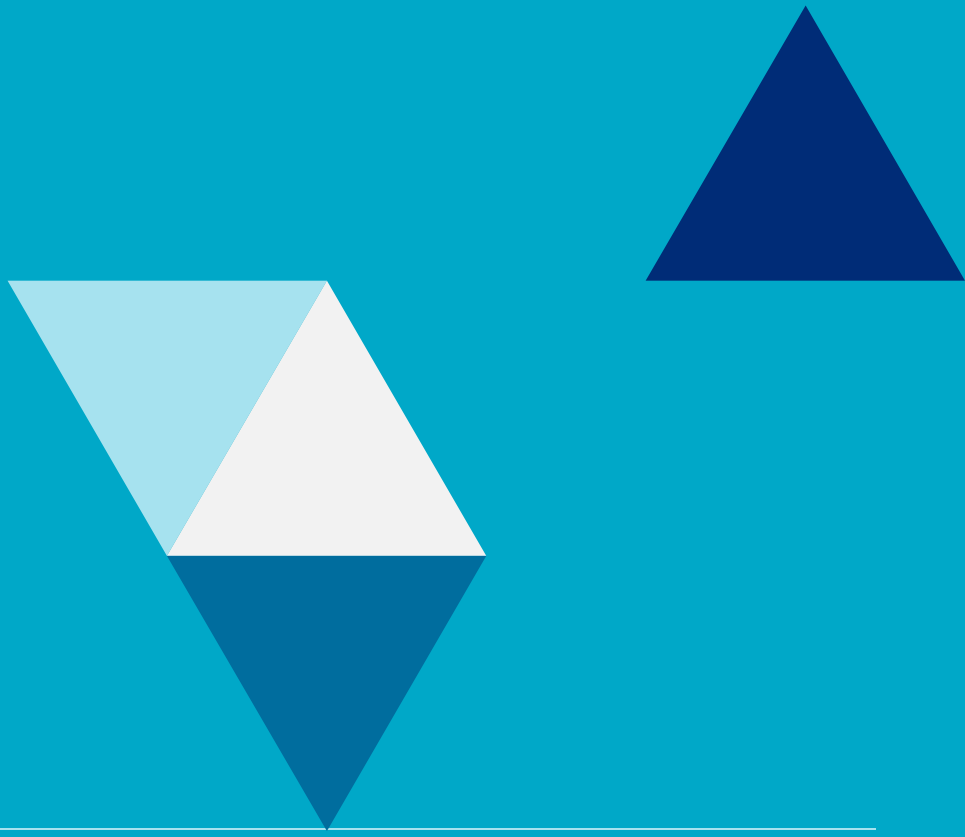
PERFORMANCE WITHHOLD OVERVIEW

Performance Metric		Application	Frequency	Withhold
1. Encounter data completeness/accuracy		Regional	Quarterly	1.00%
2. Provider Panel	a. Accepting new members			
	b. Directory accuracy/completeness	Regional	Semi-annual	1.00%
3. Healthy Children and Youth/EPSDT rate Ages 0–6		Statewide	Annual	1.00%
4. Care Management	a. Initial needs assessment for pregnant women	Statewide	Semi-annual	0.50%
	b. Follow-up timeframes for children with elevated blood levels	Statewide	Semi-annual	0.50%
5. Medicaid Reform	a. Member incentive programs	Regional	Annual	0.33%
	b. Provider incentive programs	Regional	Annual	0.33%
	c. Local Community Care Coordination Program application and approval	Regional	Annual	0.34%
TOTAL				**5.00%**

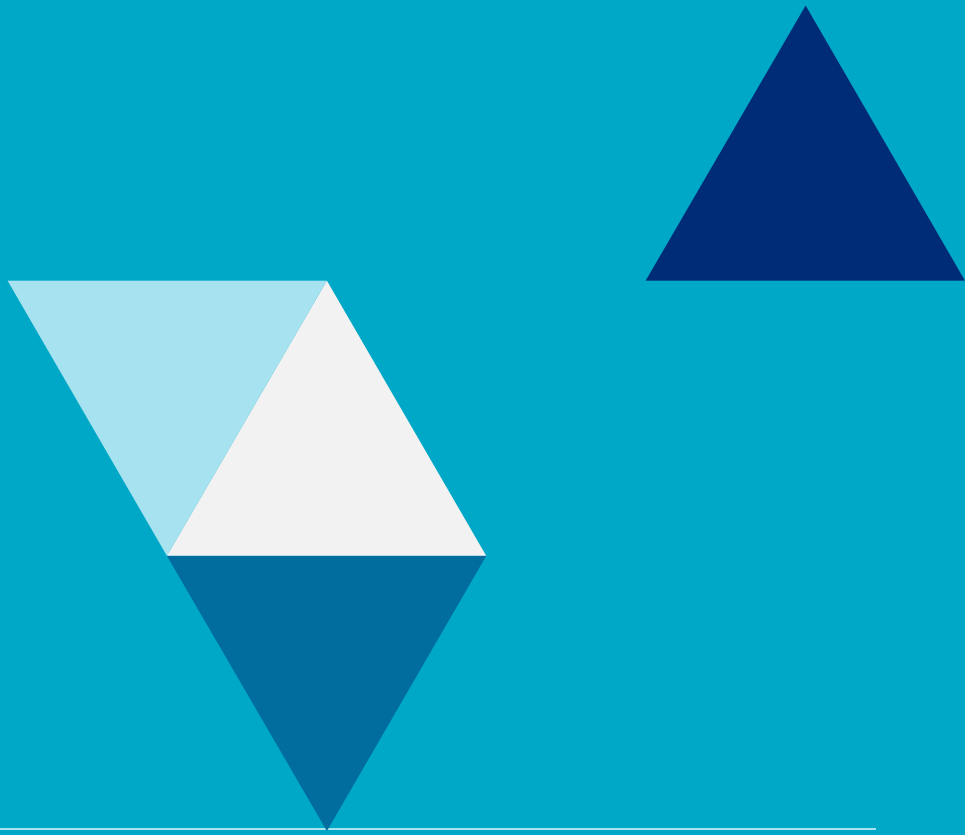
PERFORMANCE WITHHOLD OVERVIEW, CONT'D

- Withhold percentages will not be applied to supplemental payments for NICU births or deliveries
- Withhold returned for metrics met within 30 days of evaluation (per metric frequency schedule)
- For metrics identified as being evaluated quarterly, the first quarter evaluation for the contract will be extended to include May 1, 2017 through September 30, 2017. Quarters thereafter will be aligned with SFY quarters
- Special considerations are provided for HPs new to the MO HealthNet managed care program and for the Southwest and Central Regions
- Changes to performance metrics, populations and individual withhold percentages in renewal years 1 and 2 to be made in consultation with workgroup and final determinations made by State in the form of a contract amendment

QUESTIONS?



ADDITIONAL INFORMATION



FFS BASE DATA DEVELOPMENT
FFS OPT-OUT ADJUSTMENT

- Certain Medicaid individuals have the option to opt-out of the MO HealthNet Managed Care program. The populations that are eligible to opt-out of managed care include:
  - Individuals with special needs
  - Individuals who are eligible for Supplemental Security Income
  - Individuals with medical necessity
- Opt-out adjustment:
  - Developed using the cost and prevalence experience from the current MO Managed Care program. The prevalence rate is calculated by dividing the number of managed care eligible members that opted-out by the total eligible MO managed care population for the specific year
  - Developed separately by year and did not vary by region or COS

Year	PMPM	Prevalence	FFS Impact
CY 2013	$3,580.43	0.25%	-3.9%
CY 2014	$3,691.16	0.23%	-3.7%

MANAGED CARE RATE RANGE DEVELOPMENT
PROGRAM CHANGE — SMHB COVERAGE

- Estimated statewide CY 2015 enrollment before and after SMHB Coverage change based on annualized January 2015–June 2015 capitation and kick payment files from MHD

COA	Pre-SMHB Member Months	Post-SMHB Member Months
COA 1 — Newborns	459,190	468,430
COA 2 — Pregnant Women	274,514	297,868
COA 5	559,629	587,754
Delivery	27,400	30,514
NICU	346	386

- Enrollment for COAs not impacted by SMHB is reflected in Appendix K of the Data Book, Rate Build Up Summaries

MANAGED CARE RATE RANGE DEVELOPMENT
PROGRAM CHANGE — FULL MEDICAID PRICING

- Effective May 1, 2017, MHD will implement a program change to ensure sustainable pricing in the Medicaid program for hospital services. This change requires the use of Full Medicaid Pricing for reimbursement of Inpatient and Outpatient Hospital services
- Full Medicaid Pricing reimbursement methodology reflects experience included in the base data and the additional payments for the Direct Medicaid Add-On paid in FFS. In other words, aggregate payment levels assumed in the capitation rates are as follows:
  - FFS aggregate payment includes FFS per diem + FFS Direct Medicaid payment
  - MC aggregate payment includes health plan per diem + FFS Direct Medicaid payment

MANAGED CARE RATE RANGE DEVELOPMENT
RATE BUILD-UP

	Central — Current	Central — Extension	Central — Total*
Membership	1,020,034	1,193,389	2,213,424
(R1) Base Data	$194.74	$203.60	$199.52
(R2) FFS Managed Care Adjustments	n/a	-9.65%	-5.31%
(R3) Efficiency Adjustments	-1.62%	n/a	-0.77%
(R4) Annual Trend (applied for 41 months)	2.79%	0.85%	1.77%
(R5) Program Changes	35.98%	70.06%	53.46%
SMHB Coverage	*2.64%*	*2.00%*	*2.31%*
Adult Dental	*0.95%*	*0.46%*	*0.70%*
Full Medicaid Pricing	*28.23%*	*67.38%*	*48.20%*
All Other Program Changes	*2.34%*	*-0.85%*	*0.51%*
(R6) Admin/Underwriting Gain	9.86%	9.04%	9.40%
(R7) HIPF	0.00%	0.00%	0.00%
(R8) May 2017–June 2018 Contract Rate	N/A	N/A	$337.18

*Rate Development Formula: [**R8**] = ((**R1***(1+**R2**)*(1+**R3**)*((1+**R4**)^(41/12))*(1+**R5**)) / (1-**R6**)) / (1-**R7**)

*Excludes ACA Expansion

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