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MO HealthNet Managed Care Cost Avoidance Model

State of Missouri

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Managed Care Cost Avoidance Model
Overview

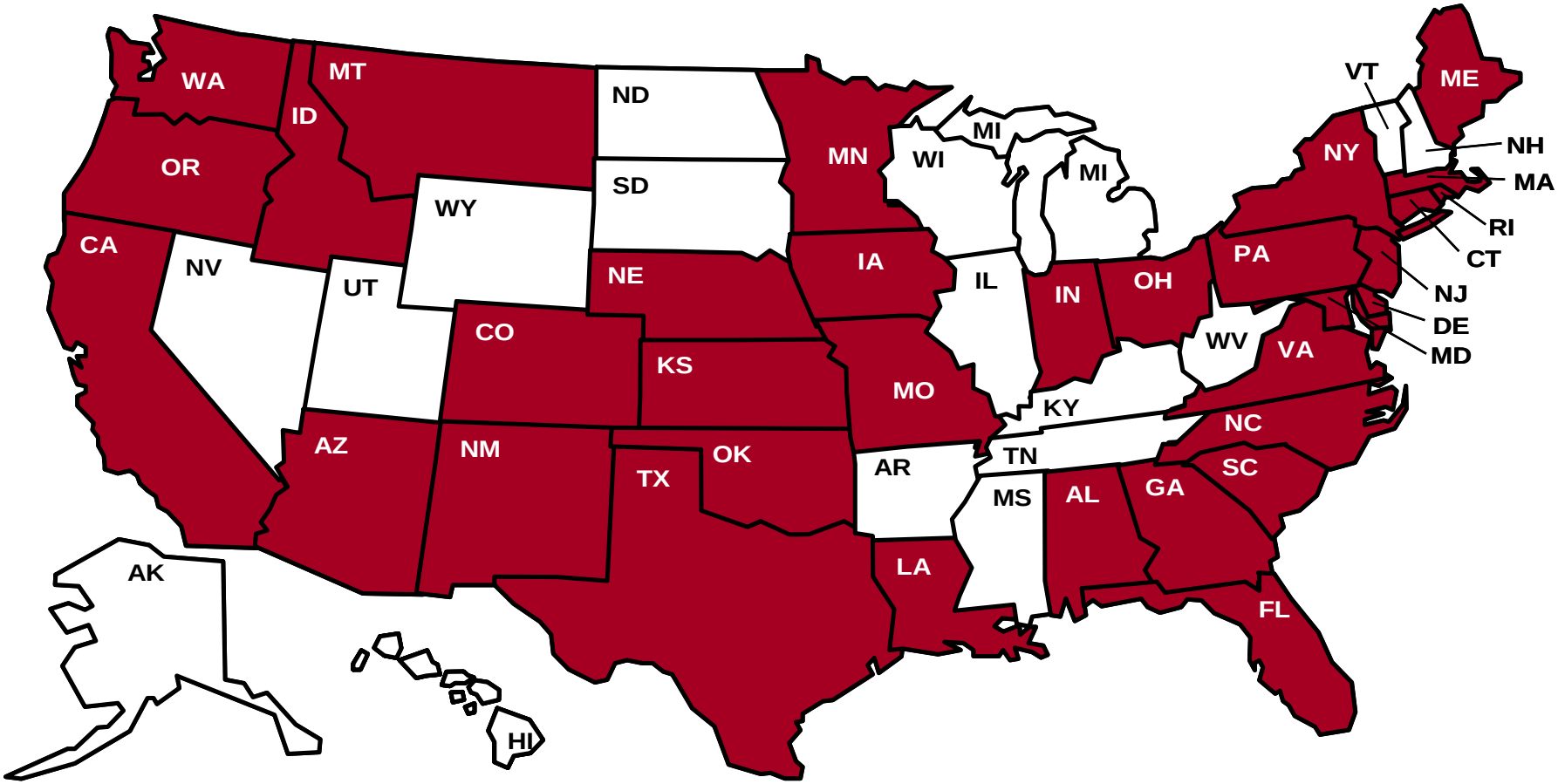
- Introduction
- Background
- Model Goals
- Managed Care Versus Benchmark Population Expenditures
- Mercer Recommendations
- Current Status
- Questions

Managed Care Cost Avoidance Model
Introduction

- Mercer Government Human Services Consulting (Mercer)
  - Dedicated to assisting publicly-funded health and welfare programs be efficient purchasers of health care
  - Consulting to state governments since 1985
  - Has worked with more than 30 state governments and currently holds contracts with over 20 states
- Mercer's range of services in Medicaid
  - Managed care (MC) and FFS rate development/financial support (acute and long term care)
  - Clinical quality assistance across physical health and mental health services
  - Pharmacy program management
  - CMS compliance support for waivers, SPAs, and external quality review
  - Uninsured program design and pricing

Managed Care Cost Avoidance Model
Introduction

Mercer's State Experience



Managed Care Cost Avoidance Model
Introduction

- Mercer was asked to review existing model evaluating managed care cost avoidance
- Mercer has conducted this work since beginning rate setting in 1985
  - Prior to implementation of BBA and Managed Care Regulations, this was a CMS rate-setting requirement
  - CMS substantially incorporated Mercer's approach to rate setting into a "Checklist" for developing rates under the Managed Care Regulations
  - Still determine cost avoidance for some states as a method of program evaluation

Managed Care Cost Avoidance Model
Background – Managed Care

- Similarities between FFS and MC delivery systems
  - Identical eligibility criteria; determined by State
  - Nearly identical benefit set
  - Nearly identical needs for administrative services
- Differences between FFS and MC delivery systems
  - Reimbursement
  - Party assuming claims risk
  - Cost control mechanisms
  - MC capitation levels include consideration for additional care management activities, other administrative functions and target profit
  - Some services are “carved out” from the MC capitation payments and are the responsibility of FFS

Managed Care Cost Avoidance Model

Background - Medical Loss Ratio Components

- FFS system includes medical and administrative expenses to State
- MC system includes medical and administrative expenses as well as profit or loss to health plan
- Medical Loss Ratio (MLR) is the percentage of health plan capitation dollars expended on medical services
- Capitation rates recently developed using about 88% MLR
  - Consistent with historical experience
  - Typically set profit as a longer-term goal of 2% - 4% over 3 to 5 years for mature MC programs
  - MO MC program pricing is consistent with this goal

Managed Care Cost Avoidance Model

Background - Managed Care Savings

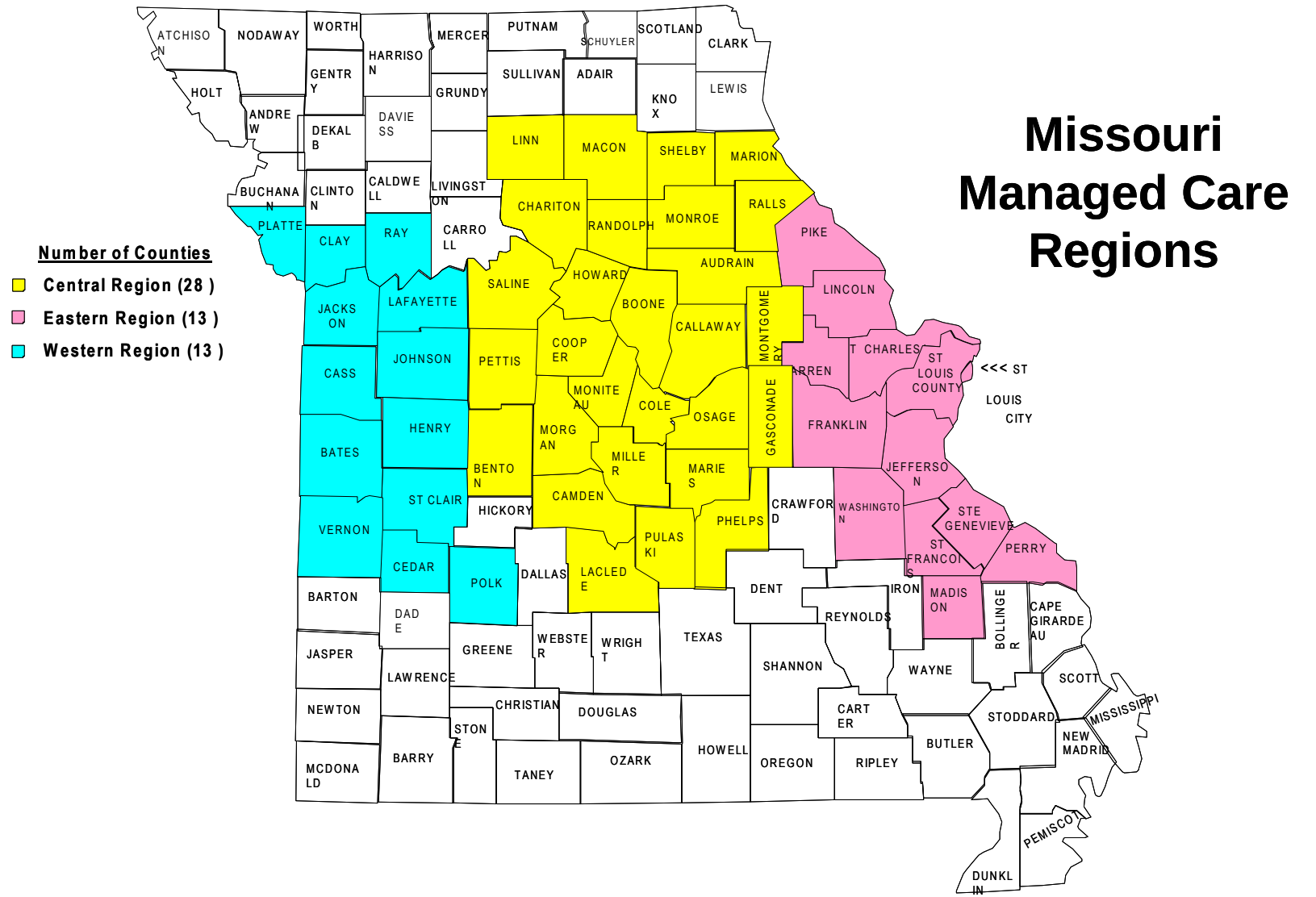
- Level of savings experienced through MC varies based on many factors
  - Rural versus urban population
  - TANF versus ABD population
  - Level of provider acceptance of managed care
  - Effectiveness of managed care organizations
  - Maturity of managed care program
  - Sophistication of existing FFS care management
- Typical long-term savings for a TANF-like population are 3 – 6%
- States experience a wide range in MC savings based on their actual environment in regards to the factors above

Managed Care Cost Avoidance Model
Background - MO HealthNet MC Eligibility

- MO HealthNet MC Eligibles
  - TANF children
  - Low income custodial adults
  - Pregnant women
  - CHIP children
- Not MC Eligible
  - Old Age Assistance
  - Permanently and Totally Disabled
  - Aid to the Blind
  - Blind Pension
  - Qualified Medicare Beneficiary
  - Missouri Children with Developmental Disabilities
  - MAF in a Vendor Institution

Managed Care Cost Avoidance Model

Background - MO HealthNet MC Eligibility



Managed Care Cost Avoidance Model

Background – Cost Avoidance Model

- Model currently used by the State to evaluate level of any cost avoidance achieved through the MC program
- Model complicated by the fact that there are no equivalent populations to compare between FFS and MC
  - Geography
  - Eligibility criteria
- Model further complicated by payments made outside claim system
- Mercer was asked to review model and make recommendations for revisions, if needed
  - Not all recommendations have been implemented/researched
  - Model and results still in development

Managed Care Cost Avoidance Model
Model Goals

- Model goal is to answer the following question:

  If the MC program did not exist, what would the cost of the existing MC eligibles be in the FFS delivery system?

- Historical financial analysis of MC program
- Not a direct comparison between the existing FFS and MC populations and delivery systems
  - Tool for historical financial performance of MC program
  - Not a depiction of anticipated savings associated with MC expansion opportunities
- Development of Benchmark population and cost to compare to MC costs
- Comparison done on a per member per month (PMPM) basis

Managed Care Cost Avoidance Model

Managed Care Versus Benchmark Population Expenditures

Expenditure Category	Managed Care Capitation Payment	Managed Care Paid Through FFS	FFS Benchmark
Medical Services Claims	X		X
MC Carve-Out Services Claims		X	X
FQHC/RHC Cost Settlements		X	X
Hospital Add-On Payments – (Direct Medicaid Hospital, GME, Outlier Payments)		X	X
Administration	X	X	X
Health Plan Profit	X		
Geographic Adjustment			X

Managed Care Cost Avoidance Model

Managed Care Versus Benchmark Population Expenditures

Administration Category	Managed Care Capitation Payment	Managed Care Paid Through FFS	FFS Benchmark
Prior Authorization	X	X	X
Member Services	X	X	X
Provider Credentialing	X		X
Care Management	X		
Staff and Facilities	X		X
State MC Program Oversight		X	
Claims Processing/Payment	X	X	X

Managed Care Cost Avoidance Model
Mercer Recommendations

- Adjust MC eligible count to be on same basis as Benchmark
- Review allocation methodology for add-on payments between FFS managed care-like eligibles and other FFS eligibles
- Review allocation methodology of State administrative costs
- Apply geographic adjustment to Benchmark
- Reflect MC FFS window claims as MC carve-out
- Reallocate retroactive mass adjustment payments from “year of payment” to “year of eligibility” to reduce distortions caused by delayed payments

Managed Care Cost Avoidance Model
Current Status

- Not all of Mercer's recommendations have been implemented yet
  - Retroactive mass adjustments
  - FFS claims prior to enrollment in health plan
- Next steps
  - Complete final research and revisions to model
  - Consider developing "incurred" model

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